

Friday, 16 June 2023

(10.00 am)

LADY HALLETT: Yes, Ms Blackwell.

MS BLACKWELL: Good morning, my Lady. The evidence today will begin with me calling Professor Clare Bamba and Professor Sir Michael Marmot, who are present in the witness box. May they be sworn, please.

PROFESSOR SIR MICHAEL MARMOT (affirmed)

and

PROFESSOR CLARE BAMBRA (sworn)

Questions from COUNSEL TO THE INQUIRY

MS BLACKWELL: Thank you both. May I begin by thanking you both for the assistance that you've given to the Inquiry so far, and for agreeing to come and give evidence to the Inquiry today.

During the questioning, please keep your voices up and speak into the microphones so that the stenographer can take a note. If I ask you a question that isn't clear, please ask me to repeat it.

If you need a break at any time, please just indicate. We will have a break part-way through your evidence, but if you want one before that, please just say and we will rise.

My Lady, the report that has been jointly prepared by Professors Marmot and Bamba is at INQ000195843.

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an elected fellow of the Faculty of Public Health at the Academy of Medical Sciences, an honorary fellow of the Royal Society of Public Health, and the British Academy, and a foreign associate member of the Institute of Medicine.

In 2000 you were awarded a knighthood, and in 2023 made a companion of honour for services to public health. In 2008 you chaired the World Health Organisation Commission on Social Determinants of Health, and you led the seminal UK Government-commissioned Marmot Review, Fair Society Healthy Lives, in 2010, as well as the Health Equity in England: The Marmot Review 10 Years On in 2020, and Build Back Fairer: The COVID-19 Marmot Review in the same year.

Hot off the press, recently announced last week, you will co-chair the Global Council on Inequality, AIDS and Pandemics, researching and asks the questions: do inequalities drive pandemics, and what is the impact of pandemics and inequalities in health?

The report that you have prepared is split into topics, and we will deal with your evidence along the same lines, covering health inequalities, the health inequalities landscape in the UK, health inequalities in pandemic planning, the consequences of failing to take

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It's currently on the screen. My Lady, you can see that it's signed at the foot of each page by each of the professors, confirming that it's their own work. Please may we have permission to publish the report?

LADY HALLETT: You do, thank you.

MS BLACKWELL: Thank you.

We can take that down.

I'm going to begin by providing an introduction of your professional backgrounds and areas of expertise.

Turning first to you, Professor Bamba, you are a professor of public health in the Population Health Sciences Institute, at the Faculty of Medical Sciences at Newcastle University. You have extensively researched health inequalities, including the unequal impact of the Covid-19 pandemic. In 2013, you were elected as a fellow of the Academy of Social Sciences and in 2022 you were awarded senior investigator status with the National Institute for Health and Care Research academic college.

You are an academic co-director of Health Equity North and a member of the World Health Organisation Europe's scientific advisory group on health equality.

Professor Sir Michael Marmot, you are a professor of epidemiology and public health at the Institute of Health Equity, University College London. You are

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account of health inequalities, and the recommendations which lie at the end of your report.

May we put on the screen, please, page 4 of the report, and highlight paragraph 2. You begin your report in this way: explaining that:

"Health inequalities are the systematic, avoidable differences in health which exist between different social groups ... Health inequalities exist between different socio-economic groups (measured using indicators of socio-economic status, including income, education, occupation or area-level deprivation), by ethnicity, and are also experienced by other social minorities (such as 'inclusion health groups', or members of the LGBTQ+ community, or people with disabilities). The term health inequalities includes both (a) inequalities in health outcomes (eg mortality rates, life expectancy etc) as well as (b) inequalities in access to healthcare and inequalities in the outcomes of healthcare."

Please can you explain to the Inquiry what is meant by inequalities in health outcomes as compared to inequalities in access to healthcare, and how do these relate one to the other?

PROFESSOR MARMOT: Inequalities in health outcomes commonly we measure by mortality, life expectancy, healthy life

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1 expectancy, or some specific measures of morbidity.
2 There's been intense debate in the scientific field as
3 to how much of the systematic inequalities between
4 social groups in those health outcomes that I've just
5 described can be attributed to inequalities in access to
6 care.

7 **MS BLACKWELL:** Yes.

8 **PROFESSOR MARMOT:** When the Commonwealth Fund has looked at
9 health systems in 11 countries, consistently until --
10 maybe not anymore, but consistently until very recently,
11 the NHS always ranked number one on equity of access.
12 Which means that, by and large, most of the inequalities
13 in health that we see are not directly related to
14 inequalities in access to healthcare.

15 In the United States, for example, there's enormous
16 interest in inequalities in access to healthcare because
17 they are huge.

18 **MS BLACKWELL:** Yes.

19 **PROFESSOR MARMOT:** But in a way we're the control country.
20 Because we've done such a good job of getting equity of
21 access to healthcare because of our National Health
22 Service, by and large, the majority of the inequalities
23 in health that we see are not attributable to
24 inequalities in access to care.

25 **MS BLACKWELL:** Right. There are several social, economic
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1 Government in 2008 commissioning you to conduct your
2 review.

3 Was that review conducted only in relation to
4 England and not the other three nations?

5 **PROFESSOR MARMOT:** Yes, because health is a devolved
6 matter --

7 **MS BLACKWELL:** Yes.

8 **PROFESSOR MARMOT:** -- for the other nations, so although we
9 think that our report for England clearly applies in
10 Scotland, Wales and Northern Ireland, as well as
11 England, but officially it was England. I've had quite
12 a lot to do with the Welsh Government based on my
13 English report, and they're very interested in it, so
14 they clearly think the conclusions apply. But because
15 health is a devolved matter, it was set up for England.

16 **MS BLACKWELL:** Do you know if any similar reviews were set
17 up to deal with Northern Ireland, Wales and Scotland?

18 **PROFESSOR MARMOT:** In the wake of my 2020 review, Health
19 Equity in England: The Marmot Review 10 Years On, the
20 Health Foundation convened a review in Scotland -- I was
21 on the advisory board for that review -- and it was very
22 much along the same lines of my 2020 report.

23 Wales hasn't done it in the same way. They've had
24 the Future Generations Act, which has been very
25 important to thinking in Wales, but they haven't quite

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1 and environmental factors which impact on people's
2 health and can give rise to inequalities; is that right?

3 **PROFESSOR MARMOT:** It's what we call the social determinants
4 of health. I don't want to divert the Inquiry, but we
5 have another term that we use. You introduced me, I'm
6 the director of the Institute of Health Equity, and the
7 reason we've introduced that term, WHO tends to use it,
8 it's these avoidable differences in health which are
9 judged to be avoidable and are not avoidable, are
10 unfair, hence inequitable.

11 **MS BLACKWELL:** Right.

12 **PROFESSOR MARMOT:** That's why we tend to talk in terms of
13 health equity, social justice, which is a judgement
14 call, whereas what Clare -- forgive me if I refer to my
15 colleague as Clare rather than Professor Bambra -- what
16 Clare and I are looking at is the evidence of avoidable
17 health inequalities, and they're avoidable, because we
18 understand the social determinants of these systematic
19 differences, and we've laid them out.

20 **MS BLACKWELL:** Yes.

21 The World Health Organisation in 2005 set up the
22 global Commission on Social Determinants of Health to
23 examine the social factors leading to ill health and
24 health inequalities, and the commission was led by you,
25 Professor Marmot, and culminated in the United Kingdom

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1 done it in the same way.

2 **MS BLACKWELL:** And Northern Ireland?

3 **PROFESSOR MARMOT:** Northern Ireland hasn't. I've, from time
4 to time, talked to government people, public health
5 people, in Northern Ireland, but they haven't done it in
6 the same systematic way.

7 Pleasingly -- drop that word. No, pleasingly,
8 there's good collaboration in public health between
9 Northern Ireland and the Republic of Ireland. That is
10 pleasing that there's good collaboration. Because
11 public health crosses borders and we talk to each other
12 all over the place, and there's good collaboration, and
13 the Republic of Ireland has been intensely interested in
14 my review, and there's quite a lot of cross-border
15 discussion, collaboration on the island of Ireland.

16 **MS BLACKWELL:** Thank you.

17 So social determinants of health inequalities are
18 the conditions in which we are born, grow, live, work
19 and age. I'd like to look at some of those
20 individually, please.

21 If we can highlight paragraph 3 of your report.
22 Thank you.

23 "Inequalities in health by social economic status
24 are not restricted to differences between the most
25 privileged groups and the most disadvantaged: health

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1 inequalities exist across the entire social gradient ...
 2 Consistently, the finding has been that the lower the
 3 socio-economic position the worse the health, the higher
 4 the age-specific mortality rates and the shorter the
 5 life expectancy ... The social gradient in health runs
 6 from the top to the bottom of society and 'even
 7 comfortably off people somewhere in the middle tend to
 8 have poorer health than those above them' ... We first
 9 demonstrated the social gradient in health in the
 10 Whitehall Studies of British Civil Servants: the higher
 11 the grade of employment the longer the life
 12 expectancy ... By way of further example, on average,
 13 people in the highest occupational groups ... have
 14 better health outcomes than those in mid-ranking
 15 occupations ... who in turn have better health outcomes
 16 than those in the lowest occupational groups ...
 17 Similarly, people with a higher income or
 18 university-level education -- on average -- have better
 19 health outcomes than those with a lower income or no
 20 educational qualifications ..."

21 The key finding, then, is that the lower a person's
 22 socio-economic position, the worse their health, the
 23 higher the age-specific mortality rates and the shorter
 24 their life expectancy. Is that right? I can see you
 25 both nodding.

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1 available, and it's pretty systematic and comparable.
 2 Healthy life expectancy in one sense is much more
 3 important, because it's quality of life as well as
 4 length of life. But it's less readily available, and
 5 it's less comparable, particularly between countries
 6 within -- we are blessed in Britain -- I affirmed,
 7 I don't know where I got "blessed" from. But we're
 8 fortunate in Britain to have brilliant statistics, which
 9 is why we know as much as we know, pre-pandemic, and why
 10 we knew what we knew during the pandemic.

11 **MS BLACKWELL:** Yes.

12 **PROFESSOR MARMOT:** So we can look at healthy life
 13 expectancy. There are various ways of doing it, but
 14 it's asking people about disability or about good
 15 health, and that tends to come from the census, and then
 16 doing a calculation.

17 **MS BLACKWELL:** Yes.

18 **PROFESSOR MARMOT:** What's striking is that the social
 19 gradient in life expectancy is steep, the social
 20 gradient in healthy life expectancy is even steeper.

21 **MS BLACKWELL:** I don't want to interrupt you, but we're
 22 going to look at those figures now.

23 **PROFESSOR MARMOT:** Okay.

24 **MS BLACKWELL:** So could we have on screen, please, the
 25 subparagraphs of paragraph 12 in the report. Thank you.

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1 **PROFESSOR MARMOT:** Yes.

2 **PROFESSOR BAMBRA:** Yes.

3 **MS BLACKWELL:** You explore socio-economic geographical
 4 inequalities in the United Kingdom at paragraphs 8 to 13
 5 in your report. We don't need to look at them.

6 And we can take that down, please.

7 In summary, is it correct that those in more
 8 deprived areas have shorter lives and lives with more
 9 ill health?

10 **PROFESSOR BAMBRA:** Yes.

11 **MS BLACKWELL:** And that -- in terms of healthy life
 12 expectancy, are you able to give a definition of what
 13 that means in terms of inequality?

14 **PROFESSOR MARMOT:** Yes, I mean, we tend to look at life
 15 expectancy, it's an artefact, it's not predicting how
 16 long an individual will live, it's a way of summarising
 17 the current age-specific mortality rates. So it's
 18 saying if somebody born today was subject to today's
 19 age-specific mortality rates, that's how long they would
 20 live. But it's not predicting what the age-specific
 21 mortality rates will look like 50 years, 60 years,
 22 70 years from now. So it's a summary. We tend to use
 23 it because everybody counts deaths, all over the world,
 24 and you can get good comparisons. Not because we think
 25 length of life is the only thing that matters, but it's

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1 Could we just scroll down a little. Thank you.

2 So here are some of the figures, Professor Marmot,
 3 that you have just been explaining to us. Looking at
 4 paragraph 12.1 and dealing with the four nations
 5 separately:

6 "12.1. In England, healthy life expectancy at birth
 7 amongst men living in the 10% most deprived areas was
 8 52.3 years in 2017-2019, compared with 70.7 years among
 9 those living in the 10% least deprived areas."

10 Now, I've had my calculator out overnight, my Lady,
 11 and that is a difference of 18.4 years.

12 "Women in the most deprived areas could expect to
 13 live 51.4 years in 'Good' health compared with
 14 71.2 years in the least deprived areas ..."

15 A difference of 19.8 years.

16 Moving down to Scotland:

17 "12.2. In Scotland, healthy life expectancy at
 18 birth amongst men living in the 10% most deprived areas
 19 was 47.0 years in 2017-2019, compared with 72.1 years
 20 amongst those living in the 10% least deprived areas."

21 Which is a difference of 25.1 years, so that's
 22 almost a third of the healthy life expectancy:

23 "Women in the most in the most deprived areas could
 24 expect to live 50.1 years in 'Good' health compared with
 25 71.6 years in the least deprived areas."

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1 Which is a difference of 21.5 years.
 2 "12.3. In Wales, healthy life expectancy at birth
 3 in 2017-19 for men was lowest in the 10% most deprived
 4 areas at 51.8 years and highest in the least deprived
 5 10% of areas at 68.6 years, a difference of 16.9 years.
 6 Similarly, healthy life expectancy at birth for women in
 7 the most deprived areas was 50.2 years compared to
 8 68.4 years in the least deprived areas ..."
 9 Which is a difference of 18.2 years.
 10 "12.4. In Northern Ireland, the healthy life
 11 expectancy inequality gap between the 20% most and least
 12 deprived areas was 13.5 years for men and 15.4 years for
 13 women [over the same time period] ... The data presented
 14 here for Northern Ireland is by quintile (20% bands)
 15 whereas [the difference] is by decile (10% bands) for
 16 the other three countries. This reflects cross-national
 17 differences in how the data is published."
 18 Is that right?
 19 **PROFESSOR BAMBRA:** Yes.
 20 **MS BLACKWELL:** Right. Thank you, we can take that down,
 21 please.
 22 In relation to inequalities arising from ethnicity
 23 in health, you explain that there has historically been
 24 a lack of routine data linking ethnicity to mortality
 25 records, explaining an absence of official regular

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1 morbidity, than white people in England.
 2 **PROFESSOR BAMBRA:** Yes, there's better data for the various
 3 groups, including minority ethnic groups, when it comes
 4 to morbidity as opposed to mortality.
 5 **MS BLACKWELL:** Right.
 6 **PROFESSOR BAMBRA:** Obviously it's something that you can do
 7 on a survey basis, it's less complicated to measure and,
 8 yes, it varies obviously by different minority ethnic
 9 group, but there are certain conditions that are more
 10 likely to be worse in some groups than others. And
 11 certainly for indicators such as self-reported health or
 12 mental health, it's particularly poor in certain ethnic
 13 minority groups, yes.
 14 **MS BLACKWELL:** Is the pattern in terms of the data or lack
 15 of data similar one in Scotland and Wales?
 16 **PROFESSOR BAMBRA:** Yes, that's correct, and there's even
 17 less data available in Northern Ireland.
 18 **MS BLACKWELL:** Minority ethnic groups in England, Scotland
 19 and Wales experience substantial inequalities in the
 20 social determinants of health, and so you said,
 21 Professor Marmot, in your 2020 report.
 22 Could we display paragraph 28 of their report,
 23 please.
 24 All right, now, there are a series of inequalities
 25 in the social determinants of health in relation to

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1 information on life expectancies for different ethnic
 2 groups; is that right?
 3 **PROFESSOR BAMBRA:** Yes, that's right. There are
 4 complexities around calculating life expectancies by
 5 ethnicity, which we go into in detail in the report.
 6 **MS BLACKWELL:** Yes. What's the importance of data
 7 collection in respect of protected characteristics and
 8 other axes of inequalities, including the importance of
 9 disaggregated data?
 10 **PROFESSOR BAMBRA:** Yes, as Michael said, we have brilliant
 11 data when we're looking at area-level disadvantage in
 12 England and the other devolved nations, but when it
 13 comes to other groups that suffer from health
 14 inequalities, such as ethnic minorities, people from
 15 LGBTQ or inclusion health groups, then it's like
 16 a contrast of riches in terms of data compared to almost
 17 no or sparse data, where it mainly has to come from
 18 cohort studies conducted by individual universities and
 19 so on.
 20 The issues are that if you don't have any data, you
 21 don't know sufficiently what the health needs are of
 22 different populations in your community.
 23 **MS BLACKWELL:** But despite the absence of data, in your
 24 report you say that there is some evidence that ethnic
 25 minority people may have much poorer health, that is

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1 minority ethnic groups set out in subparagraphs of
 2 paragraph 28, starting with the:
 3 "28.1. Educational attainment at GCSE and degree
 4 levels [which] is highest for ... Chinese and Indian
 5 ethnic groups [but] Gypsy and Irish Travellers have the
 6 lowest level of qualifications at both levels ..."
 7 If we could move over the page, please, we can see
 8 that:
 9 "28.2. White and Indian minority ethnic groups are
 10 more likely to be in employment, with unemployment
 11 highest among Black and Bangladeshi/Pakistani
 12 populations ..."
 13 And that your review, Professor Marmot:
 14 "28.3 ... noted that ... people from ethnic minority
 15 groups are 'more likely to be in low-paid, poor quality
 16 jobs, with few opportunities for advancement, often
 17 working in conditions that are harmful to health. Many
 18 are trapped in a cycle of low-paid, poor-quality work
 19 and unemployment.'"
 20 And that:
 21 "28.4. 'Workers from minority ethnic groups are
 22 more likely to be on zero-hours contracts than White
 23 workers: 1 in 24 minority ethnic workers is on
 24 a zero-hours contract compared with one in 42 White
 25 workers, and minority ethnic workers are more likely

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1 than White workers to be on agency contracts ..."
 2 "28.5. Bangladeshi, Pakistani, Chinese and Black
 3 groups are about twice as likely to be living on a low
 4 income, and experiencing child poverty, as the White
 5 population ... In Wales, for example, there is a 29%
 6 likelihood of people whose head of household came from
 7 a non-white ethnic group living in relative income
 8 poverty compared to a 24% likelihood for those whose
 9 head of household came from a white ethnic group ..."

10 And so it goes on.

11 I want to just divert slightly to ask you both: what
 12 is the impact that racism can have on health
 13 inequalities?

14 **PROFESSOR BAMBRA:** There are different types of racism.

15 **MS BLACKWELL:** Yes.

16 **PROFESSOR BAMBRA:** At the interpersonal level, institutional
 17 level or at the structural level. A lot of the research
 18 that's been conducted has been done on interpersonal
 19 racism, so that's harassment, discrimination, and
 20 violence. Those studies obviously find significant
 21 impacts particularly on mental health but also on
 22 general health, and that that lasts across people's life
 23 course.

24 In terms of institutional and structural racism,
 25 there has been less research done in the UK on that,

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1 **PROFESSOR MARMOT:** I think of it in two ways. One exactly
 2 as Clare has just described, that racism leads to social
 3 disadvantage, but the second is what Clare was
 4 describing earlier, the direct psychosocial effect of
 5 racism. It's pretty miserable to be discriminated
 6 against.

7 And we've got -- this is emerging since Clare and
 8 I prepared our report -- we've got emerging evidence
 9 that if you look at school performance, early childhood,
 10 minority ethnic groups do well. Poor Bangladeshi kids
 11 do better than poor white kids in school. The
 12 discrimination and the prejudice seems to happen
 13 afterwards, when they go into further education or into
 14 employment.

15 So exactly what we've documented here of the
 16 employment disadvantage of belonging to a minority
 17 ethnic group, it's almost as if something happens after
 18 early education.

19 So, I think -- we're in agreement on this -- there
 20 are two ways to think about it: racism leads to social
 21 and economic disadvantage, but there may be direct
 22 psychosocial effects of racism.

23 **MS BLACKWELL:** Thank you.

24 I want to turn away from racism and race for
 25 a moment and look at what are described as "inclusion

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1 although we do know from studies, for example in
 2 America, the impacts that structural racism, so the way
 3 in which society is organised, and how that is embedded
 4 within laws and cultural norms, we know that that can
 5 have an impact, for example in America, in terms of
 6 infant mortality rate gaps, and when certain laws were
 7 changed to become more inclusive of ethnic minorities
 8 there, then you see an improvement in infant mortality
 9 rates amongst those groups.

10 **MS BLACKWELL:** Right. So, taking that together with what we
 11 see set out in the subparagraphs of paragraph 28 of your
 12 report, what is your conclusion in terms of how race
 13 might affect health determinants?

14 **PROFESSOR BAMBRA:** People from minority ethnic groups are
 15 much more likely to be living in deprivation, so
 16 everything that Professor Marmot outlined in terms of
 17 the health impacts of poverty, housing and so on applies
 18 kind of even more so, it's amplified for people from
 19 minority ethnic groups.

20 So, for example, 50% of Bangladeshi and Pakistani
 21 households are in the 20% most deprived neighbourhoods,
 22 compared to 17% of the white population.

23 **MS BLACKWELL:** Thank you.

24 **PROFESSOR MARMOT:** If I could add?

25 **MS BLACKWELL:** Yes, please.

18

1 health groups".

2 Can we please display paragraph 33 of the report.
 3 Thank you. Could we highlight paragraph 33. Thank you
 4 very much.

5 "According to NHS England ... inclusion health
 6 groups are people who are socially excluded 'who
 7 typically experience multiple overlapping risk factors
 8 for poor health, such as poverty, violence and complex
 9 trauma'. Inclusion health groups include 'people who
 10 experience homelessness, drug and alcohol dependence,
 11 vulnerable migrants, Gypsy, Roma and Traveller
 12 communities, sex workers, people in contact with the
 13 justice system and victims of modern slavery'. People
 14 belonging to inclusion groups tend to have poor health
 15 outcomes, negative experiences of healthcare and a lower
 16 average age of death ... For example, a systematic
 17 review of over 300 scientific studies conducted in
 18 high-income countries (including the USA, Australia,
 19 Sweden, Canada and the UK) which was published in
 20 *The Lancet* found that mortality rates were significantly
 21 higher amongst people with a history of homelessness,
 22 imprisonment, sex work, or substance use disorder than
 23 amongst the general population, particularly for deaths
 24 due to injury, poisoning, and other external causes ...
 25 Research suggests that the adverse health experiences of

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1 inclusion health groups result from stigma, trauma,
2 social exclusion, discrimination and victimisation."
3 That's quite a wide description of various factors
4 that might affect someone's life. But is the analysis
5 of the level at which their lives are affected, in terms
6 of the lower average age of death and negative
7 consequences of healthcare, quite common amongst those
8 groups?

9 **PROFESSOR BAMBRA:** Yes, as it's stated there from the
10 scientific evidence.

11 **MS BLACKWELL:** Yes.

12 Can you explain to us what is meant by
13 intersectionality, please?

14 **PROFESSOR BAMBRA:** Yes, intersectionality is a way of
15 thinking about how people have different aspects of
16 social identity, so, for example, I'm a woman but I'm
17 also white and I'm also LGBTQ, and so I would get
18 certain advantages in life, for example, from whiteness,
19 but I might get disadvantages from being a woman. So
20 I experience the social world and therefore the health
21 consequences of that in different ways, from a privilege
22 or subordination.

23 **MS BLACKWELL:** Thank you.

24 Finally on this topic, could we highlight
25 paragraph 34, please:

21

1 curve. The rate of improvement slowed dramatically and
2 then stopped improving. One question this raises is
3 whether we have simply reached peak life expectancy; the
4 rate of improvement has to slow some time. However,
5 comparisons with other countries answer this question.
6 The slowdown in life expectancy growth during the decade
7 after 2010 was more marked in the UK than in any other
8 rich country, except Iceland and the USA ..."

9 Is it right that the only G7 country with lower life
10 expectancy going into the pandemic than the UK was the
11 United States?

12 **PROFESSOR MARMOT:** That's correct.

13 **MS BLACKWELL:** Yes.

14 Are you able, Professor Marmot, to give us a picture
15 of how the healthcare situation, the state that it was
16 in at the time that the pandemic hit, not only in terms
17 of healthcare but also in terms, for instance, of
18 vacancies in hospitals or the situation in which nurses
19 found themselves, and give us a full complexion of what
20 that picture looked like?

21 **PROFESSOR MARMOT:** As I said earlier, most of the health
22 differences that we see are not attributable to
23 healthcare, but to health. Let me make two comments
24 about this slowdown in improvement in health post-2010.

25 The first is close to unprecedented -- it's hard to

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1 "LGBTQ+ groups (lesbian, gay, bisexual, transgender,
2 and queer or questioning), also experience health
3 inequalities. Whilst data is lacking in terms of
4 mortality, life expectancy or physical health, there is
5 strong evidence of higher prevalence of mental health
6 issues amongst LGBTQ+ people ... For example, a review
7 of UK studies found higher rates of mental health
8 problems amongst LGBTQ+ people including attempted
9 suicide, self-harm, anxiety and depression ... This
10 review also found evidence of higher substance (alcohol
11 and tobacco) abuse amongst LGBTQ+ people. Mental health
12 services were perceived to be discriminatory by LGBTQ+
13 people. Researchers have suggested that this increased
14 morbidity is potentially a result of stigma, social
15 exclusion, discrimination and victimisation ..."

16 Thank you.

17 I'm going to move on now to ask about the health
18 inequalities landscape in the United Kingdom, and begin,
19 please, with what is described in your report as
20 a slowdown in health improvement.

21 Could we display, please, paragraph 36 at page 15:

22 "Until 2010, life expectancy in the UK had been
23 increasing at about one year every four years. This
24 trend had continued for all of the 20th century, with
25 small deviations. In 2010/11, there was a break in the

22

1 overstate how important this is: that we were used, as
2 a country, based on the evidence, to expect health to
3 get better every year. Fewer babies would die, fewer
4 old people would die, health would improve year on year
5 and that's what the history of the 20th century led us
6 to expect. And in 2010 that rate of improvement slowed
7 dramatically, more marked in the United Kingdom than in
8 any other rich country except Iceland and the
9 United States. That's really dramatic. It slowed in
10 many countries, but nowhere near to the extent that that
11 improvement in life expectancy slowed in the UK.

12 Second -- we've described the social gradient in
13 health -- the social gradient got steeper, so the
14 inequalities got bigger, and, particularly for people
15 from the northeast, what we saw was a decline in life
16 expectancy. A decline. Not just a slowdown in
17 improvement, a decline in life expectancy for people in
18 the bottom 10% of deprivation, the most deprived, in
19 every region of the country except London.

20 So the regional inequalities got bigger.

21 If you were lucky enough to be in London, then the
22 consequence of deprivation for your health was not as
23 bad as if you were deprived in the northeast or the
24 northwest.

25 **MS BLACKWELL:** I'm going to display some charts now which

24

1 I hope you can take us through that demonstrate the
 2 evidence you've just given, Professor Marmot.
 3 Could we have on the screen, please, paragraphs 39
 4 and 41. Thank you very much.
 5 What do we see here, Professor Marmot or
 6 Professor Bambra? We can see that the title of the
 7 figure is "Life expectancy at birth by sex, four
 8 countries of the UK", so that's between 2010 and 2012 to
 9 2016 to 2018.
 10 **PROFESSOR MARMOT:** Well, I say to my Welsh colleagues, "You
 11 look like England, only more so" -- which they don't
 12 like much -- because the slowdown was more marked in
 13 Wales and Scotland than in England. Now, there may be
 14 a number of reasons for that. One might be that England
 15 is the wrong comparator for Wales, maybe it should be
 16 northeast or northwest England, because of
 17 post-industrial effects on poverty and the like. But
 18 what we see is this slowdown in improvement in all four
 19 countries of the United Kingdom.
 20 **MS BLACKWELL:** Let's look, please, briefly at each of the
 21 countries separately, starting with Scotland, at
 22 paragraphs 40 and 41. Next page, please.
 23 (Pause)
 24 Figure 3 on page 20, please. Yes, thank you.
 25 **PROFESSOR MARMOT:** So, Scotland, when I said Wales is like
 25

1 **PROFESSOR MARMOT:** The patterns are pretty much the same.
 2 There is a consistent phenomenon in the data globally --
 3 well, amongst high income countries -- that if you look
 4 at life expectancy, the variations tend to be bigger for
 5 men than for women. When you look at ill health, the
 6 variations tend to be bigger for women than for men.
 7 And Clare may have a better answer to that than I do,
 8 but if I say I don't know the reason for that, I can
 9 then speculate, but it's troubled all of us for a very
 10 long time that women seem to have more morbidity, more
 11 ill health, and in fact, with what happened post-2010,
 12 we saw a particular impact on ill health in women going
 13 up. So the life expectancy figures, it's both genders,
 14 but particularly reported ill health was going up for
 15 women.
 16 **PROFESSOR BAMBRA:** The life expectancy for women in the most
 17 deprived areas has had declines in some cases as well.
 18 So, for example, in some of the areas of the northeast,
 19 it's lower than it was ten years ago.
 20 **MS BLACKWELL:** Thank you.
 21 May we go to figure 4 on page 21, please. We can
 22 see the same information plotted on figures for Wales,
 23 and is this a similar pattern to what we have seen in
 24 the previous two --
 25 **PROFESSOR MARMOT:** Yes.
 27

1 England only more so, Scotland is like the northeast and
 2 northwest of England, only more so. Look at the decline
 3 in life expectancy in the most deprived group.
 4 **MS BLACKWELL:** Which is at the bottom of each of these
 5 figures, yes.
 6 **PROFESSOR MARMOT:** So this is using an index of multiple
 7 deprivation, the same index across the UK, and you can
 8 see the improvement in life expectancy in the least
 9 deprived quintile --
 10 **MS BLACKWELL:** Yes.
 11 **PROFESSOR MARMOT:** -- and going up a bit in the next two
 12 quintiles, you can see it declining after 2010 in the
 13 second poorest quintile, and declining quite markedly in
 14 the poorest quintile. So the inequalities are getting
 15 bigger and life expectancy for the bottom 40% -- earlier
 16 I said the bottom 10% -- the bottom 40% is getting
 17 worse.
 18 That's really -- I mean, I can't overstate it, it's
 19 really shocking to those of us in the health field, as
 20 well as to ordinary people: the idea that it's no longer
 21 the case that you can look forward to better health year
 22 on year, it's actually getting worse.
 23 **MS BLACKWELL:** Just to confirm, the top figure relates to
 24 males and the bottom figure relates to females, but the
 25 patterns are pretty much the same.
 26

1 **MS BLACKWELL:** -- charts? Thank you.
 2 Then, finally, can we go to Northern Ireland,
 3 please, which is on page 22, figure 5.
 4 **PROFESSOR MARMOT:** Look at the dramatic decline. There you
 5 can actually see for the bottom 60%, the most
 6 deprived 60%.
 7 **MS BLACKWELL:** In relation to both men and women?
 8 **PROFESSOR MARMOT:** Yes.
 9 **MS BLACKWELL:** Yes.
 10 **PROFESSOR MARMOT:** So you asked me -- I hadn't finished
 11 answering your question --
 12 **MS BLACKWELL:** Sorry, I interrupted you.
 13 **PROFESSOR MARMOT:** -- where we were up to 2019.
 14 **MS BLACKWELL:** Yes.
 15 **PROFESSOR MARMOT:** In my 2010 review, drawing both on the
 16 World Health Organisation Commission on Social
 17 Determinants of Health, which I chaired, and the work of
 18 nine task groups, expert task groups that we set up to
 19 bring the evidence together, we made six domains of
 20 recommendations: give every child the best start in
 21 life; education and lifelong learning; employment and
 22 working conditions; number four was everyone should have
 23 at least the minimum income necessary for a healthy
 24 life; number five was healthy and sustainable places in
 25 which to live and work; number six, taking a social
 28

1 determinants approach to prevention.

2 We said: if you follow these six domains of
3 recommendations, health will improve and health
4 inequalities will diminish.

5 So then we get to -- notice we didn't say anything
6 about healthcare, for the reasons that I said earlier,
7 that the National Health Service delivered great equity
8 of access to healthcare, and in fact -- a slightly
9 complicated point -- in a way, it goes the other way.
10 What we see is that the usage of the healthcare system
11 follows the social gradient in that the more deprived
12 the area the greater the usage of the healthcare system.
13 Not because people are overusing it, but because they're
14 sick. There's more illness. So it's actually
15 inequalities in health that are putting the burden on
16 the healthcare system, not the healthcare system that's
17 responsible for inequalities in health. It actually
18 goes the other way.

19 That said, we do need a healthcare system when we
20 get sick, and where we were pre-pandemic, if you look at
21 funding for the healthcare system -- and we put this in
22 the report, adjusting for the size of the population and
23 the ageing of the population -- if you've got more
24 people, you need to spend more money on healthcare; if
25 you've got more older people, you need to spend more

29

1 There were already vacancies climbing in --

2 **MS BLACKWELL:** Vacancies of clinicians --

3 **PROFESSOR MARMOT:** Oh, doctors and nurses.

4 **MS BLACKWELL:** Yes.

5 **PROFESSOR MARMOT:** Climbing. I can't give you the figures
6 for 2019. The most recent figures suggest 150,000
7 vacancies of doctors and nurses, but there were already
8 vacancies, which puts great pressure on the existing
9 staff. Then we know there were real problems of morale.

10 There had been the first doctors' strike in the 2010s.
11 There was real concern over pay for doctors and nurses,
12 which was part of the concern over public sector pay in
13 general. But before the cost of living crisis, nurses'
14 pay had gone down by 5% over the period from 2010.

15 I'm not going to get into the intricacies of the
16 doctors' calculations of which is the right figure, but
17 doctors' pay had clearly gone down.

18 So pay and conditions, vacancies, morale, were
19 really adverse in 2019 before the pandemic.

20 **MS BLACKWELL:** The figures that you gave a moment ago relate
21 to funding the NHS in England. What about social care?

22 **LADY HALLETT:** Sorry, before we go on, I think there are two
23 separate issues. We have had the graphs on life
24 expectancy and we've now moved on to funding of the NHS.

25 Can I just go back to the graphs for a second.

31

1 money on healthcare. Older people get sick, that's the
2 nature of it. So just looking at a blanket figure for
3 spending doesn't tell you enough. And we drew on
4 figures from the Nuffield Trust that said during the
5 government from 1979 to 1997, healthcare spending went
6 up about 2% a year, after you adjust for the size of the
7 population and the ageing of the population.

8 **MS BLACKWELL:** Yes.

9 **PROFESSOR MARMOT:** In the government from 1997 to 2009, it
10 went up at 5.7, 5.8% a year. 2010, it went up by
11 minus 0.07%, and then the next five years, minus 0.03%.

12 So, adjusting for the size of the population and the
13 ageing of the population, the increase was negative
14 after 2010.

15 Now, we know, even after adjusting for population
16 size, you need positive growth because of new
17 technology, which is expensive and so on. So the
18 funding of the healthcare system was inadequate
19 post-2010.

20 If you take January 2009 the number of people
21 waiting for NHS treatment as a benchmark, it was at
22 the -- in 1997 it was about 2.3 times what it was at the
23 low level of 2009. By 2019 it had doubled compared with
24 2009. So pre-pandemic the number of people waiting for
25 NHS treatment was twice as high as it had been in 2009.

30

1 **PROFESSOR MARMOT:** Sure.

2 **MS BLACKWELL:** Of course.

3 **LADY HALLETT:** Forgive me for interrupting, Ms Blackwell.

4 **MS BLACKWELL:** Not at all.

5 **LADY HALLETT:** I confess a lack of understanding of graphs
6 on occasion -- I used to describe to colleagues I had
7 graph blindness -- so forgive me if I don't really
8 follow. But could we go back to the graph which is on
9 the screen at page 22.

10 The funding point is obviously really important and
11 we will get back to it, I promise.

12 But, as I understand it, graphs -- the way in which
13 you can get lines going like that or going like that can
14 depend a lot on the extent of space you give to your
15 differences, to your various criteria.

16 So when we look at the bottom graph, females, am
17 I reading it correctly, one or both of you, the vertical
18 graph, the vertical line axis is 78, 81, 84 years of
19 age. Is that right?

20 **PROFESSOR MARMOT:** That's correct.

21 **LADY HALLETT:** So between 78 to 81 we have got 79, 80, so if
22 we roughly fit it in, the graph seems to start, in
23 2015-2017, at the age of 80, have I got that -- no, it's
24 probably about 79.5. It's hard to say.

25 **PROFESSOR MARMOT:** Yes.

32

1 **LADY HALLETT:** Then it goes along and then it comes down,
 2 and I'm going to guess it comes down to about 79.
 3 **MS BLACKWELL:** My Lady, are you looking at the female chart?
 4 **LADY HALLETT:** I'm looking at the female chart, the most
 5 deprived.
 6 **PROFESSOR MARMOT:** Yes.
 7 **LADY HALLETT:** So I get from the graphs the significant
 8 difference between the most advantaged and the most
 9 deprived. At the moment what I'm not getting -- and
 10 that's why I'm asking for your help -- is a dramatic
 11 decrease in life expectancy if you take into account
 12 what -- the line really is reflecting what ages. So
 13 we're going from roughly 79.5 to about 79, and so my
 14 question is: is that a dramatic decrease?
 15 **PROFESSOR MARMOT:** Yes. Forgive me for this comment,
 16 I think you understand the graph perfectly well.
 17 I don't think you've got graph blindness at all.
 18 Yes, it is dramatic. Half a year doesn't sound like
 19 much, but if you think that the history had been
 20 increasing one year every four years, half a year means
 21 we've just lost two years of improvement. So it doesn't
 22 sound like a lot, but it's actually a lot.
 23 I mean, one year every four years, if you say to
 24 somebody, you know, "Run round the block three times
 25 a week and you'll add to year to your life expectancy",

33

1 **MS BLACKWELL:** As we have seen, the downward trajectory, the
 2 pattern is the same, for women and for men, in all
 3 four nations.
 4 **PROFESSOR MARMOT:** In all four nations. And, as I said
 5 earlier, in England we see a bigger fall in northern
 6 parts of the country than we do in London and the
 7 southeast.
 8 **MS BLACKWELL:** Well, before we leave this area of evidence,
 9 may we put up figure 6 at page 24, please. This is the
 10 figure for life expectancy at birth by sex for the least
 11 and most improved deciles in each region between 2010
 12 and 2016 or 2018.
 13 What do we see here, Professor Marmot?
 14 **PROFESSOR MARMOT:** The first thing we see is, if you look at
 15 the least deprived decile, the regional differences are
 16 relatively small. If you're rich, it matters less which
 17 part of the country in which you reside and I think
 18 that's quite important. The poorer you are, which is
 19 actually in figure 7, but the poorer you are, the more
 20 it matters where you live.
 21 **MS BLACKWELL:** Well, let's look at figure 7, please, because
 22 I think that is of greater interest to what you're
 23 saying. Here we see "Life expectancy at birth by sex
 24 and deprivation deciles in London and the North East",
 25 and this is what you were talking about before, the

35

1 they would probably say, "The game's not worth the
 2 candle. A year, who the hell cares?" Because it's the
 3 nature of the measure, it's not very informative, it
 4 hardly seems worth running round the block just to get
 5 another year, from 79 to 80. But it's a summary
 6 measure. So half a year is really quite a lot, it's
 7 quite a great deal.

8 I mean, your point is well taken. If we had, as
 9 we're taught in first year, to put the zero and -- you
 10 wouldn't be able to see any difference, because it would
 11 all be clustered up the top. So, to that extent, we've
 12 disobeyed the rule of always putting it at zero, so you
 13 could actually see the differences.

14 So your question is perfectly appropriate, but the
 15 comparison is not: well, what does half a year mean?
 16 It's: we expect one year every four years, and we got
 17 half a year drop. That's really quite a dramatic
 18 difference.

19 **PROFESSOR BAMBRA:** And if I could just add, it's in this
 20 historical trend of increasing life expectancy over the
 21 20th century, with the exception of World Wars, so
 22 a fall like this -- and we've also seen a corresponding
 23 increase in infant mortality rates in the lead-up to the
 24 pandemic -- are historically unprecedented from a public
 25 health perspective.

34

1 stark difference between the area in the country that
 2 you live, in which you live.

3 **PROFESSOR MARMOT:** And it's really terribly important,
 4 because this is a national index of multiple
 5 deprivation, so it's the one index that's being applied,
 6 and if you're deprived, it's worse to be in the north,
 7 if you're in the north it's worse to be deprived.

8 I mean, it's almost intersection in the way --

9 **PROFESSOR BAMBRA:** Yes, intersection of place, yes.

10 **PROFESSOR MARMOT:** -- Clare was describing it before.

11 **MS BLACKWELL:** What do we see in these charts at figure 7,
 12 please?

13 **PROFESSOR MARMOT:** So the greater -- for both London and the
 14 northeast, the greater the deprivation, the shorter the
 15 life expectancy. The gradient is steeper in the
 16 northeast than it is in London. So, as I was
 17 describing, the consequences for life expectancy are
 18 bigger if you're in the northeast and deprived than if
 19 you're in London and deprived.

20 Then, crucially, if you look at the dotted line --
 21 look at London and look at the dotted line and the solid
 22 line. So the dotted line --

23 **MS BLACKWELL:** Is the earlier period, isn't it?

24 **PROFESSOR MARMOT:** The dotted line is 2010 to 2012, and the
 25 solid line is 2016 to 2018. Look at London. You see at

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1 every point along the gradient life expectancy improved.
 2 Now look at the northeast. Life expectancy -- and
 3 particularly you see it more clearly for women. Look at
 4 the bottom graph for women. Life expectancy fell in the
 5 poorest decile. It fell marginally in the next poorest
 6 decile. It didn't improve for the bottom six deciles.
 7 It's only in the top 40% that you get an improvement.
 8 And you see it more clearly for women, it's a similar
 9 picture for men, but more clearly.
 10 So if we then go back to figure 6, if we may, it's
 11 not just the northeast, it's every region virtually
 12 outside London. If you're in the least deprived 10%,
 13 life expectancy went up a bit, the regional differences
 14 were relatively small. If you're in the most
 15 deprived 10%, the regional differences are much bigger,
 16 and life expectancy went up in London and went down in
 17 virtually every region outside London.
 18 **MS BLACKWELL:** Is that more pronounced in the bottom figure
 19 here for females? We can see it very clearly.
 20 **PROFESSOR MARMOT:** Yes, it is, and -- I'm sorry if I'm
 21 jumping ahead to your next question.
 22 **MS BLACKWELL:** Not at all, no, please.
 23 **PROFESSOR MARMOT:** But I said that I can't explain the
 24 male/female differences. When we published these
 25 figures in our 2020 report, it was put to me that the

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1 If you look at spending per person, total spending
 2 per person by local authorities, in the least
 3 deprived 20% the spending per person went down by 16%,
 4 and then the greater the deprivation, the greater the
 5 reduction. In the most deprived 20%, it went down
 6 by 32%.
 7 Now, if you were in government and worked on the
 8 assumption that everything local government does is
 9 a waste of space, then you can cut and not expect any
 10 adverse consequences. If you're not of that view, and
 11 I and Clare are not of that view, what local government
 12 does is quite important, like adult social care, like
 13 amenities, like childcare and all the good things that
 14 local government does.
 15 If you cut in that regressive way -- and I've shown
 16 these figures to economists who say, "You're making this
 17 up, I've never seen such neatly regressive settlements",
 18 but these are the government figures, the graph I've got
 19 comes from these two fiscal studies but it's based on
 20 government figures; the greater the deprivation, the
 21 greater the need; the greater the need, the greater the
 22 reduction in local authority spend in general, and on
 23 adult social care specifically -- that will damage the
 24 health of people, other things equal, and will
 25 contribute to inequalities in health.

39

1 burden of austerity fell on women to a much greater
 2 extent than on men. The various cuts had a bigger
 3 impact on women's lives than on men's lives. And when
 4 that was put to me -- we didn't put it in our report --
 5 I had to say, "Yes, that sounds credible to me". So
 6 I hadn't put it in my 2020 report, but it's at least
 7 a credible explanation for what's going on here.
 8 **MS BLACKWELL:** Thank you.
 9 So we've looked -- we can take that down now, thank
 10 you very much -- at life expectancy, we've looked at NHS
 11 funding, and I was coming on to ask you about
 12 social care funding and what happened to social care
 13 funding. What was the effect of it over the course of
 14 the ten years leading up to the pandemic?
 15 **PROFESSOR MARMOT:** If you look at social care funding per
 16 person by local authority, the spend per person by local
 17 authority, for the least deprived 20% of local
 18 authorities, social care spending per person went down
 19 by 3%, and then the greater the deprivation of the area,
 20 the steeper the cuts in social care spend. In the most
 21 deprived 20%, it went down by 17%.
 22 Now, arguably the greater the deprivation, the
 23 greater the need. The greater the need, the greater the
 24 reduction in spending and it was part of the settlement
 25 to local government spending in general.

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1 **MS BLACKWELL:** Thank you.
 2 I want to draw all this together now, please, and
 3 have a look at your expert opinion as you've set out in
 4 the course of your report.
 5 First of all, may we look at paragraph 57. That's
 6 at page 29. Thank you.
 7 "The overall impression that UK government austerity
 8 policies post-2010 had an adverse effect on health
 9 inequalities is also supported by analyses of England
 10 showing that health inequalities narrowed in the period
 11 of high public expenditure from around 2000 to 2010, and
 12 began to widen again post-2010 ..."
 13 As you have outlined in your evidence.
 14 "Scientific research has found that between 2000 and
 15 2010, geographical inequalities in life expectancy,
 16 infant mortality rates and mortality amenable to
 17 healthcare were reduced in England ... In contrast,
 18 these inequalities have increased since 2010 ..."
 19 The next paragraph, please:
 20 "Substantial systematic health inequalities by
 21 socio-economic status, ethnicity, area-level
 22 deprivation, regime, socially excluded minority groups
 23 and inclusion health groups existed during the relevant
 24 period."
 25 The relevant period being between 2010 and the onset

40

1 of the pandemic.

2 "There is evidence that such health inequalities
3 increased during the relevant period. The majority
4 scientific view is that the underlying causes of health
5 inequalities are the social determinants of health: the
6 conditions in which people are born, grow, live, work,
7 and age. It is plausible that adverse trends in these
8 social determinants of health since 2010 led to the
9 worsening health picture in the decade before the onset
10 of the pandemic. In short, the UK entered the pandemic
11 with its public services depleted, health improvement
12 stalled, health inequalities increased and health among
13 the poorest people in a state of decline."

14 Does that accurately reflect your conclusion in this
15 area?

16 **PROFESSOR BAMBRA:** Yes.

17 **PROFESSOR MARMOT:** Yes.

18 **MS BLACKWELL:** Thank you.

19 My Lady, I'm about to move on to health inequalities
20 and pandemic planning, and I wonder whether that would
21 be a suitable time to take our mid-morning break.

22 **LADY HALLETT:** Certainly. I shall return at 11.20.

23 (11.06 am)

(A short break)

24 (11.20 am)

41

1 **MS BLACKWELL:** More recently, however, and post pandemic,
2 the documents that you have considered and analysed do
3 tend to begin, at least, to consider those with
4 vulnerabilities and health inequalities; is that right?

5 **PROFESSOR BAMBRA:** Yes, there has been an improvement and
6 a broadening of what the term "vulnerable" means within
7 the risk registers, which is to be welcomed.

8 **MS BLACKWELL:** Thank you.

9 You also looked at the Civil Contingencies Act
10 of 2004, and a series of both statutory and
11 non-statutory guidance that is relevant to that Act of
12 Parliament.

13 What did you find in relation to those bodies of
14 work in terms of reflection on vulnerabilities and
15 inequalities?

16 **PROFESSOR BAMBRA:** Obviously these documents refer to all
17 different types of civil emergency, so it could be
18 a flood, a terrorist act, or indeed a pandemic. So the
19 definition of vulnerability used within those documents
20 is often quite narrow, such as, you know, people who
21 might have difficulties helping themselves in the event
22 of an emergency, very narrow and somewhat outdated, and
23 doesn't really apply across when we think about it from
24 a public health or a pandemic perspective.

25 **MS BLACKWELL:** On that point, may we display paragraph 97 of

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1 **MS BLACKWELL:** Thank you, my Lady.

2 We're now going to consider the extent to which
3 inequalities were taken into account in pandemic
4 planning by the United Kingdom Government and the
5 devolved administrations. I think, Professor Bambra, it
6 falls to you to answer most of the questions in relation
7 to this topic.

8 You were good enough to consider a wealth of
9 documentation which was provided to you, most of which
10 has been obtained by the Inquiry during the course of
11 its preparation for these public hearings, including
12 a series of National Security Risk Assessments and
13 National Risk Register processes.

14 Am I able to summarise the position in relation to
15 the NSRA and NRR documents in this way: that up to very
16 recent editions of those assessments, there has been no
17 mention at all of consequences, risk consequences on any
18 vulnerable groups?

19 **PROFESSOR BAMBRA:** Yes, the risk registers pre-pandemic that
20 we reviewed had very little by way of vulnerability
21 other than clinical risk factors or age in some cases,
22 and there was certainly nothing in terms of,
23 for example, minority ethnic groups, deprivation, other
24 things which we know are major factors in the Covid
25 pandemic.

42

1 your report, please. I'm afraid I don't have a page
2 number for that.

3 **LADY HALLETT:** 40?

4 **MS BLACKWELL:** I think it might be page 40, thank you.

5 The previous page, thank you.

6 Here, just to underline the point -- thank you --
7 you are referring to the glossary of the Civil
8 Contingencies Act and you say:

9 "... vulnerability is defined as 'the susceptibility
10 of individuals or a community, services or
11 infrastructure to damage or harm arising from
12 an emergency or other incident' ..."

13 What comment do you have upon the description there
14 and the definition?

15 **PROFESSOR BAMBRA:** I think from a health perspective we'd
16 obviously define vulnerability differently, as we did in
17 our earlier comments about the different types of health
18 inequalities.

19 **MS BLACKWELL:** Yes. All right.

20 I'd like now to look, please, at a different
21 document. It's the witness statement of Mark Lloyd, who
22 is the chief executive of the Local Government
23 Association. It's at INQ000177803.

24 Can we go, please, to page 43, which is
25 paragraph 160.

44

1 Just to put this in context, one of the
 2 non-statutory pieces of guidance which you looked at to
 3 the Civil Contingencies Act is the emergency response
 4 and recovery guidance; is that right?
 5 **PROFESSOR BAMBRA:** That's right.
 6 **MS BLACKWELL:** Thank you.
 7 It's page -- thank you. Now, paragraph 160 of
 8 Mr Lloyd's statement reads as follows:
 9 "There is an expectation that in formulating
 10 emergency plans, LRFs and individual agencies including
 11 local authorities will take into account the needs of
 12 vulnerable people. Vulnerability is not framed in
 13 government guidance in terms of protected
 14 characteristics, nor is it clearly, or narrowly,
 15 defined, but instead includes broad references to
 16 children and young people; faith, religious, cultural
 17 and minority ethnic communities; and elderly people and
 18 people with disabilities. Previous research from the
 19 British Red Cross ... published shortly before Covid
 20 indicates different practices on whether vulnerability
 21 is defined in local plans, and on whether this is seen
 22 as a responsibility of the [local resilience forum] or
 23 of councils. However, the [Local Government
 24 Association] understands that there is very limited
 25 direction and no specific requirement from Government as
 45

1 terms?
 2 **PROFESSOR BAMBRA:** Yes, I think part of the problem with
 3 some of the work that we reviewed is that because the
 4 Civil Contingencies Act, as I said, is for all different
 5 types of emergency --
 6 **MS BLACKWELL:** Yes.
 7 **PROFESSOR BAMBRA:** -- they're either going to have a very
 8 broad definition or, you know, potentially a narrow one.
 9 But when we're thinking specifically about pandemic
 10 planning as an emergency, then obviously, for the
 11 reasons that Michael and I outlined earlier, it's very
 12 important you think about which groups are going to have
 13 the highest health risk and that, of course, could
 14 differ completely from people who might be most affected
 15 by a flood or terrorism. We have much better data on
 16 being able to predict and ascertain which social and
 17 economic groups would be most impacted by a pandemic,
 18 and that needs to be reflected in these types of
 19 guidance when they're thinking about a pandemic.
 20 **MS BLACKWELL:** Thank you.
 21 You also looked at the Dame Deirdre Hine review from
 22 July of 2010, which was brought about as a result of the
 23 swine flu in 2009, the H1N1 pandemic response.
 24 What did you discover about the level of
 25 consideration within that review to vulnerable groups?
 47

1 to the issues for which councils and [local resilience
 2 forums] should test and exercise, even where these could
 3 be identified as national level rather than local
 4 issues."
 5 Does that reflect what you found in your analysis of
 6 the relevant guidance?
 7 **PROFESSOR BAMBRA:** I think I'd slightly disagree with the
 8 list of -- you know, saying there's broad references to
 9 these different groups, because the balance, in my
 10 reading of the 40 or so documents, is that predominantly
 11 it would be children, older people, sometimes people
 12 with disabilities, and on very rare occasions would you
 13 get mention of faith or minority ethnic communities,
 14 you know, literally like once or twice, and often in the
 15 context of perhaps adherence or responses to behavioural
 16 messaging, rather than in a: how can we help people in
 17 an emergency?
 18 **MS BLACKWELL:** Does this demonstrate that there was,
 19 certainly in amongst the legislation and the guidance
 20 that you have considered, no common definition of
 21 vulnerability, and those suffering from health
 22 inequalities and matters of that nature?
 23 **PROFESSOR BAMBRA:** Yes.
 24 **MS BLACKWELL:** And is it important, in your view, that there
 25 should be a common understanding and definition of these
 46

1 **PROFESSOR BAMBRA:** Yes, the Hine review was the independent
 2 inquiry into H1N1 and, again, vulnerability was largely
 3 defined in terms of clinical risk factors: age,
 4 pregnancy, that sort of thing. Nothing in terms of
 5 a broader definition of thinking about health
 6 inequalities. And there is, as we present in the
 7 report, evidence that there were socio-economic and
 8 ethnic inequalities in the swine flu pandemic in England
 9 and Wales.
 10 **MS BLACKWELL:** So did it surprise you that there was little,
 11 if any, reference to those within the report?
 12 **PROFESSOR BAMBRA:** The report pre-dates the research studies
 13 by a few years. However, the research studies use
 14 official government data, so I would be surprised if the
 15 government didn't have access to that data before the
 16 researchers.
 17 Secondly, we know about seasonal flu, the
 18 inequalities we see in that replicate the inequalities
 19 we see in swine flu, for example, and also other
 20 respiratory tract infections, which, for example, are
 21 higher in some British Asian groups. So yes, I was very
 22 surprised that the 2010 report didn't think about the
 23 health inequalities that had happened within that small
 24 pandemic.
 25 **MS BLACKWELL:** Just to set out what some of those
 48

1 inequalities were, and we don't need to put this up now,
 2 but these are set out in paragraphs 174 through to 176
 3 in your report, the mortality rate in the most
 4 deprived 20% of England's neighbourhoods, in relation to
 5 swine flu, was three times higher than in the least
 6 deprived 20%, and a study of ethnic inequalities in
 7 mortality from the swine flu in England found people
 8 from some minority ethnic groups experienced
 9 an increased mortality risk compared to the white
 10 population during the pandemic, with the highest risk of
 11 death being in those of Pakistani ethnicity and the
 12 lowest in the black minority ethnic group.

13 **PROFESSOR BAMBRA:** That's correct.

14 **MS BLACKWELL:** Thank you.
 15 You also looked at the United Kingdom influenza
 16 pandemic preparedness strategy for 2011, and what did
 17 you find in relation to any reference to vulnerabilities
 18 or inequalities in that document?

19 **PROFESSOR BAMBRA:** That reflected the Hine review and was
 20 an update of the previous 2007 flu strategy. Again, as
 21 with the other documents, clinical risk factors and age
 22 are the only references to vulnerability or
 23 inequalities.

24 **MS BLACKWELL:** Nothing --

25 **PROFESSOR BAMBRA:** Nothing in terms of socio-economic status

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1 **MS BLACKWELL:** Yes.

2 **PROFESSOR BAMBRA:** So the concern from that point of view
 3 would be that there would be no anticipation or planning
 4 or thinking about how different groups, different
 5 communities, different parts of the country, could
 6 potentially be more at risk and more affected by
 7 a pandemic.

8 **MS BLACKWELL:** You reviewed the material generated by
 9 several exercises, Winter Willow, Taliesin, Valverde,
 10 Alice, Silver Swan, Broad Street, Cerberus and Pica.
 11 Were health inequalities examined in any of those
 12 exercises?

13 **PROFESSOR BAMBRA:** No, they were not.

14 **MS BLACKWELL:** You also considered the material surrounding
 15 Exercise Cygnus, to which you've just made reference,
 16 in 2016. Does the Cygnus report mention planning for
 17 local surges? I think this is set out in paragraph 137
 18 of your report where you say it does mention local
 19 surges:
 20 "... but the potential role of area-level
 21 deprivation or other community characteristics (eg the
 22 ethnic composition of the population) in leading to
 23 local surges is not discussed [at all]."

24 **PROFESSOR BAMBRA:** Yes, so thoughts about where you might
 25 get local surges or where you're more likely to get them

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1 or minority ethnic groups, for example.

2 **MS BLACKWELL:** There was also an additional document
 3 connected to that strategy, entitled "Analysis of Impact
 4 on Equality" report. Did you look at that as well?

5 **PROFESSOR BAMBRA:** Yes, I looked at that, it was an equality
 6 impact assessment that they needed to do under the
 7 Equality Act.

8 **MS BLACKWELL:** What are your concerns, if any, about the way
 9 in which that was carried out?

10 **PROFESSOR BAMBRA:** Again, it's limited in terms of -- it's
 11 trying to think about how the flu strategy might have
 12 unequal effects, and I think it's very limited in terms
 13 of how it conceives that, and thinking about how
 14 different groups might be differently affected is not
 15 thought about within that, that exercise.

16 **MS BLACKWELL:** If that document, the strategy, was still in
 17 place in the run-up to the pandemic -- which we know it
 18 was -- and had not been updated, what do you have to say
 19 about the fact that that document had very little, if
 20 any, consideration of the effect of a pandemic on those
 21 with health inequalities and vulnerabilities?

22 **PROFESSOR BAMBRA:** So the 2011 document was updated,
 23 for example, after Exercise Cygnus in 2016, but again it
 24 still did not have any references to the health
 25 inequalities we've talked about.

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1 because of the risk profile of the community is not
 2 thought about.

3 **MS BLACKWELL:** Yes, finally on this topic, may I ask that
 4 the following document is displayed: INQ000192271, at
 5 page 4, paragraph 15.
 6 This is the witness statement provided to
 7 the Inquiry by Sir Christopher Wormald,
 8 Permanent Secretary of the Department of Health and
 9 Social Care, which of course, as you know, was the lead
 10 government department for pandemic risk.
 11 If we can highlight paragraph 15, please:
 12 "In terms of how the Department [that's the
 13 Department of Health and Social Care] approaches its
 14 duties in respect of equalities, any such impacts are
 15 routinely assessed and taken into account during the
 16 formation of policies and the decision-making process,
 17 which generally takes place in the usual Government
 18 fashion [that is] by the provision of submissions to the
 19 decision-maker(s)."
 20 Based upon the evidence that you have seen and the
 21 wide range of documents that you have considered, does
 22 it appear that equality impacts have been routinely
 23 assessed and taken into account in the formation of
 24 policies relating to pandemic preparedness?

25 **PROFESSOR BAMBRA:** In the documents that we looked at, there

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1 was only the one equality impact assessment, which we've
2 just discussed, so out of a whole body of work there was
3 only one from 2011, so I don't think we could see that
4 as routinely assessed in regards to the planning.

5 **MS BLACKWELL:** Thank you.

6 We can take that down, please.

7 You were asked by the Inquiry team to address the
8 following question: did the specialist structures
9 concerned with risk management and civil emergency
10 planning allow for the proper consideration of
11 structural racism and its impact?

12 Did you find that there was no mention of structural
13 racism or its potential impacts in any of the planning
14 documents reviewed under this topic, nor were there any
15 considerations of other causes of health inequalities in
16 the documents, such as social determinants of health or
17 austerity?

18 **PROFESSOR BAMBRA:** No, there was no mention of health
19 inequality, so there was certainly no mention of any of
20 the causes of the health inequalities.

21 **MS BLACKWELL:** Are you able to give the Inquiry an example
22 of how structural racism might have been utilised during
23 the course of the preparation of these documents? How
24 it might have appeared?

25 **PROFESSOR BAMBRA:** I think having a knowledge of who was
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1 Turning, then, please, to the consequences of
2 failing to take account of health inequalities, you
3 describe, Professor Bamba, the Covid-19 pandemic as
4 syndemic. Can you explain to us, please, what you mean
5 by that?

6 **PROFESSOR BAMBRA:** Yes, it's because Covid acted
7 synergistically with existing socio-economic and health
8 inequalities to exacerbate and amplify the impacts of
9 the pandemic but also the impacts of those existing
10 inequalities.

11 **MS BLACKWELL:** Within the report you outline five key
12 pathways through which existing inequalities in the
13 social determinants in health result in higher mortality
14 and morbidity from an infectious respiratory virus.
15 Could you take us through those, please.

16 **PROFESSOR BAMBRA:** Yes, the first one is about how people
17 are unequally exposed to the virus. So if we think,
18 for example, of key workers, many of whom were from
19 minority -- disproportionately from minority ethnic
20 groups and from low paid employment sectors, then they
21 were more likely to be exposed because they were still
22 going in to work when a lot of office workers were
23 working from home.

24 The second pathway is about unequal transmission.
25 So once you have an infection within a community, if
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1 most likely to be at risk and why that might be the case
2 would be the way that you would think about using that
3 within a planning document. But, as I said, there is
4 kind of no reflection on which groups might be at risk.
5 So it would be quite difficult for them then to think
6 about why they might be at risk when they're not
7 thinking about them at all.

8 **MS BLACKWELL:** So let's move, please, to look at
9 paragraph 149 of your report. In fact we don't need to
10 display this, I'm able to summarise it in these terms:
11 did you both conclude in relation to this topic that,
12 with some exceptions, the specialist structures
13 concerned with risk management in civil emergency
14 planning did not properly consider societal, economic
15 and health impacts in light of pre-existing inequalities
16 and the UK Government and the devolved administrations
17 and relevant public health bodies did not systematically
18 or comprehensively assess pre-existing social and
19 economic inequalities and the vulnerabilities of
20 different groups during a pandemic in their planning for
21 risk assessment processes?

22 **PROFESSOR BAMBRA:** That's correct, that's our expert
23 opinion.

24 **PROFESSOR MARMOT:** Yes.

25 **MS BLACKWELL:** Thank you very much.
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1 people are in an urban area or if they're in a smaller
2 property, more overcrowded property, then it's much more
3 likely to spread. If they're less likely to
4 self-isolate because of, for example, low payments for
5 being off sick during the pandemic, then that could
6 increase spread, again a risk that is higher in more
7 deprived areas and amongst minority ethnic groups.

8 The third one is the unequal vulnerability, and so
9 this is thinking about pre-existing health conditions.
10 So, for example, if you have diabetes or a heart
11 condition, then you're more vulnerable if you get the
12 illness.

13 The fourth one is the unequal susceptibility. So
14 this is thinking about actually, as Professor Marmot's
15 work has shown, people have lower immune responses from
16 the result of the chronic stress of psychosocial
17 factors, so we can think about that, that links across
18 to what Professor Marmot was saying about the
19 psychosocial impacts of racism and being in a social
20 hierarchy, so you have a suppressed, compared to someone
21 more affluent, for example, immune system, so again,
22 you're more vulnerable to an adverse event as a result
23 of your infection.

24 The final pathway would be about unequal treatment,
25 so in terms of, for example, access to antivirals or the
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1 vaccine. Of course, in the UK case, that inequality is
2 there, we can see that in the vaccine uptake,
3 for example.

4 **MS BLACKWELL:** Thank you.

5 So did you conclude in relation to this topic that:

6 "The UK entered the pandemic with increasing health
7 inequalities and health among the poorest people in
8 a state of decline. [That you] knew from previous
9 pandemics and research into lower respiratory tract
10 infections that people from lower socio-economic
11 backgrounds, people living in areas or regions with
12 higher rates of deprivation, and people from minority
13 ethnic groups and people with disabilities, are much
14 more likely to be severely impacted by a respiratory
15 pandemic. Lack of consideration of pre-existing social
16 and ethnic inequalities in health in our pandemic plans
17 may have meant that our responses were unable to
18 mitigate the disproportionate impact experienced by
19 minority ethnic, low socio-economic status and other
20 socially excluded communities."

21 **PROFESSOR BAMBRA:** Yes.

22 **MS BLACKWELL:** Thank you.

23 Before we turn to your recommendations, I just have
24 a couple of questions to ask you about what is contained
25 in section 6 of your report under the topic whole-system

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1 I was in New Orleans a year and a bit after
2 Hurricane Katrina. We had a workshop there and, as my
3 colleague said, Katrina -- the reason for the workshop
4 was not to hit the US Government round the head because
5 of their mismanagement of the hurricane and its
6 consequences, but it exposed the fault lines in American
7 society.

8 The people who were affected by Katrina were poor
9 and African American, overwhelmingly. In the Lower
10 Ninth Ward, which was flooded, coming back, what was
11 left were liquor stores, no health clinics, no place to
12 buy groceries, nothing normal. If you were sick, you
13 couldn't get treatment a year and a half after Katrina.

14 So you get these big external shocks and that's why
15 we say they expose the underlying inequalities in
16 society and amplify them.

17 Now, I don't think of dental caries as a big
18 external shock, but the reason I started with that was
19 to show that, whatever's happening, we see your social
20 position determines your susceptibility to that big
21 shock.

22 **MS BLACKWELL:** Thank you.

23 Going back some time to the Spanish flu and when
24 that hit in England and Wales, have you,
25 Professor Bamba, considered a case study that

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1 catastrophic shocks. To what extent do whole-system
2 catastrophic shocks expose or amplifies pre-existing
3 health inequalities, please?

4 **PROFESSOR MARMOT:** Building on what Clare has just laid out
5 in relation to infectious disease, if you plot on
6 a graph -- I know this is Module 1, but if you plot on
7 a graph mortality from Covid, now plot on a graph
8 childhood obesity by deprivation, it looks the same.
9 The more deprived, the greater the childhood obesity.
10 It looks the same. We don't think childhood obesity is
11 caused by a virus. Now, plot a graph and look at dental
12 caries in children by deprivation. Looks the same.

13 So, in other words, social and economic inequalities
14 are increasing risk to whatever the threat is going to
15 be. So then when you get a big external shock,
16 a pandemic, of course, a hurricane, a tsunami, civil
17 unrest, it is entirely predictable, and that's exactly
18 what happens: the lower the socio-economic position, the
19 greater the deprivation, the greater the consequences of
20 this big external threat.

21 So we know in Puerto Rico, when Hurricane Maria hit,
22 the excess mortality, over predicted, was highest in
23 people of low socio-economic position, middle in people
24 of socio-economic position, and lowest in people of high
25 socio-economic position.

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1 demonstrates strong geographical inequalities, even at
2 that time, in terms of who was affected and the manner
3 and severity with which they experienced the pandemic?

4 **PROFESSOR BAMBRA:** Oh, yes, and it reflects what Michael was
5 saying about the social patterning. When you look at
6 what happened in 1918 Spanish flu, then you find there
7 were socio-economic inequalities. We can see that from
8 data, historical data from different European countries
9 and from North America, there were racial inequalities
10 in the mortality. Higher amongst people with
11 disabilities, for example, in a Norwegian study. And in
12 England and Wales, higher in urban compared to rural
13 areas and also higher in the north and parts of Wales
14 than in the south of England.

15 **MS BLACKWELL:** Thank you.

16 So moving, then, please, to your recommendations.

17 Can we display, please, page 82 of your report, and
18 begin at paragraph 199. Thank you.

19 If we read through this together, please. You begin
20 your recommendations in this way:

21 "Based on the research and analysis conducted within
22 this report, [you] make the following recommendations:

23 "199.1. Reduce health inequalities so that the
24 health of all communities across the UK is better placed
25 to withstand future pandemics. This requires different

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1 actions in each of the four UK nations but in each case,
2 it should be based on ..."

3 I'm sorry, my screen has gone off -- there we are,
4 it's back on, mid-sentence.

5 I'll start from the beginning of that sentence
6 again:

7 "This requires different actions in each of the four
8 UK nations but in each case, it should be based on key
9 learning from the Marmot Reviews of 2010 and 2020 which
10 set out the following six evidence-based areas for
11 policy action ..."

12 Now, Professor Marmot, you've made reference to this
13 already, but would you please take us through these
14 subparagraphs.

15 **PROFESSOR MARMOT:** "Give every child the best start in
16 life."

17 We know that early child development is actually
18 crucial to what happens to children in school. What
19 happens in school is crucial to what happens post
20 school, in the world of work, which is important for
21 income, where you live, and in terms of health and
22 health inequalities. So it all starts at the beginning
23 of life. Not just because of health of children, but
24 because of the consequences of early child development
25 for what happens later. And we know that adverse

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1 at the evidence from previous pandemics, including the
2 current one that we're considering --

3 **MS BLACKWELL:** Yes.

4 **PROFESSOR MARMOT:** -- that the impact of the pandemic is
5 very much influenced by pre-existing inequalities in
6 society, including inequalities in health.

7 **MS BLACKWELL:** Yes.

8 **PROFESSOR MARMOT:** So action -- it's not just specific
9 pandemic planning, it's not just whether there's
10 a report somewhere in government about planning for
11 a pandemic; you've got to plan for better health, and
12 narrow health inequalities, and that will protect you
13 from the pandemic.

14 **MS BLACKWELL:** Thank you.

15 **PROFESSOR MARMOT:** So that's the general point.

16 **MS BLACKWELL:** That's the point.

17 Let's move, then, please, to paragraph 199.3,
18 because here I think you do draw together the health
19 equity lens and the pandemic planning and preparation
20 that my Lady needs to consider in her recommendations.

21 "Pandemic planning and preparation should integrate
22 a health equity lens across all aspects of the process.
23 It should consider if, in future pandemics, additional
24 social groups should be added to those based on age or
25 clinical risk. This could lead to prioritising access

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1 childhood experiences have a dramatic impact on mental
2 health subsequently and, increasingly the evidence
3 shows, on physical health.

4 So good early child development has the positive
5 component of nurturing, supporting and so on, and the
6 negative of adverse childhood experience, and both of
7 those follow the social gradient, the greater --

8 **LADY HALLETT:** I apologise for interfering. There is
9 a limit to what I can do in conducting this Inquiry, and
10 as noble as this recommendation and aim may be, I think
11 it may be stretching beyond my terms of reference or
12 what it's possible for me to recommend and achieve.

13 **MS BLACKWELL:** I take that into account, my Lady.

14 Professor, in terms of the key learning that was set
15 out in your review and what you're expressing and
16 explaining now, are there specific matters which you can
17 draw together in order to explain how it affects risk
18 management and pandemic planning?

19 I appreciate that you're setting out the principles
20 behind what lies in your review in terms of giving every
21 child a start in life and creating fair employment and
22 good work, but are you able to draw that together and
23 bring it back to what her Ladyship has to consider in
24 terms of recommendations in this module of the Inquiry?

25 **PROFESSOR MARMOT:** Yes. My general view is that if you look
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1 to testing, PPE, vaccines, and antiviral medications.

2 Public communication messages about risk and mitigating
3 actions should be both universal for the whole
4 population and targeted to specific at-risk communities.
5 Suitable PPE equipment should be stockpiled in advance
6 and distributed according to relative occupational risk.
7 Enhanced testing should be conducted within at risk
8 communities. Inequalities between and within
9 communities (eg Local Authorities, voluntary sector and
10 NHS capacity) in terms of the ability and capacity to
11 respond to pandemics needs to be addressed. A
12 'universal proportionalism' strategy should be applied
13 in future pandemic planning so that mitigations are
14 delivered for the whole population (universalism) but
15 enhanced for those most in need (proportionalism)."

16 So, planning, taking into account all of the
17 vulnerabilities and health inequalities, but also
18 enhancing preparations, resources, for those who are
19 most at need?

20 **PROFESSOR BAMBRA:** Yes, this reflects what we looked at in
21 terms of the planning documents and the lack of regard
22 for different types of social inequality, so we're
23 suggesting here that these, ethnicity, deprivation and
24 so on, should be added as risk factors in terms of
25 pandemic planning, and then of course this has

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1 implications. It's not just about having a plan, like
 2 Michael says, but what does that plan mean, for example
 3 in terms of public communications? Having it translated
 4 into minority ethnic languages, for example, would
 5 clearly be a strong recommendation.

6 **MS BLACKWELL:** So it's all well and good having a set of
 7 documents that purport to have considered these issues,
 8 but what really matters are the practicalities that need
 9 to be in place for when the next pandemic hits?

10 **PROFESSOR BAMBRA:** Yes, what does it mean and what do we
 11 need to do differently and better, and we've made some
 12 suggestions, my Lady, as a way to start off thinking
 13 about this, yes.

14 **MS BLACKWELL:** Thank you very much.
 15 Well, my Lady, those are my questions.

16 **PROFESSOR MARMOT:** Can I --

17 **MS BLACKWELL:** Would you excuse my back, please, whilst
 18 I just take instructions on who is going next?

19 **LADY HALLETT:** Of course.
 20 **MS BLACKWELL:** Thank you.

21 (Pause)

22 My Lady, as with other witnesses, you have given
 23 a provisional indication that those representing the
 24 Covid-19 Bereaved Families for Justice UK are entitled
 25 to ask questions on a particular topic, and I think

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1 everyone. So the response rates are much lower,
 2 for example, in some minority ethnic groups. So that
 3 means you don't necessarily have a clear concise
 4 knowledge of the population size. We also have
 5 difficulties in recording mortality, so the deaths, in
 6 terms of whether ethnicity is coded or not.
 7 Putting those together, and obviously it's more
 8 complicated that I've alluded to here, and we go through
 9 some of the further issues in the report, it means you
 10 haven't got the numbers correct either in terms of
 11 population size or deaths in order to make accurate
 12 estimates, for example of life expectancy, and we also
 13 have migration patterns where people come in and go out,
 14 and so you find different results in terms of life
 15 expectancy for British minority ethnic groups who are
 16 British-born compared to more recent migrants,
 17 for example.

18 So there are complexities. The ONS has produced
 19 what they call experimental statistics, and that's
 20 because of these complexities in the calculation to do
 21 with the data, what data is available.

22 As to why we don't try to have better data in terms
 23 of minority ethnic groups and other socially excluded
 24 populations, I'm afraid I don't have an answer for that
 25 one. But clearly the health and public health community

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1 Ms Munroe King's Counsel is ready to step up and ask her
 2 questions now, subject to your Ladyship's permission.
 3 **LADY HALLETT:** Certainly. Yes, please, Ms Munroe,
 4 thank you.

Questions from MS MUNROE KC

6 **MS MUNROE:** Thank you, my Lady.

7 Good morning, Professor Bamba, good morning,
 8 Professor Marmot. My name is Allison Munroe and
 9 I represent the Bereaved Families UK, and I just have
 10 a very few questions to ask you on the topic of data
 11 capture, surveillance monitoring.

12 Ms Blackwell King's Counsel very helpfully raised
 13 the issue and introduced it earlier this morning, and in
 14 answer to a question from her regarding the paucity of
 15 data and statistics for certain groups in the
 16 population, Professor Bamba, you said:

17 "The issues are that if you don't have any data, you
 18 don't know sufficiently what the health needs are of
 19 different populations in your community."

20 Are you able to explain why there has historically
 21 been this lack of routine and reliable data, firstly in
 22 relation to ethnicity?

23 **PROFESSOR BAMBRA:** Yes. So we're very reliant on the census
 24 in terms of, for example, thinking about calculating
 25 life expectancy, but the census doesn't actually capture

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1 need to do better in terms of making sure that we record
 2 people, because if there's no data, there's no problem,
 3 we don't see the health needs, we don't see the
 4 disparities.

5 **MS MUNROE:** Thank you.

6 Likewise, are you able to assist with this question:
 7 the paucity of, again, reliable, regularly reported data
 8 in respect of other marginalised communities, such as
 9 the LGBTQ+ community, disabled people?

10 **PROFESSOR BAMBRA:** Yes. So could in a way be seen as kind
 11 of hidden populations, so it's only in the most recently
 12 census that there has been questions asked about,
 13 for example, people's sexual identity. But again, you
 14 wouldn't necessarily have that recorded at the mortality
 15 point. So it's about how much data you want to record
 16 and how much data people are happy to share. But
 17 certainly that's why there's less.

18 There is more in terms of survey data, for example,
 19 hence we know quite a bit about mental health, but there
 20 is less when we're looking at mortality or causes of
 21 death.

22 **MS MUNROE:** Would it be correct to say that during the
 23 relevant period that this Inquiry is concerned with,
 24 that you both are of the view that there was an obvious
 25 need for a national system of data capture based upon

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1 race, ethnicity and the other marginalised groups that
 2 we've been discussing this morning?
 3 **PROFESSOR BAMBRA:** I think if we had had that, with the
 4 caveats that I've outlined, then we certainly would have
 5 had more knowledge of who was most likely to be
 6 impacted, their specific health needs, and so on.
 7 However, because of looking at the planning documents,
 8 I'm not sure that would have been taken into account in
 9 planning, even if we had had such a robust data capture
 10 system.
 11 **PROFESSOR MARMOT:** If I could add, I lamented in my 2020
 12 review the lack of routine data on minority ethnic
 13 groups. I'm pleased to say that the Race and Health
 14 Observatory, the NHS Race and Health Observatory, is now
 15 set up with the explicit mission of redressing that
 16 problem, of making sure that we do get regular data by
 17 minority ethnic status.
 18 **MS MUNROE:** Professors, when one talks about national
 19 systems, are we talking about a UK-wide data capture or
 20 does it need to be broken down into the constituent
 21 parts of the UK?
 22 **PROFESSOR BAMBRA:** Currently the data -- because health is
 23 devolved, then the data is set up by each nation, so if
 24 that process would continue then each country would need
 25 to do that, yes, and then it would be up to them if they

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1 social determinants of health, and so we need to
 2 understand ethnic differences in all the key
 3 determinants.
 4 Saving my Lady's patience, I won't go through them
 5 all, but we do need to understand not just
 6 socio-economic differences but ethnic differences in
 7 those social determinants. So it means we need to have
 8 them across all those domains.
 9 **MS MUNROE:** Ade Adegemi, who is from the Federation of
 10 Ethnic Minority Healthcare Organisations, FEHMO, who
 11 will in due course be giving evidence to the Inquiry, he
 12 has described the absence of a national system of data
 13 capture regarding race and ethnicity as being perhaps
 14 one of the most egregious and the biggest system
 15 failures in emergency planning to be exposed by the
 16 pandemic.
 17 Would you concur with his observations there?
 18 **PROFESSOR BAMBRA:** I guess there were quite a few flaws, in
 19 the planning that we've talked about today, with regard
 20 to health inequalities and groups not being considered
 21 within, for example, the risk register or the
 22 contingencies and civil emergency planning. And
 23 certainly the lack of data is also an important
 24 hindrance, yes.
 25 **MS MUNROE:** And you've talked about the lack of data and how

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1 wanted to harmonise that across the UK.
 2 **MS MUNROE:** What, in your opinion, has been the impact of
 3 the lack of data with regards to pandemic planning and
 4 preparedness, for example, modelling and tracking the
 5 pandemic disease? What has been that impact of the lack
 6 of data?
 7 **PROFESSOR BAMBRA:** So, again, if you're not -- when you're
 8 thinking of modelling what the pandemic might look at
 9 and you're only looking at average or overall effects,
 10 you're obviously missing, then, whether it's going to
 11 affect some groups of people, some areas, more than
 12 others, so that might influence your decisions about
 13 what you'd do. So if you had health inequalities
 14 embedded in your modelling, in your data collection
 15 processes, then you could feed that in to how you think
 16 about resource deployment, for example, in the early
 17 stage of the pandemic.
 18 **MS MUNROE:** Should that data gathering, and specifically
 19 we're talking about minority ethnic groups, other
 20 marginalised groups within the population, disabled
 21 people, LGBTQ community, should such data gathering
 22 reach beyond healthcare?
 23 Professor Marmot, you're nodding.
 24 **PROFESSOR MARMOT:** Yes, very much so. I mean, if -- the
 25 whole thrust of what we have been doing is about the

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1 that impacts upon planning, modelling, tracking the
 2 disease. Would you agree that it's also important in
 3 terms of laboratory and case studies, in epidemiological
 4 studies in any event?
 5 **PROFESSOR BAMBRA:** Yes, absolutely, as Michael was
 6 outlining, we would need to have more data, not just in
 7 studying pandemics and planning, but in studying all
 8 other issues of health and disease as well.
 9 **MS MUNROE:** Finally, if we can just go back to your
 10 conclusions, if we could have it up, please, my Lady, at
 11 page 83 of the report.
 12 **LADY HALLETT:** Sorry, which of the questions you were going
 13 to ask is this one, Ms Munroe?
 14 **MS MUNROE:** Yes, it is, my Lady, it's the last. I've
 15 changed the order slightly. I think that's ...
 16 Thank you. If we could look at paragraph 199.6,
 17 that's your very final paragraph, where you've
 18 identified the need for robust data surveillance and
 19 monitoring of health -- healthcare inequalities in
 20 respect of protected characteristics, other minority and
 21 marginalised groups in the UK, as a whole.
 22 Dr Marmot, I think it was you who said, just before
 23 I stood up, that reducing health inequalities means
 24 better health, and that means protection from pandemics.
 25 So is it fair to say that a robust data surveillance

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1 and monitoring system is also crucial in order to
 2 identify, assess and, importantly, mitigate against
 3 health inequalities generally?
 4 **PROFESSOR MARMOT:** Absolutely. I said earlier that we have
 5 excellent statistics, routine statistics, available in
 6 this country, much better than most other countries, but
 7 a lack has been the one that we have just been
 8 discussing, the routine data available for minority
 9 ethnic groups, which is absolutely crucial to
 10 understanding health, health inequalities, and the
 11 likely impact of a pandemic.
 12 **MS MUNROE:** Thank you very much, Professor Marmot,
 13 Professor Bamba. Thank you, my Lady.
 14 My Lady, before I sit down, before I stood up
 15 actually, I think -- I may be wrong -- that
 16 Professor Marmot looked as if he had his hand up to say
 17 something else. I don't know if that's right.
 18 **PROFESSOR MARMOT:** I did, but that was long past.
 19 **LADY HALLETT:** You can't remember now? I have had that
 20 feeling before now.
 21 Thank you very much indeed, Professors Marmot and
 22 Bamba, you have been extremely helpful, if some of the
 23 stuff you have had to tell me has been rather
 24 depressing. But anyway, thank you very much indeed for
 25 all that you've done.

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1 administrative matters relating to your evidence.
 2 You've produced two witness statements, I believe, the
 3 first a first witness statement dated 3 April 2023,
 4 could we have that, please, on the screen, INQ000145773.
 5 Then the last page, page 35, please. Is that your
 6 statement of truth and your name?
 7 **A.** It is.
 8 **Q.** Then your second statement, incongruously perhaps called
 9 the third witness statement, INQ000203354. Thank you.
 10 Ah, no, it's the "Supplementary witness statement", not
 11 a third, although I think it says "Statement No. 3" in
 12 the top right. Then page 4, please. Again, is that
 13 a statement of truth, which you've signed, and your name
 14 and date?
 15 **A.** It is.
 16 **Q.** You've produced, very helpfully, a number of exhibits.
 17 We won't go through them all, or perhaps even many. But
 18 have you also made yourself familiar with the corporate
 19 witness statements provided on behalf of the
 20 Cabinet Office --
 21 **A.** Yes.
 22 **Q.** -- in which, of course, you worked during part of the
 23 relevant period? You have seen and considered, no
 24 doubt, the statements from your colleague,
 25 Mr Hargreaves, there have been a number of those

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1 **PROFESSOR MARMOT:** Thank you.
 2 **MS BLACKWELL:** Thank you, my Lady, and that concludes their
 3 evidence.
 4 I think we are ready to go straight on to the next
 5 witness, Katharine Hammond. It just needs a quick
 6 change around in the witness box. I don't think,
 7 my Lady, you need to rise. Thank you very much.
 8 **(The witnesses withdrew)**
 9 **MR KEITH:** Yes, if the oath or affirmation could be put,
 10 please.
 11 **MS KATHARINE HAMMOND (affirmed)**
 12 **Questions from LEAD COUNSEL TO THE INQUIRY**
 13 **LADY HALLETT:** Thank you for coming a bit earlier than
 14 expected, Ms Hammond, we're very grateful.
 15 **THE WITNESS:** No problem.
 16 **MR KEITH:** Ms Hammond, whilst you give evidence, could
 17 I remind you to try to keep your voice up. It's very
 18 important that we hear what you have to say, and also
 19 that the stenographers can hear you clearly for the
 20 transcript.
 21 If I ask a question that's not clear, which is quite
 22 possible, please ask me to put it again. There will be
 23 a break at lunchtime, and we'll break in the course of
 24 the afternoon as well.
 25 May I please commence with just some of the

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1 statements, and also the statement of Alex Chisholm, who
 2 was the Permanent Secretary at part of the relevant time
 3 for the Cabinet Office, and its chief operating officer,
 4 or at least the chief operating officer for the Civil
 5 Service. And also a statement from
 6 a Mr Matthew Collins, who was the Deputy National
 7 Security Adviser. So you have had an opportunity of
 8 looking at that material?
 9 **A.** I have.
 10 **Q.** Ms Hammond, in August of 2016, you became the director
 11 of the Civil Contingencies Secretariat in the
 12 Cabinet Office. Is that the same job that Bruce Mann,
 13 from whom we heard yesterday, held a few years prior to
 14 your occupation of that post, in fact between 2004 and
 15 2009?
 16 **A.** Yes, it is.
 17 **Q.** Is it the same job, in fact, that Mr Hargreaves, to whom
 18 I've just made reference, who provided the corporate
 19 statements, has held since you left that post in 2020?
 20 I think you left in August 2020 and he took up the
 21 position in October 2020.
 22 **A.** That's right, although the structure has evolved since
 23 then, and Mr Hargreaves now leads the COBR unit rather
 24 than the Civil Contingencies Secretariat as a whole.
 25 **Q.** Indeed.

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1 Now, Ms Hammond, it's plain to the Inquiry that
2 you're not responsible, of course, for the drawing up,
3 let alone the management and supervision of the EPRR
4 systems in this country. You're also not a corporate
5 witness for the whole of government. But are you in
6 a position to assist the Inquiry with areas relating to
7 the EPRR system that might technically go outwith the
8 precise functions identified as the director, once upon
9 a time, of the Civil Contingencies Secretariat?

10 **A.** I will do my absolute best to assist.

11 **Q.** Thank you.

12 May we start with the position of the
13 Cabinet Office. In relation to the issue of the
14 management or supervision of or liaising between other
15 government departments, what is the Cabinet Office's
16 primary role? What does it do in the field of civil
17 contingencies insofar as other government departments
18 are concerned?

19 **A.** The Cabinet Office role is primarily one of
20 co-ordination between departments. That, I think, is
21 the simplest way of putting it.

22 **Q.** So it supports government decision-making, it acts as
23 a broker, it promotes and advances, as best it can, the
24 corporate position of the government; it helps set it
25 out, it helps manage it, and it helps bring about proper

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1 **Q.** -- without a difference.

2 But in any event, Ms Hammond, the CCS was the body
3 in the Cabinet Office essentially charged with preparing
4 for, responding to, recovering from and learning lessons
5 from major civil emergencies?

6 **A.** That's right.

7 **Q.** If one was to ask the very basic and perhaps a little
8 unfair question, "Who is in charge, which body or which
9 secretariat or which part of the government is in
10 charge, or was in charge at the time you were director
11 of civil emergencies in the United Kingdom?" what body
12 would that have been?

13 **A.** I think CCS is the point at which that comes together.

14 "In charge" implies that there are --

15 **(Alarm)**

16 **Q.** Just pause a moment.

17 **A.** Sure. I haven't touched anything.

18 **Q.** Don't worry, Ms Hammond.

19 **LADY HALLETT:** I was told there wouldn't be a fire alarm
20 today.

21 **MR KEITH:** I don't think we were anticipating a test, which
22 may require us, in the best traditions of civil
23 emergencies, to leave. Or not.

24 Could you tell my Lady, please, in very broad terms,
25 the difference between hazards and threats. Were they,

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1 and efficient government, which is an extremely complex
2 area?

3 **A.** And I would add to that list, manages effective
4 decision-making, which is a really important
5 Cabinet Office function.

6 **Q.** In the context of the Civil Contingencies Secretariat,
7 of which you were the director, is that the broad
8 function of the secretariat, in the specific field of
9 civil contingencies or was it when you were there?

10 **A.** Broadly, yes.

11 **Q.** So, as the director, your secretariat was responsible
12 for co-ordinating government preparation, it was
13 responsible for oversight of the necessary policies, the
14 documents, the guidance that would go out to various
15 parts of the government, as well as ensuring that, in
16 practice, other parts of government stepped up to the
17 mark? You had to supervise, to a very large extent,
18 what went on?

19 **A.** I wouldn't describe it as supervise. There is
20 a well established lead government department model,
21 which I know the Inquiry has heard evidence on already.
22 I don't think the Cabinet Office's role is supervisory
23 in relation to that. It's co-ordination.

24 **Q.** All right. That may be a distinction, we will see --

25 **A.** That may be so.

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1 are they matters which were regarded as different beasts
2 and to which the government would, in very general
3 terms, respond differently?

4 **A.** So, in simple terms, a hazard has a non-malicious cause,
5 and a threat has a malicious cause. Both threats and
6 hazards give rise to risk, which is a combination of
7 likelihood and impact. Forgive me, Mr Keith, I've
8 forgotten the second part of your question.

9 **Q.** It was simply to ask you to identify whether or not the
10 government, in very general terms, responded differently
11 to hazards as opposed to threats, as opposed to
12 identifying the conceptual difference?

13 **A.** There's a lot of commonality between the two. There are
14 some capabilities that are essential for both, the
15 police being the most obvious. The departmental
16 responsibilities are different, so it tends not to be
17 quite the same departments focused on hazards as on
18 threats. But a lot of the same underpinning doctrine is
19 used between the two, particularly around risk
20 assessment.

21 **Q.** So hazards are, as you say, non-malicious matters, they
22 are risks with non-malicious causes such as flooding or
23 infectious disease?

24 **A.** Exactly.

25 **Q.** Threats, which are known as risks with a malicious

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1 cause, would be, as you have rightly said, something
 2 addressed by the police: terrorism, cyber crime,
 3 a cyber attack or a CBRNE attack, a chemical,
 4 biological, radiological, nuclear or explosive attack;
 5 it's malicious?
 6 **A.** Anything with a malicious actor, yes.
 7 **Q.** All right.
 8 Now, the Civil Contingencies Secretariat used to sit
 9 within a part of the Cabinet Office called the National
 10 Security Secretariat; is that correct?
 11 **A.** Correct.
 12 **Q.** Was that, and perhaps it may still be, headed by the
 13 National Security Adviser?
 14 **A.** Yes.
 15 **Q.** The National Security Adviser is the senior adviser in
 16 government on national security.
 17 Were there, when you were a director, a number of
 18 Cabinet Office NSC, National Security Council,
 19 committees --
 20 **A.** Yes.
 21 **Q.** -- which addressed both threats and hazards?
 22 **A.** There tended to be a division between the two. So the
 23 subcommittee which was most concerned with hazards had
 24 the acronym THRC, threats, hazards, resilience and
 25 contingencies. It tended to focus more of its efforts

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1 **LADY HALLETT:** Carry on.
 2 **MR KEITH:** -- committee attended by officials met weekly.
 3 How often did the analogous committee that dealt
 4 with, as you've said, threats, hazards, resilience and
 5 contingencies, the non-malicious committee, meet?
 6 **A.** So the ministerial version of that or the officials
 7 version of that, which are you referring to?
 8 **Q.** Whichever you prefer to deal with first.
 9 **A.** So the ministerial version, when I arrived in post,
 10 hadn't physically met for some time, two or three years,
 11 and you have, I think, in my evidence the rhythm of
 12 meetings from early 2017 onwards, which was more
 13 frequent than that.
 14 Beneath it sit two officials committees, a THRC(O),
 15 which was chaired by the Deputy National Security
 16 Adviser, and that would meet, I think, roughly once
 17 a quarter -- forgive my memory if that's not right, but
 18 something like that -- and a further acronym,
 19 I'm afraid, THRC(R)(O), with the R standing for
 20 resilience, chaired by me, as director of the Civil
 21 Contingencies Secretariat, and that would meet on
 22 a sort of eight to ten-week rhythm or so. I can check
 23 more precisely, if you'd like.
 24 **Q.** So the national security malicious committee, staffed by
 25 officials, met weekly, but on the non-malicious side,

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1 on hazards.
 2 **Q.** Was there a committee called the national security -- at
 3 the NSC, officials committee --
 4 **A.** Yes.
 5 **Q.** -- which was comprised, as it says on the tin, by
 6 officials --
 7 **A.** Yes.
 8 **Q.** -- and which would meet to discuss, in general terms,
 9 malicious threats?
 10 **A.** It could take either threats or hazards. I didn't
 11 attend that committee routinely, but I think it spent
 12 more of its time on threats than on hazards, would be
 13 fair to say.
 14 **Q.** How often did the threats -- the malicious threats
 15 officials committee of the national security council
 16 meet, in your experience?
 17 **A.** It varies over time, but on a regular basis.
 18 **Q.** Weekly?
 19 **A.** Yes, sometimes weekly.
 20 **(Alarm)**
 21 **MR KEITH:** That sounds rather more serious, my Lady.
 22 **(Pause)**
 23 **LADY HALLETT:** Apparently it was something on the second
 24 floor, and it's been dealt with.
 25 **MR KEITH:** So the malicious -- the threats --

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1 the hazard side, on the ministerial side, it hadn't sat
 2 or convened at all for a number of years when you came
 3 into position?
 4 **A.** That's right, although I think a qualification is that
 5 NSC(O) wasn't exclusively talking about threats, it did
 6 on occasion take hazard risks too. That was also true
 7 of the NSC.
 8 **Q.** Yes, but it was an occasional thing?
 9 **A.** It was not the biggest proportion of its business, is
 10 how I would frame it.
 11 **Q.** No, and the ministerial committee, which provided
 12 oversight, the ministerial National Security Council
 13 committee, threats, hazards, resilience, contingencies,
 14 failed to convene at all for a number of years, and
 15 during your tenure of the directorship of the Civil
 16 Contingencies Secretariat, was that ministerial
 17 committee in fact abolished altogether?
 18 **A.** It was taken out of the committee structure in
 19 July 2019, which was the point at which the whole
 20 structure was being rationalised to take into account
 21 the focus on Brexit. When it was taken out of the
 22 structure, it was always my understanding that it would
 23 be reinstated once that phase was over.
 24 **Q.** Ms Hammond, when a committee is taken out of the
 25 committee structure, it no longer exists, does it?

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1 **A.** True, but with one qualification, which is that at that
 2 point it was really clear it could be reconvened if
 3 needed, for example to provide clearance for the risk
 4 assessment.
 5 **Q.** Was it abolished?
 6 **A.** If you wish to use that word, yes.
 7 **Q.** Did it ever sit again?
 8 **A.** It didn't sit again in my time in CCS.
 9 **Q.** No. There is evidence before the Inquiry and before
 10 my Lady that there was a sense in government that more
 11 focus was paid to threats, malicious threats, than to
 12 non-malicious hazards, in terms of the roles of the
 13 National Security Adviser, his or her deputy, the amount
 14 of time devoted to those two issues. Would you agree?
 15 **A.** Yes, I think that is true of the centre of government.
 16 There are obviously a lot of departments who focus more
 17 on hazards than on threats.
 18 **Q.** Yes.
 19 The evidence shows that, in terms of the ministerial
 20 side and the lines of accountability, there were
 21 a number of ministerial roles that may have been
 22 responsible for civil contingencies and general
 23 resilience. So could you help, please, my Lady with
 24 explaining the difference between the positions of the
 25 Minister for Implementation, the Minister for the

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1 **Q.** Yes.
 2 So, in terms of relative ministerial clout, where
 3 did civil emergencies, resilience and non-malicious
 4 hazards come in the general order of things?
 5 **A.** Well, in terms of clout, Cabinet Office ministers tend
 6 to have rather a lot of that. Sitting at the centre,
 7 close to the Prime Minister, they can wield a lot of
 8 influence. In my time in CCS, Cabinet Office ministers
 9 did use that clout in relation to civil contingencies,
 10 we had two CDLs who paid close attention to this, and,
 11 likewise, ministers for the Cabinet Office. But, as you
 12 rightly say, it's part of a busy job.
 13 **Q.** When you say CDL, do you mean the Chancellor of the
 14 Duchy of Lancaster?
 15 **A.** I do, sorry.
 16 **Q.** You don't need to apologise, but if I may gently suggest
 17 that acronyms aren't always welcome in this room.
 18 **A.** Understood.
 19 **Q.** So Chancellor of the Duchy of Lancaster.
 20 The Civil Contingencies Secretariat was, as you
 21 absolutely correctly said a few moments ago, split after
 22 your time as the director, and it was split into two
 23 parts: the COBR -- and I'm going to use the acronym --
 24 the Cabinet Office Briefing Room unit, which went into
 25 what is called the National Security Secretariat, and

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1 Cabinet Office, and the Chancellor of the Duchy of
 2 Lancaster? We've been confronted with a number of
 3 ministerial roles, and it's not altogether clear.
 4 **A.** I think some of the lack of clarity comes from the fact
 5 that the Cabinet Office ministerial structure isn't
 6 fixed, it changes over time. The period you're
 7 considering includes a change of government. Basically
 8 the first two ministerial positions you described are
 9 the more junior in the Cabinet Office, and CDL is the
 10 more senior, the secretary of state-level minister.
 11 **Q.** Is the Chancellor of the Duchy of Lancaster, CDL,
 12 responsible solely for civil emergencies, general
 13 resilience, or is that a ministerial position post which
 14 addresses an omnibus of different areas?
 15 **A.** In my time he had a very wide portfolio, yes.
 16 **Q.** The Minister for Implementation is something different.
 17 Did the Minister for Implementation deal with the
 18 following areas: cross-government delivery,
 19 civil service, human resources, fraud error, government
 20 digital service, government security group, government
 21 property, government commercial function, and
 22 resilience?
 23 **A.** I couldn't verify the whole list but --
 24 **Q.** Does that sound about right?
 25 **A.** It sounds about right.

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1 that is, I suppose, the physical or the direct part of
 2 government dealing with crisis management, and a second
 3 part, the Resilience Directorate.
 4 **A.** Yes.
 5 **Q.** Can you assist with why, after the onset of the pandemic
 6 and its impact, the Civil Contingencies Secretariat was
 7 split into two parts and then posted, if you like, in
 8 different areas of the Cabinet Office? What had led to
 9 that split?
 10 **A.** Well, I think the answer is in the report that you have
 11 from Mr Rycroft and Mr Wilson.
 12 **Q.** Crisis capabilities review?
 13 **A.** Correct. I have to say I was not part of those
 14 discussions so I can't really describe to you any more
 15 than that.
 16 **Q.** But if you know of the report, Ms Hammond, and you know
 17 its authors, you surely know of the very general
 18 conclusion in relation to the COBR unit?
 19 **A.** Yes.
 20 **Q.** And what is it?
 21 **A.** I think in broad terms they recommended consolidation of
 22 those response resources and separation from the
 23 planning teams.
 24 **Q.** Could you elaborate on that?
 25 **A.** Well, I think the role of the Resilience Directorate is

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1 to focus on risk assessment and long-term planning. The
2 role of the COBR unit is to respond when something has
3 happened. So the separation of those two functions is
4 part of the recommendation, I think in order to allow
5 for sufficient focus on both.

6 **Q.** Would you agree that the crisis capabilities review
7 reached the conclusion that there was a need for that
8 split, for the functions in your former secretariat to
9 be split, because, under the intense pressure of Covid,
10 the general, the generic governmental system in the CCS
11 had not performed terribly well? Now, that's nothing to
12 do with the individuals, it's to do with the structure.

13 **A.** I think that's the conclusion reached in the report,
14 yes. I'm not sure I would agree with it.

15 **Q.** The Cabinet Office Briefing Room is the United Kingdom's
16 national crisis management capability, to use a phrase
17 from your own statement. Did it essentially, and does
18 it essentially, manage national crises?

19 **A.** Yes, it's where you take -- COBR is a Cabinet
20 subcommittee that takes decisions quickly in a crisis.

21 **Q.** It's self-evident, is it not, Ms Hammond, that there
22 will be different types of emergencies that a country or
23 a region or a locality in a country may face, and some
24 emergencies are more serious than others, and if there
25 is what's known as a level 2 or 3 emergency,

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1 Cabinet Office Briefing Room, played less and less of
2 a role and the other committees to which I've made
3 reference began to take over?

4 **A.** I'm afraid I can't give you evidence on that point.

5 **Q.** All right.

6 **A.** That would be for others.

7 **Q.** One other important area dealt with, or one other area
8 within the functions of the Civil Contingencies
9 Secretariat, was dealing with training doctrine and
10 standards.

11 Training appears to be a relatively self-evident
12 word, as is doctrine. But there are a lot of references
13 to standards in the paperwork. What do you mean by
14 standards? What is meant by standards?

15 **A.** Standards, the process of describing what good looks
16 like. Specifically in my time in CCS it meant
17 contribution to international standards on resilience
18 and civil protection, and it meant development of the
19 first set of resilience standards for use by local
20 resilience fora in the UK, which you have in your
21 evidence, I think.

22 **Q.** As part of the Cabinet Office's management of training
23 doctrine and standards in the field of civil
24 contingencies, was it a co-manager in fact of the
25 United Kingdom's sole planning college?

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1 a catastrophic emergency, something threatening the
2 nation as a whole, that is the sort of thing that would
3 be dealt with by, would lead to the convening of, the
4 Cabinet Office Briefing Room, COBR?

5 **A.** Yes.

6 **Q.** It operated at least at the start of Covid, did it not?

7 **A.** Yes, and was still operating in support of Covid as
8 I left in August 2020.

9 **Q.** Did it continue to be the primary body leading the
10 defence to Covid, do you know, or were its functions in
11 practice taken over by ministerial implementation
12 committees, Covid operation committees, and the like?

13 **A.** For the period I was in post, those things operated in
14 parallel and had slightly different functions. One of
15 the key things that COBR did was bring together
16 four-nation decision-making at the most senior level.
17 Some of those other groups you've described did more
18 detailed work on specific policy areas and issues. So
19 the two operated in parallel for quite some time.

20 **Q.** But not all the time?

21 **A.** Whilst I was in post, both were in operation, I think.

22 **Q.** But you, of course, left the directorship of the CCS in
23 August of that first terrible year?

24 **A.** Correct.

25 **Q.** But you're aware that thereafter COBR, the

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1 **A.** So the Emergency Planning College, which I think is what
2 you're referring to, the contract for the operation of
3 that was managed by CCS. The college itself was managed
4 by a private sector provider.

5 **Q.** Was that the sole institute or body for the training of
6 central government civil servants, of local authority
7 responders --

8 **A.** No.

9 **Q.** -- or were there other bodies?

10 **A.** No, not the sole one. It's the only one with that link
11 to CCS. There are other training providers, there are
12 universities who provide training, so it's certainly not
13 the only point you can go to for it, no.

14 **Q.** But it is the sole formal institute with the imprimatur
15 of government with it that provides training at the
16 behest of the Cabinet Office?

17 **A.** It's the only one with a link to the Cabinet Office,
18 yes, but others provide quite similar material.

19 **Q.** All right.

20 Can we then turn to the principle and the notion of
21 lead government departments. We've heard evidence about
22 lead government departments, and the principle appears
23 to be that under the system of civil contingencies, the
24 lead government department will be responsible for
25 identifying and managing risks which arise in whatever

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1 area that that government department has responsibility
 2 for, and then it will take on the obligation of making
 3 sure that its approach, its own approach to those risks
 4 is properly managed and assured, which is another word
 5 for being tested, and also that thereafter it takes
 6 responsibility for responding in central government to
 7 whatever the emergency is which engages it. So in the
 8 context of a pandemic, infectious disease, it's
 9 obviously going to be the Department of Health and
 10 Social Care.

11 **A.** Broadly, yes, with one qualification, that lead
 12 government departments are called lead for a reason,
 13 it's not assumed that they would do that on their own.

14 **Q.** Indeed.

15 **A.** You have, I think, a really good description of how that
 16 system works with other departments in the statement
 17 from Sir Philip Rutnam, who describes that both from the
 18 perspective of his departments in the lead and in
 19 support of others.

20 **Q.** Was Mr Rutnam the Permanent Secretary of the Home Office
 21 until February 2020?

22 **A.** I think that's right, yes.

23 **Q.** Yes.

24 So just to introduce a bit of history, the principle
 25 of lead government department I think has its genesis in

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1 extent can the Cabinet Office intervene or take charge
 2 or manage? Does it have a formal position thereafter,
 3 or is it a matter of political persuasion and ensuring,
 4 by personal contact and by virtue of the importance of
 5 the Cabinet Office, that things are done?

6 **A.** It would be a very close working relationship, and,
 7 depending on the magnitude of the risk, would be a joint
 8 decision between the lead government department, the
 9 Cabinet Office and Number 10 on whether, for example, to
 10 activate the COBR committee.

11 **Q.** Once an emergency ensues, does the Cabinet Office have
 12 any formal powers to ensure co-ordination and
 13 accountability across departments?

14 **A.** Well, it has the power of being the department at the
 15 centre of government. I think if you are asking me to
 16 point to a power in a piece of legislation, I can't do
 17 that. But that convening power of a department which
 18 has oversight across others I wouldn't underestimate.

19 **Q.** The former Cabinet Secretary, Lord O'Donnell, has
 20 indicated in his evidence that:

21 "The Cabinet Office had no formal powers to ensure
 22 co-ordination and accountability across departments; we
 23 had political persuasion."
 24 Would you agree?

25 **A.** I'm sure that's technically right, but I would say I --

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1 a Parliamentary question in July 2002, and then guidance
 2 was issued by government in March 2004.

3 Would the lead government department therefore lead
 4 co-ordination on all phases of emergency management?

5 **A.** Yes, working alongside the Cabinet Office.

6 **Q.** If, in the course of reacting to and dealing with the
 7 management of an emergency, it becomes apparent that it
 8 is more sensible that a different government department
 9 responds, then there can be a change in lead government
 10 department. So, for example, I think in your very own
 11 statement, or certainly that of Mr Hargreaves, you give
 12 the example or he gives the example of how, in relation
 13 to severe flooding, the lead government department might
 14 change from DEFRA, which obviously bears the prime
 15 responsibility for dealing with the environment, to
 16 DLUHC, the Department for Levelling Up, Housing and
 17 Communities, on recovery, getting through the aftermath
 18 of the emergency.

19 **A.** Normally that change reflects a change in the phase of
 20 the response, exactly as you say, moving from dealing
 21 with a live event into returning to normality, and it
 22 reflects, as you said before, what those departments'
 23 standing responsibilities are.

24 **Q.** Once the lead government department takes responsibility
 25 for managing the response to an emergency, to what

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1 in my time in CCS, I can't really think of examples of
 2 departments saying, "You have no formal powers", and
 3 walking away on that basis.

4 **Q.** Is it possible to identify and was it possible to
 5 identify during Covid a single government department in
 6 charge, so that the world or this country or its
 7 citizens could understand that there was a particular
 8 body in charge?

9 **A.** I think in a crisis like Covid, which drew on the
 10 responsibility of a very large number of departments,
 11 COBR was the body in charge. It drew together those
 12 perspectives and made big decisions, including some of
 13 the moves into lockdown, for example. That went well
 14 beyond the responsibilities of any single department.

15 **Q.** But over time, the relative importance of COBR's role
 16 diminished and other power structures, the ministerial
 17 committees and so on and so forth, grew in strength, did
 18 they not?

19 **A.** They were certainly added to that decision-making
 20 landscape, yes.

21 **MR KEITH:** All right.

22 **LADY HALLETT:** Are you moving to a different topic,
 23 Mr Keith?

24 **MR KEITH:** Yes, my Lady, that's a perfect moment.

25 **LADY HALLETT:** Right. We'll break now, and I shall return

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1 at 1.45, and I just need to warn everybody that we're
2 finishing today, in case they wish to make arrangements,
3 at 4.30 latest. Thank you.

4 (12.47 pm)

5 (The short adjournment)

6 (1.45 pm)

7 **MR KEITH:** Ms Hammond, just before lunch, you were giving
8 evidence about the lead government department. In March
9 of 2004, did the Civil Contingencies Secretariat publish
10 guidance called *The Lead Government Department and its*
11 *role - Guidance and Best Practice?* You recall that?
12 You obviously weren't in position then, but ...

13 **A.** I wasn't in position, but I'm aware of the document.

14 **Q.** Because it was in force, in fact, during your time as
15 director?

16 **A.** The model, yes, that's still the model we were using.

17 **Q.** You mean it's the same document?

18 **A.** Yes.

19 **Q.** Right.

20 **A.** Well, to qualify that, there are parts of this document
21 which had been superseded by the Resilience Capabilities
22 Programme, but I think the section you're referring to
23 was substantially in force, yes.

24 **Q.** So when you were in post between 2016 and 2020, the
25 relevant parts of this guidance issued in 2004 were

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1 incorporate assurance on contingency planning within the
2 annual assurance and risk control mechanisms presently
3 being developed within the Central Government corporate
4 governance regime. Senior officials will need assurance
5 that the processes used to develop contingency plans and
6 to determine both the planning process and plan content
7 are adequate and that some level of validation (testing)
8 has been carried out. Assurances will necessarily be
9 obtained from a variety sources within the LGD [lead
10 government department], its stakeholders and other
11 appropriate reviewers."

12 Would you be good enough to translate that for us?

13 Is this the system whereby lead government departments
14 were tested themselves?

15 **A.** I think this is describing how a lead government
16 department would take its national risk responsibilities
17 into its corporate risk process. So it's one of the
18 ways in which you might assure yourself. There are
19 others, including exercising, for example, including
20 specific reviews of specific plans, and sometimes CCS
21 would be asked to come in and assist with those.

22 **Q.** Was there any body, any other government department or
23 inspectorate or any other entity that could look at the
24 lead government department and say, in terms, "Your
25 plans and procedures are up to date, your policy

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1 still in force?

2 **A.** Yes.

3 **Q.** Was the guidance updated, in relation to this area, at
4 any time during your time as director?

5 **A.** No, I don't believe so.

6 **Q.** So from 2004 to 2020, in fact, the Cabinet Office
7 guidance relating to lead government department was
8 substantially unaltered; that is correct, isn't it?

9 **A.** I think that's right. Obviously some names of
10 departments changed over time.

11 **Q.** Yes. Presumably somebody in the Cabinet Office or
12 somebody in the Civil Contingencies Secretariat would go
13 through the old guidance and say, "Well, this has got to
14 change, there has been changes in the department,
15 changes in the structure, changes in parts of
16 government, we'd better change the nomenclature". Did
17 that ever happen?

18 **A.** I don't think we formally re-issued it with an update,
19 no.

20 **Q.** All right.

21 So this particular document, INQ000022687, page 4,
22 paragraph 5, deals with what is called assurance, that
23 is to say the testing or the supervision of the lead
24 government department in the model to which you refer.

25 "[Lead government departments] will be required to
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1 documentation is up to date, your emergency preparations
2 are satisfactory and adequate, so that you can continue
3 to fulfil your role of being the prime department
4 responding to the emergency in the area for which you
5 have responsibility"?

6 **A.** There is no inspectorate as such, no.

7 **Q.** So if a lead government department issued policy
8 guidance that was plainly erroneous or failed to put
9 into place its own proper, internal risk control
10 mechanisms or failed to consider sufficiently whether or
11 not it was ready to deal with a civil emergency, how
12 would one know?

13 **A.** Well, I think there are several ways. So firstly,
14 I can't think of an example of issuing erroneous
15 guidance from my time in office. You've got evidence
16 from senior permanent secretaries of how they ran that
17 within their own departments, and it varies between
18 them. Many will have their national risk as part of the
19 consideration of the risk owned by the department, and
20 will form part of those discussions by the departmental
21 board, for example. There are different patterns for
22 doing that, I think, in different departments.

23 **Q.** The lead government department wasn't the only
24 department, of course, in this overall structure.

25 **A.** Correct.

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1 Q. You've referred already in your evidence, and it's in
2 your statement, that an important part was the
3 Resilience and Emergencies Division of what is now the
4 Department for Levelling Up, Housing and Communities.
5 A. Yes.
6 Q. Will you just explain for us how it is that in this
7 overall system of emergency preparation there is
8 a second government department responsible for one major
9 part of the process, namely DLUHC?
10 A. So RED, the Resilience and Emergencies Division, is
11 basically the link point between central government and
12 local responders. That's its clear function.
13 Q. Did it replace, in fact, in 2011 the Government Office
14 of the ... Regions?
15 A. Obviously before my time in office.
16 Q. Indeed.
17 A. But, yes, I think some elements of the government office
18 function were incorporated into RED.
19 Q. Could we have, please, the organogram INQ000204014,
20 please, on the screen, at page 17.
21 (Pause)
22 This is 2009, the United Kingdom and England. On
23 the left-hand side of the page, is it right, Ms Hammond,
24 we can see Ministry of Housing -- because that's what
25 the department was then called -- Communities & Local

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1 A. That's before my time in CCS, I'm afraid, so I don't
2 know that I can give you much evidence about its impact
3 on its work.
4 Q. All right, but the Government Offices for the ...
5 Regions, what was a Major government department, it was
6 abolished and superseded by the Ministry of Housing,
7 Communities & Local Government and other government
8 departments, the functions were spread amongst a number
9 of other areas; is that not generally right?
10 A. I'm afraid that --
11 Q. You don't know?
12 A. -- not my area of expertise, forgive me.
13 Q. All right.
14 In terms of providing guidance to local authorities,
15 local resilience forums, category 1 and 2 responders and
16 so on, did the Cabinet Office publish a very significant
17 document called "*Responding to Emergencies - The ...*
18 *Concept of Operations*"?
19 A. Yes.
20 Q. What was that?
21 A. That is, it's a document which sets out how the system
22 is set up to work in a crisis, not a document that has
23 to be, you know, adhered to in terms of every word, but
24 it's a guide as to how the system operates.
25 Q. Is it -- would you agree that it's one of the primary

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1 Government, and underneath it the Resilience and
2 Emergencies Division, and that was the link from local
3 resilience forums into central government?
4 A. Correct.
5 Q. Then if we go through, please, to page 3 and then 4 in
6 rapid succession, we can see, on the left-hand side,
7 August 2018 -- actually it still says the Ministry of
8 Housing, Communities & Local Government, and Resilience
9 and Emergencies Division.
10 So in fact the Ministry of Housing, Communities &
11 Local Government was, in 2018, still known as that,
12 rather than Department for Levelling Up, Housing and
13 Communities, which it became thereafter.
14 So that switch from the Government Offices for
15 the ... Regions to this division in the Ministry of
16 Housing called the Resilience and Emergencies Division
17 happened in 2011.
18 Do you know why there was that switch, why
19 resilience was no longer managed or supervised through
20 the Government Offices for the ... Regions?
21 A. I think it was part of a suite of changes made by the
22 government at the time to reorganise regional structures
23 in the UK.
24 Q. Was that of some import? Was of that importance or
25 significance?

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1 documents for all these moving parts in this system to
2 understand how to respond to emergencies? It's the
3 primary emergency manual, if you like, from the
4 Cabinet Office, on responding to emergencies?
5 A. It's one of a set, and not the only source of that
6 information. So people arriving in the system would do
7 training courses, for example, which would help them to
8 understand.
9 Q. If they didn't have training courses and they were
10 looking to the Cabinet Office to see what the core
11 operational document -- it's called "Concept of
12 Operations" --
13 A. That's right.
14 Q. -- was, they would go to this document?
15 A. Yes, I expect so.
16 Q. All right. Can we have that document up, please,
17 INQ000036475:
18 "Responding to Emergencies ... Concept of
19 Operations."
20 It was originally published in March 2010.
21 You can see in the bottom right-hand corner of this
22 page that chapter 6 was, however, updated in April 2013.
23 Could we please have page 16 of the document, and
24 paragraph 2.18(i):
25 "In England, the role of the [lead government

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1 department] for Recovery, in consultation with other
 2 government departments, and if appropriate the devolved
 3 administrations, will be to:
 4 "(i) Act as the focal point for communication
 5 between central government and the multi-agency Recovery
 6 Co-ordinating Group(s) at local level involving relevant
 7 government offices in the English regions ..."
 8 Is that a reference to the by then abolished
 9 Government Offices for the ... Regions?
 10 **A.** I'm afraid I'm not sure. If it was, I would expect it
 11 to say "Government Offices for the ... Regions".
 12 I think this may be referring to other structures.
 13 **Q.** What other structures, other than the former, but now
 14 abolished, Government Offices of the ... Regions, do you
 15 think that could be a reference to?
 16 **A.** I'm afraid I don't know, I would have to go away and
 17 look into that a little.
 18 **Q.** Ms Hammond, you more than anyone have expertise and
 19 a corporate understanding of the system concerning civil
 20 contingencies, that is a reference, isn't it, to what
 21 was, by then, the abolished Government Offices for the
 22 ... Regions?
 23 **A.** I'm afraid I can't be sure.
 24 **Q.** All right?
 25 **A.** It's three years since I left this point, so you can

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1 **A.** It appears to --
 2 **Q.** Capital letters?
 3 **A.** It appears to be, yes.
 4 **Q.** All right. So in the primary CCS, Civil Contingencies
 5 Secretariat, Cabinet Office document for the whole of
 6 England and Wales, the local authorities, the local
 7 resilience forums, and all the many moving parts,
 8 Concept of Operations, it was not only not updated for
 9 many years, 2010 to 2023, other than in small part, but
 10 it continued to refer to government departments that had
 11 actually been abolished?
 12 **A.** I think that is a fair criticism of the document,
 13 Mr Keith. I will say that's not my experience of
 14 practice.
 15 **Q.** No, but it is the reality, is it not?
 16 **A.** Of the document.
 17 **Q.** Of the document.
 18 **A.** It is, it would appear to be, yes.
 19 **Q.** And page 45, paragraph 4.2(v):
 20 "Convening Regional Co-ordinating Groups or Regional
 21 Civil Contingencies Committees in England, will be
 22 considered by COBR and/or the Lead Government
 23 Department ..."
 24 Then further down:
 25 "The Government Offices in the English regions will

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1 imagine on some points of detail I might need to go back
 2 and check.
 3 **Q.** Page 24, please, paragraph 3.11:
 4 "In order to ensure accurate and timely information
 5 is available in the CRIP ..."
 6 I think that's a reference to a form of blackboard
 7 or whiteboard, a commonly recognised information
 8 picture?
 9 **A.** Not normally a blackboard or whiteboard, but essentially
 10 where information is brought together on what the
 11 current situation is, often a deck of slides, for
 12 example.
 13 **Q.** A Sit Rep? A situation report?
 14 **A.** Exactly, exactly that.
 15 **Q.** But called, in this documentation, a CRIP?
 16 **A.** That's what it's called when you take it to COBR.
 17 **Q.** "... the Cabinet Office will request situation reports
 18 (Sit Reps) from other Government Departments and
 19 agencies as appropriate providing a national summary of
 20 nationally managed or co-ordinated services. Government
 21 Offices in the English regions will be expected to
 22 provide a Common Regional Recognised Information
 23 Picture ..."
 24 That is a clear reference, is it not, to the
 25 abolished Government Offices for the English Regions?

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1 provide the default Government Liaison Officer ..."
 2 So why did not somebody update the primary emergency
 3 response documentation for the civil contingencies
 4 system?
 5 **A.** Well, I don't think that lack of an update was affecting
 6 how things worked in practice. It was really well
 7 understood that that role would be carried out by the
 8 Resilience and Emergencies Division, and that's
 9 certainly what happened in all the responses I was
 10 involved in.
 11 CCS owns a lot of guidance documentation, as you've
 12 identified. There is always a balance between spending
 13 time updating that and responding to incidents.
 14 Generally speaking, where there is an incident that
 15 meant you could reduce harm to people or communities, we
 16 would prioritise that.
 17 **Q.** Another major part of the system was, as you've
 18 correctly identified, the Civil Contingencies Act 2004?
 19 **A.** Yes.
 20 **Q.** We've heard evidence that that Act had two parts in it.
 21 The first part set out the duties on the category 1 and
 22 category 2 responders, and the non-statutory bodies and
 23 so on and so forth, and provided the legal framework for
 24 civil contingencies response; is that correct?
 25 **A.** Correct.

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1 **Q.** Was the Civil Contingencies Act 2004 reviewed by the
2 Cabinet Office to make sure it was still fit for purpose
3 between 2004 and the onset of Covid in 2020?
4 **A.** Yes, we did, in my time, what's called a post
5 implementation review. You do those every five years.
6 I think there was a subsequent one in 2022, which you
7 have in your bundle of evidence.
8 **Q.** Yes. Conducted, in fact, by Mr Mann, I think, you know?
9 **A.** I wasn't involved in that, I'm afraid.
10 **Q.** You didn't know. All right.
11 Could we have INQ000005260, please, and page 8.
12 This is a report of the post implementation review of
13 the Act, CCA 2004. It's dated March 2017. Page 8,
14 paragraph 20:
15 "CCS and the Department for Communities and Local
16 Government's Resilience and Emergencies Division (...
17 RED) [the division to which you referred] have
18 a well-developed knowledge of the practice of local
19 resilience through working with both local resilience
20 forums, and with local responders planning for and
21 responding to emergencies. This knowledge, which
22 includes learning from emergencies and exercises,
23 indicates that although there may be a need to consider
24 the way in which the CCA, Regulations and guidance are
25 being interpreted ... there is no clear case for

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1 **A.** Exactly.
2 **Q.** Of the total of 79 transport companies, category 2
3 responders, and 57 utility companies who were invited to
4 participate, responses were received from ten transport
5 companies and 34 utility companies.
6 So there wasn't an overwhelming response to the
7 survey?
8 **A.** That's a subset of the total respondents. The response
9 rate from LRFs tended to be much higher than that.
10 That's two particular category 2 responders.
11 **Q.** Was there any consideration of the fundamentals of the
12 Act, that is to say whether or not the legal duties on
13 category 2 responders be brought more in line with
14 category 1 responders, which was an issue to which
15 you'll know Mr Mann and Professor Alexander referred to
16 in evidence? Was there any debate at any time over this
17 period, from 2004 to 2020, of that essential issue?
18 **A.** I don't think -- so in collecting information for the
19 PIR, we would have asked quite open questions, so asked
20 people to raise the issues they thought were there.
21 I don't recall powers for category 2 -- or duties,
22 rather, for category 2 responders being a major theme,
23 but this is some time ago.
24 **Q.** You'll know from the evidence of Mr Mann in
25 particular -- which I'm sure was brought to your

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1 reviewing the regulatory framework ..."
2 Ms Hammond, do you happen to know what level of
3 knowledge was brought to the attention of the authors of
4 that report? I mean, to what extent was there evidence
5 from local responders and the emergency services and so
6 on and so forth to indicate that there might be a clear
7 case for changing the regulatory framework?
8 **A.** I would have to return to the documents and refresh my
9 memory to give you an exact list of who was consulted,
10 but from recollection, you know, views were taken from
11 some, if not all, LRFs, so the local responder
12 community, and from government departments.
13 **Q.** If we could have, please, paragraph 21 on the page, it
14 would appear that the post implementation review took
15 data from something called the National Capabilities
16 Survey 2004(sic).
17 **A.** Yes.
18 **Q.** What was the National Capabilities Survey?
19 **A.** It was a survey document provided or responded to by
20 local responders, which was intended to assess the state
21 of play in relation to key capabilities for civil
22 emergency response. Does that make sense?
23 **Q.** It was the survey from -- it was a survey directed at
24 and responded to by entities in the civil contingencies
25 system?

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1 attention -- that there has never been any time in which
2 a legal duty under the Act or any other piece of
3 legislation has been imposed on central government
4 itself, whether it be --
5 **A.** Correct.
6 **Q.** -- the RED division of DLUHC or the lead government
7 departments. During your time in office as the
8 director, was there any consideration at any time given
9 to an expansion of the legal duties to central
10 government? Did anybody say, "This is something worth
11 thinking about and considering"?
12 **A.** I don't think it was a topic of major debate. We ...
13 when we had thought about that, I think we'd reflected
14 that secretaries of state already have very considerable
15 levers to set the priorities for their departments, so
16 I think there would have been a question what a legal
17 duty would have added to those abilities.
18 **Q.** May I press you, please, Ms Hammond?
19 **A.** Of course.
20 **Q.** You say you don't know whether there was debate, but you
21 go on to say that you think that that was an issue --
22 **A.** I said I --
23 **Q.** Do you recall it --
24 **A.** -- wasn't a major theme of debate.
25 **Q.** Was the issue of whether or not government departments

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1 should have a legal duty imposed upon them ever the
2 subject of debate at your level of seniority in the
3 Cabinet Office?

4 **A.** I recall it as, you know, one part of a lot of,
5 you know, much wider-ranging conversation. I don't
6 think we ever did a serious and focused piece of work on
7 that single issue.

8 **LADY HALLETT:** Your answer to Mr Keith's question was:

9 "... that secretaries of state already [had] very
10 considerable levers to set the [parameters] for their
11 departments ..."

12 I think the point is, if there was a legal duty then
13 that would become one of their priorities, because
14 they've got a legal duty. I think that's the point.

15 **A.** Yes, I understand. But I think if you think of it the
16 other way round, if you have a secretary of state who
17 doesn't consider this to be a priority, I am not
18 entirely clear what difference the duty would make.
19 Departments are having to make prioritisation calls all
20 the time, and of course they're going to listen to their
21 secretary of state.

22 **LADY HALLETT:** But wouldn't a legal duty make it a priority,
23 inevitably?

24 **A.** One would hope so, but I think where there are different
25 trades to be made, allocation of resources can vary over

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1 safeguarding the UK's constitutional settlement."

2 Would you agree that the coronavirus pandemic, by
3 virtue of not being an influenza pandemic, was
4 an unexpected and most unwelcome development?

5 **A.** Unwelcome, of course. It had a horrible impact on the
6 lives of so many people. In the national risk
7 assessment the pandemic was judged to be the reasonable
8 worst-case scenario -- sorry a flu pandemic was judged
9 to be the reasonable worst-case scenario.

10 **Q.** Indeed.

11 **A.** There is consideration of other emerging infectious
12 disease issues which included coronavirus, but the
13 assessment was that the magnitude of the impacts would
14 be lower than a flu pandemic, hence that was the focus
15 for planning.

16 **Q.** By virtue of likelihood, and by virtue of impact,
17 a pandemic influenza was regarded as being of the
18 highest overall risk, it was therefore the expected
19 development, was it not?

20 **A.** I think likelihood was judged to be the same, but impact
21 was judged to be considerably higher for an influenza
22 pandemic.

23 **Q.** Ms Hammond, you are aware, of course, that in the NSRA
24 the overall risk rating for pandemic influenza was very
25 high --

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1 time. So I think the more effective route is for
2 governments to make it a priority.

3 **MR KEITH:** Ms Hammond, if there is no point imposing a legal
4 duty, because ultimately everything is about pragmatism
5 and resources and making choices, as you would say, why
6 did central government impose legal duties on category 1
7 and 2 responders?

8 **A.** I think you have slightly missummarised my answer, and
9 I think I'm talking about the particular circumstances
10 of departments and the decisions they have to make.

11 **Q.** One of the major functions of the Civil Contingencies
12 Secretariat was to draft policy documents and draw up
13 the strategy for dealing with the United Kingdom's
14 ability to prepare for emergencies. Can we look back at
15 that Concept of Operations, that important document,
16 INQ000036475, and page 5. Paragraph 1.2, in the very
17 first section, indeed the very first part of the first
18 section of this core document, the Cabinet Office said
19 this:

20 "History has taught us to expect the unexpected.
21 Events can, and do, take place that by their nature can
22 not be anticipated exactly. Response arrangements
23 therefore need to be flexible in order to adapt to the
24 circumstances at the time while applying good practice,
25 including lessons from previous emergencies, and

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1 **A.** Yes.

2 **Q.** -- and for new and emerging infectious disease, high?

3 **A.** Yes.

4 **Q.** So, of the two, pandemic influenza was the more
5 expected, was it not?

6 **A.** I think the likelihood assessment was the same, the
7 impact assessment was different. So when you ask me
8 what was more expected, I think the answer is that there
9 is not much difference. The difference is in the level
10 of impact anticipated.

11 **Q.** In your own statement you acknowledge that the
12 preparations made by this country for infectious disease
13 did tend to focus upon influenza pandemic.

14 **A.** Correct.

15 **Q.** You go on to explain why there were areas that were not
16 anticipated, why there were areas in which we didn't
17 respond as well as we did in other areas and so on.
18 That was because, was it not, coronavirus was more
19 unexpected than a pandemic influenza?

20 **A.** It's because --

21 **Q.** Would you agree?

22 **A.** -- the impact was expected to be less severe.

23 **Q.** Would you agree with this proposition, on a general
24 level we were blindsided by the appearance of
25 coronavirus?

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- 1 A. I don't think "blindsided" is the word that I would use.
 2 Certainly the pandemic that happened in 2020 was
 3 different from the reasonable worst-case scenario
 4 produced by experts which focused on a flu pandemic.
 5 That, of course, is built on statistical analysis of the
 6 past. We have had a number of influenza pandemics
 7 before. Coronavirus events have tended to be much
 8 smaller in scale; SARS and MERS you'll be familiar with.
 9 So that is the basis, I think, for the analysis.
- 10 Q. That is why, due to the very statistical analysis to
 11 which you refer, coronavirus was more unexpected than
 12 an influenza pandemic?
- 13 A. The scale of the impacts was different.
- 14 Q. All right.
- 15 Could we look at INQ000055887, which was another
 16 major piece of guidance issued by the Cabinet Office
 17 called "Revision to Emergency Preparedness"; are you
 18 aware of that document?
- 19 A. Yes.
- 20 Q. This is a 591-page document. Do you recall when it was
 21 first issued?
- 22 A. Before my arrival in CCS. I'm afraid I do not have the
 23 document on the screen.
- 24 Q. No, it's just being brought up.
- 25 A. Thank you.

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- 1 over a period of time. So --
- 2 Q. I thought you said there was a series of different
 3 emergencies which had impacted your ability to respond?
- 4 A. Yes. So the structure of CCS is based on having
 5 a fairly small standing response team, which is
 6 augmented by other parts of the organisation as needed.
 7 That means that when you have a large number of
 8 emergencies which last for some time, of necessity some
 9 of the work is set aside.
- 10 Q. Was one of the reasons why the Civil Contingencies
 11 Secretariat and the Cabinet Office had to set aside
 12 valuable workstreams, put to another side or another
 13 time work that it understood that it ought to be doing,
 14 Operation Yellowhammer?
- 15 A. Yes. Yellowhammer was a really major consumer of
 16 resources in my time.
- 17 Q. That was not an emergency, and the answer to my first
 18 question was you said there were a number of -- a series
 19 of emergencies that you had to deal with.
- 20 **LADY HALLETT:** "Events" I think was the expression.
- 21 **MR KEITH:** If I've used the wrong word, I apologise.
- 22 A. And I think I was referring to the period before
 23 Yellowhammer. So in my time as director of CCS, between
 24 2016 and 2018 there were a series of quite substantial
 25 events, and then as you rightly say, we did a very

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- 1 Q. INQ000055887, page 1. Revision to Emergency
 2 Preparedness, and the bottom left-hand corner,
 3 March 2012.
 4 You must have come across this document whilst you
 5 were director?
- 6 A. Yes.
- 7 Q. Was it ever updated between March 2012 and 2020?
- 8 A. I don't think it was re-issued. There were certainly
 9 intentions to update it in my time; I think those were
 10 set aside by events.
- 11 Q. What events?
- 12 A. The series of emergencies that happened from 2016
 13 onwards.
- 14 Q. Which emergencies were they, Ms Hammond?
- 15 A. Well, you have a list of some of them, I think, in
 16 Mr Hargreaves' statement. CCS was involved in
 17 responding to quite a number in that period, of quite
 18 substantial size.
- 19 Q. If you had to order in terms of the impact upon the
 20 ability of the CCS to bring its documentation up to
 21 speed and up to date, and in terms of your ability to
 22 respond, what were the three most significant events
 23 impacting on your abilities?
- 24 A. I don't think it's necessarily about individual ones,
 25 it's about the number and the sustained nature of them

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- 1 intensive period of work on a no-deal exit from the EU.
- 2 Q. This document sets out for local resilience forums and
 3 other entities how to prepare for and respond to
 4 emergencies, does it not?
- 5 A. It does.
- 6 Q. Could we have, please, page 160.
 7 An important part of the document sets out for those
 8 persons reading it what sort of risk categories they
 9 should have regard to, what sort of outcomes may result
 10 from those risks, and also who the lead government
 11 department is for that particular risk.
- 12 If we go down the page, please, I'm afraid, zoomed
 13 in, I've now lost the reference to it. If we go -- yes,
 14 that's the start of the chart. Could we then go,
 15 please, to page 164. "Risk categories" in the top left.
 16 Further down the page you will see:
 17 "Human health
 18 "Influenza-type disease (epidemic)
 19 "Influenza type disease (pandemic)
 20 "SARS-type disease."
 21 So from the publication of this document in
 22 March 2012, there appears to have been an equality of
 23 approach to both influenza-type disease and SARS-type
 24 disease. They're both identified there on the face of
 25 the document.

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1 A. Well, I think the part of the document you were
2 referring to, if I'm reading the top of the page
3 correctly, is an "Illustration of Local Risk Assessment
4 Guidance". So that would be based on the national risk
5 assessment that was relevant at that time, which I would
6 say is --

7 Q. Indeed.

8 A. -- the more important document.

9 Q. But the point from this page is, to the professional
10 reader of the document, the chair perhaps of a local
11 resilience forum, they would be alerted to the fact that
12 one of the major risk categories was influenza-type
13 disease as well as the possibility of a SARS-type
14 disease?

15 A. Yes, although I would say, you implied there was parity
16 between those scenarios here. There is no information
17 to suggest that.

18 Q. Well, there is nothing given in terms of likelihood
19 rating, that's blank. What is provided here is the lead
20 government is the Department of Health, as the DHSC was
21 then known?

22 A. Correct.

23 Q. So on the face of it there is a degree of parity, and
24 what I wanted to ask you was: when you took over the
25 directorship of the CCS, was there a general

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1 A. I think an LRF would look at this annex as an example of
2 a tool that one might use, but I am pretty confident
3 they would have considered the risk assessment to be the
4 more authoritative document.

5 Q. They would be looking at the National Risk Register, the
6 public facing version of the national risk assessment,
7 or the official sensitive National Security Risk
8 Assessment?

9 A. LRFs had access to the classified version.

10 Q. So the NSRA, the National Security Risk Assessment, and
11 before then the national risk assessment?

12 A. Yes.

13 Q. They would have had to have regard to this document, all
14 891 pages, the ConOps document to which --

15 LADY HALLETT: Just before you move to another document.

16 MR KEITH: Yes.

17 LADY HALLETT: I'm just wondering, Ms Hammond, forgive me if
18 I'm failing to spot something, what exactly anyone would
19 get from this. You've got the identification of
20 a number of risks, and you're told who the lead
21 government department is, but everything else seems to
22 be blank.

23 A. So I think this is a template for LRFs to use,
24 essentially.

25 LADY HALLETT: Oh, they fill it in?

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1 understanding then prevalent that an influenza pandemic
2 was the more likely risk, the more expected risk, the
3 one to guard against as opposed to a SARS-type disease?

4 A. The understanding was as set out in the risk assessment,
5 which is that the combination of risk and -- of
6 likelihood and impact was higher for a flu pandemic.

7 Q. Do you recall whether or not this description of the two
8 risks reflected the National Security Risk Assessment or
9 the national risk assessment at that time? We know
10 later, from 2019, that, you're right, a different risk
11 level is given to influenza pandemic than to a new and
12 emerging disease. But do you recall what the position
13 was further back in time?

14 A. So I think in 2016 -- and forgive me, I'd have to look
15 again at the risk summary -- influenza was still
16 considered to be the higher of the two risks in the risk
17 assessment.

18 Q. All right.

19 A. But I do say, I don't think the way they're set out in
20 this document implies parity.

21 Q. If you are a local resilience forum and you're wading
22 your way through the paperwork in order to inform
23 yourself, educate yourself as to how to prepare for
24 an emergency, is this a document to which one would have
25 had to have had regard?

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1 A. That's been partially populated. So "Illustration of
2 Local Risk Assessment Guidance". So if you were -- the
3 way the system operates, if you were a local resilience
4 forum, you take the national risk picture as your
5 starting point and you look at how that might apply to
6 your local area. So what you might do is work through
7 the risk categories set out here, interpreting them for
8 your area. So, you know, for example, you know, what
9 might the economic impact be expected to be based on
10 your knowledge of the particular make-up of your
11 location.

12 MR KEITH: It's a very considerable document.

13 A. Yes.

14 Q. What else would the LRFs have to grapple with? So the
15 NSRA, the official sensitive risk assessment process to
16 which you've referred and we'll come to in a moment; the
17 ConOps, Concept of Operations document; this document,
18 *Revision to Emergency Preparedness*. Was there another
19 document called *Emergency response and recovery*?

20 A. Yes.

21 Q. Was there material relating to the Resilience
22 Capabilities Programme?

23 A. Yes. There was also specific pieces of guidance on
24 elements of response, humanitarian assistance, voluntary
25 sector involvement, et cetera.

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1 Q. Material from the DHSC's pandemic influenza preparedness
2 programme?
3 A. Yes, and there's a published strategy.
4 Q. Engagement with and guidance material from the Pandemic
5 Flu Readiness Board from 2017 onwards?
6 A. LRFs wouldn't have had all of the material from the
7 PFRB. The Resilience and Emergencies Division again
8 performed their link role in relation to that work. So
9 they were describing to LRFs and consulting them on some
10 of its work.
11 Q. Was some of the material from the Pandemic Flu Readiness
12 Board provided to local resilience forums for their
13 reading?
14 A. It would have been through that consultation mechanism
15 I've just described.
16 Q. Yes. Was it provided to them?
17 A. Yes.
18 Q. Multiple successive editions of the National Resilience
19 Standards. What are the National Resilience Standards?
20 A. So the National Resilience Standards set out for LRFs,
21 in quite short form, what their statutory obligations
22 are, what good practice looks like, and what leading
23 practice looks like under a series of headings. Some of
24 those are specific to preparing for particular risks.
25 Others are about capabilities you would need in

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1 Q. How many different standards were there? Because you've
2 told us that standards related to different aspects of
3 the performance of the local resilience forums.
4 A. So they grew over time. I think the first set was 12,
5 and we added potentially another six. Forgive me,
6 I can't remember what the final number was when I left.
7 Q. That might be 18, but the point is that the local
8 resilience forums would have had to then themselves
9 gauge, under this process of self-assessment, their
10 performance, their ability to respond to emergency,
11 against no less than 18 separate standards?
12 A. Each standard is a page long, so I don't think that's
13 an unduly arduous process. I will say from my
14 experience in CCS there was a real desire to have those
15 standards from LRFs, they found it useful to bring that
16 information into one place, and lots of them used them.
17 Q. Would LRFs also have to consider local risk management
18 guidance?
19 A. Yes, they'd be using that to write their local risk
20 register.
21 Q. JESIP paperwork, that's to say the -- it's an acronym
22 that is quite, quite beyond me. But anyway, will you
23 tell us please, what JESIP is?
24 A. JESIP is essentially a set of rules which help emergency
25 responders work together effectively in a crisis.

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1 responding to any risk. They were a commitment made in
2 the integrated review, I think, in 2015.
3 Q. They were documents, were they, against which the local
4 resilience forums were obliged to assess their own
5 conduct, their own standards?
6 A. Not obliged, but there was a really big appetite to have
7 these standards from LRFs, and I know that quite
8 a number of them put them to use.
9 Q. So they weren't obliged. Do you mean that this was
10 a process of self-assessment?
11 A. Correct.
12 Q. So the LRFs would be told: these are standards against
13 which you must measure your performance, they are
14 standards to which you must adhere, you must meet them,
15 but it's up to you how you grade your performance?
16 A. So some element of self-assessment through the
17 resilience capabilities survey, as you've already
18 described, but --
19 Q. Is that the survey that was abolished in 2017?
20 A. Correct.
21 Q. Right.
22 A. But there are different elements to these standards.
23 So, as I said, some of it reflects statutory obligation,
24 some of it reflects the best practice available so that
25 LRFs are aware of what that looks like.

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1 Q. An intra-operability framework?
2 A. Yes, based on learning from events where that join-up
3 has not been effective.
4 Q. LRFs would also have to consider humanitarian aspects in
5 emergency management guidance?
6 A. Yes, for those risks where that was relevant.
7 Q. UK Influenza Pandemic Preparedness Strategy material
8 from the Department of Health?
9 A. Yes.
10 Q. Health and Social Care Influenza Pandemic Preparedness
11 and Response?
12 A. Yes.
13 Q. Pandemic Influenza Strategic Framework from 2014 and the
14 Pandemic Influenza Response Plan from Public Health
15 England?
16 A. Those are all available documents for LRFs to use.
17 Q. Some of those documents have multiple references online
18 to 30, 40, 50 other documents?
19 A. Some of them do. It's a complicated business.
20 Q. Well, is it? From the viewpoint of local resilience
21 forums and those who are tasked with the heavy
22 obligation of responding outside central government, is
23 there not an argument for culling this profusion of
24 paperwork and for identifying a clear, objective
25 standard against which they can be tested, perhaps

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1 an inspectorate, and a single manual so that they know
 2 what, in the heat of an emergency, they are practically
 3 obligated to do? Get food to somebody in a particular
 4 building. Recreate local transport networks. Deal with
 5 householders who have been evicted from their homes
 6 because of flooding. The practical side of it.

7 **A.** So I think it's a completely fair point that there is
 8 a lot of documentation there. In my time in CCS, some
 9 of the things we did were to try to put that in the
 10 single place so it was easy to locate. Most of those
 11 pieces of guidance have been written based on demand for
 12 them, so particularly the humanitarian aspects one you
 13 referred to. If you're an LRF, what you want to do is
 14 learn from how other people do things, and it's really
 15 helpful to have that good practice described. There is
 16 always a case for rationalising paperwork, but there is
 17 also a huge amount of really useful expert material in
 18 there.

19 **Q.** How strong was that demand, Ms Hammond? I mean, 2014
 20 and 2017, you conducted a National Capabilities Survey.
 21 This is the survey that was abolished in 2017, perhaps
 22 because it served little purpose. But the take-up rates
 23 by way of responses to the Cabinet Office surveys from
 24 local resilience forums would indicate that they weren't
 25 crying out for more tests, more paperwork, more surveys,

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1 risk-specific ones, of which pandemic influenza was one
 2 of the first.

3 **Q.** Could we have up INQ000023122 and page 1 of 39.
 4 This is called the National Resilience Standards for
 5 Local Resilience Forums. It's dated August 2020, so
 6 it's post-Covid.

7 If we have a look, please, at page 3 we will see its
 8 contents: local risk assessment, intra-operability,
 9 training, exercising, strategic co-ordination centre,
 10 cyber incident preparation.

11 Obviously a cyber incident is something to which
 12 local resilience forums must have regard and must be
 13 ready for, and that standard, "Are they ready?" must be
 14 checked; is that right?

15 **A.** So ... so I think, I'm just trying to be clear on the
 16 last part of your question, Mr Keith. These are
 17 standards for LRFs to use, and to assess their own
 18 performance against.

19 **Q.** Yes. So they need to be told, "You must test your
 20 systems, your approach, your policies, your risk
 21 assessments, all the work you do, against a standard
 22 that is suitable for dealing with a cyber incident or
 23 a pandemic influenza"?

24 **A.** It's intended to allow them to do that, yes.

25 **Q.** Yes. And for this one, which is post-Covid, standard

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1 more guidance, more policy?

2 **A.** I think the take-up rates from LRFs were actually pretty
 3 good, more than 70%, from recollection, although I would
 4 have to go and check that, and I'm happy to do so.

5 **Q.** I think there was a difference, was there not, between
 6 the 2014 and 2017 take-up, you may recall?

7 **A.** That may be right.

8 **Q.** Yes. You've referred to standards. The standards to
 9 which you referred, and I think you said there were
 10 18 in all, presumably those standards told the local
 11 resilience forums what areas or things they needed to be
 12 ready for. So are you ready to prepare a local
 13 resilience plan? Are you ready to inform the public of
 14 what they might have to do? Are you ready to deal with
 15 other emergency services and responders and so on and so
 16 forth?

17 **A.** Yes, they covered elements of a response of that nature.

18 **Q.** Presumably, therefore, those standards had to check
 19 whether the local resilience forums were on top of their
 20 game in relation to particular risks, so a pandemic, or
 21 a flood, or something of that sort? Is that how the
 22 standards system worked or not?

23 **A.** So the first set that were produced dealt with those
 24 generic capabilities, how do you run a good strategic
 25 co-ordinating group, for example. We then began to add

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1 15, on page 36, is pandemic influenza preparedness,
 2 local resilience forums need to be told, "The standard
 3 against which you must measure yourself in the context
 4 of pandemic influenza preparedness is this". And you
 5 referred earlier to different -- it's a single page,
 6 you're right, but there is a number of moving parts in
 7 it, because these bodies are told: well, on the one hand
 8 there is a desired outcome, on the other there's
 9 a summary of legal duties, but then you must also have
 10 regard to good practice.

11 **A.** Yes, that's what's in each standard, yes.

12 **Q.** Right. So page 36, please, yes, if you keep it on that
 13 page, thank you.

14 We can see that to achieve good practice in this
 15 area local resilience forum must set out roles and
 16 responsibilities for the full range of supporters --
 17 responders and supporting organisations, that there must
 18 be a pandemic influenza -- pan-flu -- that's based on
 19 scientific evidence, set out the arrangements for
 20 emergency services, expectations of local institutions,
 21 how to put multi-agency recovery arrangements into
 22 practice, have an antiviral distribution strategy, and
 23 so on and so forth.

24 There is a lot there for them to do to be properly
 25 ready for a pandemic influenza.

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- 1 **A.** Yes.
- 2 **Q.** In July 2018, the first version of the National
3 Resilience Standards was published by your department,
4 by the Cabinet Office.
- 5 Could we have that, please, INQ000022975.
- 6 Could we have, please, we can see the date,
7 July 2018, in the bottom right-hand corner.
- 8 Could we have page 2.
- 9 There's the list of contents. Where is the
10 reference on this page or any other page in the National
11 Resilience Standards to pandemic influenza?
- 12 **A.** So I think, as I said before, this is the first set of
13 standards that we published, and we began with the
14 capabilities that you would need for any risk, pandemic
15 included. So, for example, you can see, you know,
16 operating an SCG, as I referred to before, at number 11.
17 That was the first set, with the intention then to add
18 risk specific ones thereafter. And pandemic flu was one
19 of the first we added, because it was the most serious
20 risk.
- 21 **Q.** When did you add pandemic flu, Ms Hammond?
- 22 **A.** So from memory I think it was out for consultation with
23 LRFs towards the end of 2018 and it was published
24 towards the end of 2019 for the first time.
- 25 **Q.** It was published in December of 2019, was it not?

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- 1 **Q.** Not in the primary document which told them whether they
2 were ready or not?
- 3 **A.** Not at this point.
- 4 **Q.** Not until December 2019, on the very cusp of the
5 pandemic?
- 6 **A.** But the risk assessment would have been in their
7 possession throughout.
- 8 **Q.** How are government departments, central government
9 departments, for example the Cabinet Office and the CCS,
10 trained or supervised or made ready by reference to
11 National Resilience Standards?
- 12 **A.** The resilience standards are for local responders, not
13 for the centre of government.
- 14 **Q.** But central government responds in just the same way.
15 Of course, in Covid, the primary response was on the
16 part of central government, was it not?
- 17 **A.** Indeed, and that response is one of the, you know,
18 responsibilities of CCS, to ensure it functions well.
19 That's tested in a number of ways. You know, exercising
20 being one of the really good ones.
- 21 **Q.** Including Operation Cygnus?
- 22 **A.** Exercise Cygnus.
- 23 **Q.** Exercise Cygnus. We'll come to that in a moment.
24 Was there any system of formal validation or
25 assurance, to use the correct terminology, or standards

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- 1 **A.** That sounds about right.
- 2 **Q.** Can I return, please, to my first question on this
3 subject: the integrated review, the ConOps documents,
4 the emergency preparedness documents, the various
5 materials to which we've referred, including that chart
6 at annex 2E of one of those two documents, referred to
7 an influenza pandemic as being one of the risks that
8 everyone had to be on guard for.
- 9 The sole, albeit self-assessed, system for standards
10 and for checking that the moving parts of this system
11 were up to scratch, when first published, made no
12 reference to influenza pandemic at all.
- 13 **A.** The first set of standards didn't include the pandemic
14 influenza one, that's true, but you would need to use
15 all of the capabilities covered by the others in
16 responding to an influenza pandemic.
- 17 **Q.** The local resilience forums pick up this document, and
18 they say, "This is how we must get ready, we must check
19 that we are ready by reference to this document for
20 particular important risks", and we've seen after Covid
21 two of them are pandemic influenza and cyber. Where
22 were the references to the risks to which they had to
23 have regard when checking whether they were
24 satisfactorily prepared?
- 25 **A.** In the national risk assessment.

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- 1 by which the Cabinet Office or government departments
2 could assess either under self-assurance or be assessed
3 to ensure that they were up to scratch?
- 4 **A.** We didn't produce standards for central government.
- 5 **Q.** All right.
- 6 **A.** But as you say, there are documents which describe the
7 responsibilities in the system, including the ConOps.
- 8 **Q.** You've referred to the National Capabilities Survey and
9 I've asked you about that in outline. Was this
10 a voluntary online survey that was renamed in 2016 and
11 then abolished in 2017?
- 12 **A.** Yes, and is it helpful for me to explain a little about
13 that decision in 2017?
- 14 **Q.** Please.
- 15 **A.** So you will have seen from my evidence and from others
16 that after the events in 2017 we reached a view that
17 that survey wasn't quite serving the purpose it was
18 intended for, and there was a piece of work through the
19 summer of that year which resulted in a set of
20 propositions about moving towards a more -- more of
21 an assurance model, for which the resilience
22 capabilities survey wouldn't have been the right tool.
23 So that's the reason we decided not to run it again in
24 that form. It was superseded by some other work on how
25 you assess readiness for particular risks and particular

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1 capabilities, and I think you have in the no doubt large
 2 amount of disclosure to this Inquiry some of the results
 3 of that.

4 **Q.** All right.

5 The National Capabilities Survey, which was
 6 abolished in 2017, was a self-assessment process, was it
 7 not?

8 **A.** Correct.

9 **Q.** The material in that process wasn't even in its granular
 10 form, that's to say the detail of the data, received by
 11 the Civil Contingencies Secretariat, it was, in your own
 12 words, in the Grenfell Inquiry, aggregated by
 13 a third party?

14 **A.** It was aggregated, I think, by a team in CCS, but
 15 forgive me if I've misremembered that.

16 **Q.** That survey was then abolished, and your department,
 17 when you were in post, proposed something called the
 18 local resilience assurance team, that is to say a team
 19 of civil servants in your own department, managed and
 20 supervised of course by your department, who would then
 21 go out and try to replicate the information that had
 22 once upon a time sought to be secured by the survey?

23 **A.** I wouldn't say replicate the survey, no.

24 **Q.** All right. What happened to the local resilience
 25 assurance team?

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1 resilience forums between 2018 and 2019?

2 **A.** That's right.

3 **Q.** When you were in post?

4 **A.** Correct.

5 **Q.** What happened to that voluntary scheme, Ms Hammond?

6 **A.** I think it was impacted by Operation Yellowhammer, with
 7 the expectation that it would be picked back up once
 8 that work concluded.

9 **Q.** You mean nothing happened to the scheme thereafter
 10 because your attention and capacity and resources were
 11 diverted elsewhere?

12 **A.** I think it was set aside, yes.

13 **Q.** Was it -- nothing happened to the scheme, it wasn't just
 14 impacted, it ended?

15 **A.** Not -- so set aside. By set aside I mean not that it
 16 was an intention to permanently cease it, but that work
 17 was deprioritised for that period.

18 **Q.** Ms Hammond, would you agree with the following
 19 propositions, drawing upon your expertise as the former
 20 director of the Civil Contingencies Secretariat: in the
 21 field of civil contingencies, the Cabinet Office has no
 22 local or operational role? It doesn't deliver response
 23 activity on the ground, for example.

24 **A.** Yes, that's broadly correct. There is a very small
 25 number of exceptions to that, with the -- some of the

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1 **A.** It was put forward as a proposal into the -- forgive me,
 2 I've forgotten the name of the process in 2017. Perhaps
 3 you'll remind me.

4 **Q.** The integrated review?

5 **A.** That sounds right. There are a lot of different
 6 processes, forgive me.

7 **Q.** There are.

8 **A.** But the funding for the creation of that team wasn't
 9 provided.

10 **Q.** So it wasn't set up?

11 **A.** It wasn't.

12 **Q.** So the survey was replaced by nothing?

13 **A.** At the time I left CCS, the survey had not been --
 14 didn't have a clear successor, that's correct.

15 **Q.** Ms Hammond, it didn't not just have a clear successor,
 16 it was replaced by nothing?

17 **A.** I don't think that's quite true. So the piece of work
 18 I'd just described on how you analyse -- created a tool
 19 for analysing readiness for risks was in existence.
 20 I think you have some of the reports that were produced
 21 having used that. What we hadn't been able to do was
 22 roll it out to the same extent we would have liked to.

23 **Q.** Is that a reference to what replaced the local
 24 resilience assurance team, which was never started,
 25 which was a voluntary scheme by a proportion of local

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1 work that we did on capacity for managing excess deaths
 2 being an example, where we were slightly more
 3 operationally involved.

4 **Q.** But as a general rule that is a correct proposition, is
 5 it not?

6 **A.** Generally, yes.

7 **Q.** The Cabinet Office and the CCS monitored what everybody
 8 else did, it brokered policy solution, it liaised, it
 9 made the wheels of government turn?

10 **A.** It set the standards and it managed those relationships,
 11 yes.

12 **Q.** Yes. The standards which in the context of the local
 13 resilience forums we've just looked at, they're those
 14 three versions from 2017 onwards?

15 **A.** Those standards and the other -- sorry, standards small
 16 S rather than capital S, the other standards set out in
 17 the bits of guidance you've referred to.

18 **Q.** Day-to-day control of national emergencies was deferred
 19 to local government departments, other government
 20 departments, and local emergencies to local resilience
 21 forums and strategic co-ordinating groups?

22 **A.** The system is based on the idea that you manage
 23 an emergency at the lowest sensible level. So they
 24 would only be escalated to central government if that
 25 was necessary.

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1 **Q.** Yes, which is why I repeat, day-to-day control of
 2 national emergencies would be in the hands of government
 3 departments, but the local side, if it was a local
 4 emergency, would be, under the principle of
 5 subsidiarity, deferred to local resilience forums and
 6 strategic co-ordinating groups?
 7 **A.** I would add to the first part of your statement,
 8 departments and the centre of government, the
 9 Cabinet Office.
 10 **Q.** The Cabinet Office has no inspectorate role, it didn't
 11 inspect local bodies, local resilience forums or
 12 category 1 or 2 responders?
 13 **A.** Correct.
 14 **Q.** It doesn't formally assess or assure local or
 15 departmental readiness. That's a quote from your
 16 colleague Mr Hargreaves.
 17 **A.** Correct.
 18 **Q.** It works to drive -- in again your own words --
 19 cross-cutting preparedness?
 20 **A.** That's right, it's about making sure that the whole is
 21 coherent when you add it together.
 22 **Q.** There was no formal process of inspection of local
 23 resilience forums, the process was self-assured, and the
 24 survey procedure ended, the National Resilience
 25 Standards against which their performances were rated

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1 have a quick word?
 2 **MR KEITH:** Would my Lady excuse me a moment.
 3 **(Pause)**
 4 INQ000097685.
 5 **LADY HALLETT:** I think you were getting mixed messages
 6 there.
 7 **MR KEITH:** I think I was, my Lady.
 8 INQ000097685, please. Paragraph 25, page 19.
 9 This is an extract from the Resilience Framework
 10 document published by the United Kingdom Government in
 11 December 2022, after your time in office in the CCS, of
 12 course. But on the subject of the lead government
 13 department model, and that's how you described it
 14 earlier, the government itself says this in
 15 paragraph 25, thank you:
 16 "The UK Government will continue to use the Lead
 17 Government Department model to guide risk ownership, but
 18 there will be further clarification of roles and
 19 responsibilities for complex risks."
 20 My Lady, we'll come back to what that means in
 21 evidence next week:
 22 "... NSRA risks are primarily owned and managed
 23 within Lead Government Departments ... although LGDs
 24 must work with a range of departments and regulators to
 25 make sure they are well understood, managed and invested

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1 were rated by themselves, and in any event made no
 2 reference to pandemic influenza until December of 2019?
 3 **A.** No, but the capabilities they described would all have
 4 been relevant for a pandemic influenza response.
 5 **Q.** Local resilience forums were supervised along with
 6 strategic co-ordinating groups by the RED division of
 7 the Department for Levelling Up, Housing and
 8 Communities, so there was no direct link between the
 9 Cabinet Office and local resilience forums or a local
 10 government department and local resilience forums?
 11 **A.** I don't think that is completely correct. So
 12 Cabinet Office did have contact with LRFs. So,
 13 for example, we ran along with RED an annual set of
 14 chairs conferences, so there's some direct contact
 15 there. But the primary link is through RED.
 16 **Q.** Could we have, please, N7685 [sic], please. I'm afraid
 17 I have only a paragraph 25 reference. I don't know the
 18 page number, if somebody could help. It's the
 19 Resilience Framework.

(Pause)

21 My Lady, would that be a convenient point for
 22 a break? I'm hearing whispers that levels of exhaustion
 23 are increasing.
 24 **LADY HALLETT:** Oh, right. We wouldn't normally take it now,
 25 but if that's a convenient moment. Do you want to just

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1 in across the risk lifecycle."
 2 Then, perhaps passing over the valuable role of the
 3 Cabinet Office in the next sentence:
 4 "This model works well in principle, and in
 5 practice, in the vast majority of cases. But there are
 6 also limitations of the LGD model, particularly where
 7 risks become more complex, meaning that their impacts
 8 can cross departmental and sectoral boundaries. For
 9 example, the response to COVID-19 demonstrated the
 10 challenge for a single part of government leading on an
 11 emergency which reached deeply into all parts of the
 12 economy and society, and required leadership from all
 13 parts of government. Although there was an
 14 understanding of the risk of pandemic flu, treating it
 15 as a health emergency [that is to say therefore to be
 16 dealt with by the Department of Health and Social Care]
 17 meant that there was limited planning outside of the
 18 healthcare sector."
 19 Do you believe that the lead government department
 20 model remains fit for purpose, Ms Hammond?
 21 **A.** Can I give you an answer which is yes and no?
 22 **Q.** Well, I think I'd be disappointed if you didn't, so why
 23 don't you.
 24 **A.** So the yes is: I think lead government departments are
 25 important because they mean the people who are primarily

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1 leading the work in relation to a risk are the people
2 who understand it, and that application of expertise is
3 extremely important, I think particularly in relation to
4 health risks where the vast majority of other responders
5 will not be health professionals. That seems to me to
6 be really critical.

7 But I do think for the risks that are in the top
8 right-hand corner of that matrix, in the red boxes --
9 **Q.** No one has seen the red box, but we'll come to that
10 after the break.

11 **A.** You have, I hope, and assume.

12 There can be an issue of scale which kicks in as you
13 get into the response, and I think that's what we saw in
14 Covid-19 in particular. So that's my yes and my no.

15 **Q.** Quite, thank you.

16 One final question, perhaps, if my Lady will allow
17 me just on these structural points, we've looked now at
18 almost all the formal parts of the civil contingencies
19 structure but another very important area are the links
20 between the United Kingdom central government and the
21 devolved administrations.

22 **A.** Yes.

23 **Q.** What formal structures or procedures were in place
24 pre-Covid for liaison between the Cabinet Office,
25 central government, lead government departments and the

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1 come from them. So we were often invited to the Wales
2 Resilience Forum, for example. It's a pretty regular
3 pattern of contact.

4 **Q.** What formal structure obligated the regular, transparent
5 and significant meetings -- meeting between the CCS, the
6 Cabinet Office and the devolved administrations in this
7 vital field of civil contingencies?

8 **A.** I don't think there is an obligatory structure, but
9 I can say from my time in post those were very positive
10 working relationships.

11 **Q.** So positive that by the time Covid struck the lines of
12 communication had atrophied?

13 **A.** I wouldn't agree with that statement.

14 **MR KEITH:** All right.

15 My Lady, is that a convenient point?

16 **LADY HALLETT:** You're determined, Mr Keith, aren't you?

17 **MR KEITH:** Yes.

18 **LADY HALLETT:** Right. I shall return at 3.10, please.

19 (2.55 pm)

(A short break)

21 (3.10 pm)

22 **MR KEITH:** So, Ms Hammond, may we then, please, look at the
23 National Security Risk Assessment process in detail, and
24 you've referred to the red boxes and we're going to look
25 at that in detail now.

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1 devolved administrations?

2 **A.** So in my time in CCS we tried to build those links, we
3 thought it was really important. So just to give you
4 some examples of formal points of contact, the devolved
5 administrations were members of the Pandemic Flu
6 Readiness Board, and part of that programme of work.

7 **Q.** And that was the board that was instituted in 2017 --

8 **A.** That's correct.

9 **Q.** -- by order of the National Security Council THRC
10 committee chaired by the then Prime Minister?

11 **A.** Correct.

12 **Q.** But the Pandemic Flu Readiness Board's work was
13 significantly interfered with by what?

14 **A.** By Operation Yellowhammer.

15 **Q.** All right. So that's one area of formal liaison. What
16 other areas were there?

17 **A.** There were pretty regular meetings between CCS and
18 devolved administrations.

19 **Q.** On a personal, individual level -- or not a personal but
20 individual level you mean?

21 **A.** On an individual level, on a team level. So I'm just
22 trying to give you some more examples --

23 **Q.** You would reach out to them and say, "We are the CCS, we
24 should meet"?

25 **A.** Yes, in some cases. In some cases the invitation would

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1 Could you help us, please, with a general
2 description of the NSRA process. I call it NSRA
3 although it had a different part before, I think, 2016,
4 the national risk assessment, and then they came
5 together in 2019 and there is a public-facing National
6 Risk Register as well.

7 **A.** Correct.

8 **Q.** But essentially, the process started around about 2010,
9 and you'll correct me if I'm wrong with that date, of
10 the government providing a document that assessed the
11 top risks facing the United Kingdom, in very broad
12 terms, and that process, which involved the publication
13 of these assessments, both at official sensitive level
14 and a variant that was public facing?

15 **A.** Yes.

16 **Q.** That process has meant, I think, perhaps around about
17 nine or ten different assessments or documents have been
18 made available over time. Is that right?

19 **A.** I haven't counted, but --

20 **Q.** I haven't counted them either.

21 **A.** It's on a regular two-year cycle through that period,
22 yes.

23 **Q.** All right. The National Security Risk Assessment, and
24 we'll use that description because that's the one that
25 it has been called collectively since 2019, it doesn't

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1 seek to cover every possible risk, does it?
 2 **A.** No. It groups risks together using the reasonable
 3 worst-case scenario for that set of risks.
 4 **Q.** So it groups different risks together like, I don't
 5 know, two or three, or perhaps there is only one
 6 category of flooding or there might be one category of
 7 cyber attack or there might be some other form of risk
 8 in a generic sense, and in the field of disease, for
 9 a long time the National Security Risk Assessment
 10 identified pandemic influenza, of course, and it
 11 identified a new and emerging disease?
 12 **A.** Yes.
 13 **Q.** What is done then is that a reasonable worst-case
 14 scenario is assessed for each of those risks, and the
 15 government asks itself, on expert advice internally --
 16 **A.** And externally.
 17 **Q.** Are you referring there to the Royal Academy of
 18 Engineering external advice or to advice at the time?
 19 **A.** I'm referring to external input into the process of
 20 assessing the risk.
 21 **Q.** What sort of external input was done during your time?
 22 **A.** So there are, I think, three points at which that takes
 23 place. So the first is at the start of the process,
 24 when departments are identifying their lead risk
 25 scenario, and they draw on all of the networks at their

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1 **Q.** So perhaps I can return then to my original proposition.
 2 The risk assessments were not externally validated
 3 or checked by anybody outside government, in the sense
 4 of the people who were looking at this process not being
 5 government employees or scientists?
 6 **A.** No, I don't think that's right. Those first two steps
 7 definitely incorporate people who are not on any sort of
 8 government payroll.
 9 **Q.** The first step was the risk assessment steering group,
 10 RASG. There was then a step under which the assessments
 11 were considered by expert challenge groups, and then
 12 also a review by the network of Government Chief
 13 Scientific Advisers, senior civil servants across
 14 Whitehall and economic behavioural science and CBRN
 15 specialists?
 16 **A.** Yes, it's particularly those expert challenge groups
 17 that bring in external expertise.
 18 **Q.** So are you saying that the government went outside
 19 itself and approached academics and scientists and
 20 experts in the private sector and said, "Will you come
 21 and review these documents for us"?
 22 **A.** Yes, they formed groups of particular expertise. You
 23 have evidence, I think, of some of the members of those
 24 groups.
 25 **Q.** So those risks would be identified, and then the

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1 disposal, which will include external contacts,
 2 academia, experts they're in touch with. That's the
 3 first point.
 4 The second then is, in the process of assessing that
 5 scenario, there was a structure called expert groups,
 6 which brought together experts in particular fields to
 7 look at assessing the risks, and challenging them, and
 8 in some cases making suggestions about methodology, as
 9 you can see from Dr Rubin's statement. Then, in the
 10 process of clearing the risk assessment, there is
 11 a degree of scrutiny from across the government chief
 12 scientific adviser community.
 13 So I think those are the three things I'm referring
 14 to.
 15 **Q.** We may be at cross-purposes.
 16 **A.** Oh, forgive me.
 17 **Q.** I meant external of government.
 18 **A.** Indeed, I think I am including the chief scientific
 19 community in that bracket because so many of them bring
 20 external scientific expertise and networks.
 21 **Q.** The Chief Scientific Advisers are Government Chief
 22 Scientific Advisers, are they not?
 23 **A.** That's correct, whilst they're in that post. But many
 24 of them, like Sir Patrick Vallance, bring external
 25 expertise.

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1 reasonable worst-case scenario for each risk would be
 2 identified, so that the emergency system would know what
 3 to plan for. So if the reasonable worst-case scenario
 4 for pandemic influenza is, for argument's sake, 800,000
 5 deaths, then that is the basis upon which the rest of
 6 the country, but in particular government departments
 7 and local resilience forums, can prepare?
 8 **A.** Yes. We produced a set of planning assumptions based on
 9 those risks which allow you to see what capabilities you
 10 need.
 11 **Q.** The principle underpinning this risk assessment process
 12 was this, wasn't it: that because it's impossible to
 13 identify in advance every single risk, and you can't
 14 prepare and plan in any event for every single risk, the
 15 system is built on the idea of identifying a general
 16 risk, planning for the worst -- the reasonable
 17 worst-case scenario in relation to that risk, and then
 18 saying "That's what we need to be ready for"; is that
 19 a fair summary?
 20 **A.** Yes, I think that's a reasonably fair summary.
 21 **Q.** But it follows, does it not, Ms Hammond, that there was
 22 no planning for specific risks or, for example,
 23 a disease with particular characteristics?
 24 **A.** So the idea of the reasonable worst-case scenario is
 25 that it would enable you to be prepared for a whole

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1 variety of scenarios which were less severe than that,
2 hence you pick something realistic but at the top end of
3 the worst that you might expect.

4 Of course there are variants of risks that some
5 departments look at specifically, and, you know,
6 flooding is a good example of that, which can vary by
7 location, but that's the doctrine of creating that risk
8 picture.

9 **Q.** But this doctrine failed to pay any regard to the
10 particular characteristics of the risk or, in this case,
11 the disease which might in practice determine what the
12 reasonable worst-case scenario really would be?

13 **A.** I don't think that's true. I think the reasonable
14 worst-case scenario for a pandemic, for example, was
15 based on modelling of what that particular scenario
16 might look like, which is based on a set of assumptions
17 about those characteristics.

18 **Q.** Well, let's have a look at disease, then, or perhaps
19 coronavirus.

20 So the risk identified in advance of Covid was
21 two-fold, there were two risks, pandemic influenza and
22 a new and emerging disease, in broad terms?

23 **A.** Correct.

24 **Q.** Neither of those risks said anything at all, did they,
25 about the particular characteristics of, on the one

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1 **Q.** Precisely.

2 **A.** Because the planning then in part is about how you
3 mitigate that impact. It is the reasonable worst-case
4 scenario.

5 **Q.** But bluntly, if you focus everybody's attention on the
6 reasonable worst-case scenario, 820,000 deaths, where is
7 the consideration of whether or not, in practice, that
8 number can be reduced when the disease strikes, that
9 steps can be taken to make sure it never gets to that
10 level of death?

11 **A.** I think that's part of the planning process, that the
12 risk scenario is intended to be a tool that helps in
13 that. So the work of the public health system,
14 for example, wouldn't simply be focused on how you
15 manage that number, it would be focused on how you
16 prevent the disease in the first place.

17 **Q.** But, Ms Hammond, you know and you accept in your witness
18 statement that, as a result of this reasonable
19 worst-case scenario approach, there were aspects of
20 coronavirus that weren't planned for, because the focus
21 was too -- the focus was placed too closely on the
22 number of excess deaths, so no one stopped to ask
23 themselves: why are we assuming, why are we planning for
24 an eventuality with so much death, when in reality there
25 may be means open to us to prevent it ever getting as

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1 hand, influenza or, the other hand, a new and emerging
2 disease, like how long the incubation period might be of
3 the disease, whether the disease was asymptomatic or
4 symptomatic, whether it would have a fast or a slow
5 transmission rate?

6 **A.** So I think for influenza those assumptions are built
7 into the modelling which generates, for example, the
8 number of expected fatalities, as you described.

9 **Q.** Yes.

10 **A.** And some of them are described in the risk assessment
11 documents. So, for example, on influenza, there is
12 a reference to case numbers likely to be being higher
13 than the recorded numbers because there may be some
14 asymptomatic individuals.

15 **Q.** The reasonable worst-case scenario for pandemic
16 influenza was, I think, around about 820,000 deaths; is
17 that right?

18 **A.** That's right.

19 **Q.** Right. So an assumption was made that an influenza
20 pandemic would cause that number of deaths, and
21 therefore that is what everyone had to plan for;
22 correct?

23 **A.** Yes, the assumption is based -- doesn't build in the
24 things that you might do that could bring that number
25 down.

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1 bad as that?

2 **A.** If I may, I don't quite agree with that assessment.
3 I don't think it's the use of that reasonable worst-case
4 scenario doctrine that is the issue. I do think,
5 though, one of the things we learned from coronavirus is
6 there perhaps needs to be another stage, which is:
7 having worked out plans that would allow you to deal
8 with your reasonable worst-case scenario, thinking about
9 what are the differences in how a risk could materialise
10 that would render those plans less effective, and then
11 looking at how likely those differences are. And for
12 things like a pandemic, they can be relatively small
13 clinical differences that can make a difference.

14 **Q.** Well, indeed, and we'll come to some of those clinical
15 differences in a moment. But you accept in your
16 statement that it's obvious that the Civil Contingencies
17 Secretariat would have been better prepared if the
18 reasonable worst-case scenario for a pandemic had been
19 closer to the realities of Covid?

20 **A.** I think that has to be true.

21 **Q.** And the reason that the reasonable worst-case scenario
22 was not as close as it should have been to the realities
23 of Covid is that it paid no regard to the particular
24 characteristics of any disease, whether it be
25 a coronavirus or an influenza virus, that may --

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1 A. I don't think that's right.
 2 Q. -- have affected the outcome and therefore the need for
 3 planning?
 4 A. I don't think that's right. I think the reason is that
 5 the expert opinion on the most likely reasonable
 6 worst-case scenario didn't precisely match the scenario
 7 that we saw in 2020.
 8 Q. Diseases have individual characteristics, do they not?
 9 A. Indeed.
 10 Q. A short or a longer incubation period?
 11 A. Yes.
 12 Q. There may or may not be an antiviral in existence?
 13 A. That's right. I wouldn't say that's a characteristic of
 14 the disease, I'd say that's a characteristic of the
 15 medical ability to deal with it.
 16 Q. All right, it's a facet of the countermeasures, maybe?
 17 A. Correct.
 18 Q. There may or may not be a vaccine?
 19 A. Again, a countermeasure I think.
 20 Q. The coronavirus or virus may or may not be asymptomatic?
 21 A. Correct.
 22 Q. It may have stuttering transmission or be very, very
 23 readily transmitted?
 24 A. I don't think you could generate assumptions about the
 25 impact of a disease without having made some assumptions

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1 asking you about is whether or not you would accept the
 2 proposition that, because the risks were identified at
 3 generically such a broad level, the plans and the
 4 assumptions and the reasonable worst-case scenarios
 5 which directed everybody as to how they should respond
 6 failed to have sufficient regard to the reality of the
 7 disease, which would necessarily affect the number of
 8 deaths, the number of excess deaths, the mortuary
 9 capacity, all the other clinical aspects that you've
 10 referred to?

11 A. Forgive me, Mr Keith, I do understand your question,
 12 I think I'm just disagreeing with your proposition that
 13 it's the breadth of the assessment that is the issue.

14 Q. In your witness statement -- could we have, please,
 15 INQ000145733, page 28 -- you say:

16 "Even though the scenario used in the [National
 17 Security Risk Assessment] was a pandemic generated by
 18 influenza not coronavirus, the NRPA's, [that's to say the
 19 planning assumptions] generated had identified many of
 20 the impacts seen in the Covid-19 pandemic."

21 So what you're saying is: broadly, the planning, the
 22 risk, the reasonable worst-case scenario and the
 23 planning assumptions that are drawn from it worked
 24 insofar as they identified many of the impacts. So the
 25 impacts were, to a large extent, foreseen.

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1 about those characteristics. This is really, you know,
 2 an area of deep expertise on epidemiological modelling
 3 which sits more in the Department for Health and Social
 4 Care than in CCS. But I don't think it would be fair to
 5 say that there had been no assumptions about
 6 characteristics in generating the scenario.

7 Q. But you were, to use your own terminology, the owner of
 8 this assessment process in the Cabinet Office. The NSRA
 9 and the reasonable worst-case scenario is your field.
 10 You're the one who produces it or did produce it and
 11 brought it together and took the expertise in, and told
 12 the country: this is how you go about planning and
 13 preparing.

14 A. It's absolutely right to say that CCS owns that process
 15 and the bringing together of the risks. What we
 16 weren't, clearly, was an expert in every single risk
 17 area. So for each risk there was a departmental lead,
 18 which is often but not always the same as the lead
 19 government department for a response, and those
 20 departmental leads are the people who have the best
 21 understanding of the risk and how you assess it. You
 22 would want your best epidemiologists assessing this
 23 risk, I think that is clear.

24 Q. Well, I don't think anybody suggests there was
 25 a shortage of intelligence or expertise. What I'm

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1 A. Yes, although I think the following sentence is
 2 an important qualification.

3 Q. Yes:

4 "Using the information generated by that process
 5 should have given ... the ability to be ready for many
 6 of the impacts seen (eg, workforce absence rates in most
 7 sectors stayed below 25%). Those assumptions of course
 8 did not build in the impacts of policy decisions taken
 9 in relation to the Covid-19 pandemic."

10 So what you're saying is: in essence, the risk
 11 assessment and planning assumption process worked
 12 because it did correctly identify, to use your words,
 13 many of the impacts seen in the pandemic; is that what
 14 you're saying?

15 A. I think that is true. What I'm not suggesting is that
 16 the risk identified was exactly the one that we saw
 17 materialise. That's clearly not the case.

18 Q. When you say "the NRPA's generated had identified many of
 19 the impacts", and then you go on to give the example of
 20 workplace absence rates, what other many impacts can you
 21 identify for us, please?

22 A. So let me try to think of good examples.

23 So there were some -- there is some assessment of
 24 economic impact which doesn't fully match the
 25 coronavirus impact, for the reason set out in the

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1 sentence below, that it doesn't build in the effects of
 2 lockdowns. There is impact of assessment on the
 3 workforce.

4 The mortality numbers were broadly in line with the
 5 estimates for an unmitigated Covid-19 pandemic, although
 6 happily the measures put in place brought those numbers
 7 down. The reasonable worst case of course assumes that
 8 hasn't taken place, because it's a reasonable worst
 9 case.

10 **Q.** So of the many impacts to which you referred to yourself
 11 in paragraph 4.2, the two which you can recall are that
 12 the assessment process correctly identified a real
 13 problem with workforce absence rates, and obviously, and
 14 terribly, the appalling number of excess deaths?

15 **A.** Those are two good examples, I think, yes.

16 **Q.** What other areas -- you used the words "many of the
 17 impacts were correctly identified". What other impacts
 18 did you identify?

19 **A.** I think I would need to go and look, refresh my memory
 20 of the impacts set out in the risk assessment in order
 21 to give you a fully answer, but I'm very happy to do
 22 that.

23 **Q.** Ms Hammond, you have long known and it is as wide(?) as
 24 in your own statement, that this would form a central
 25 part of examination today in this Inquiry. The impacts

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1 **A.** By all means.

2 **Q.** Correctly identified was a certain amount, a stockpile,
 3 of personal protective equipment and associated
 4 equipment. Did that stockpile -- was that stockpile
 5 correctly envisaged to be inadequate in terms of the
 6 amount of time it would last for?

7 **A.** Erm --

8 **Q.** Did the NRPA correctly identify the need for protective
 9 equipment over such a long period and in such vast
 10 quantities?

11 **A.** No, I don't think so.

12 **Q.** A stockpile of antibiotics was available and planned for
 13 to deal with secondary bacterial infections, often
 14 associated with respiratory infections. But the fact
 15 that there was no antiviral for coronavirus was not
 16 anticipated or planned for, was it?

17 **A.** No, that's correct.

18 **Q.** The fact that there was no vaccine was not anticipated
 19 or planned for?

20 **A.** No, for flu there is a fairly established vaccination
 21 production route.

22 **Q.** Because the government had a stockpile of Tamiflu,
 23 antiviral for flu, it had a National Pandemic Flu
 24 Service, and there were vaccines which could be modified
 25 with some ease in order to cater for a new moderated flu

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1 anticipated from the reasonable worst-case scenario risk
 2 assessment process lie at the very heart of your own
 3 acceptance that what transpired was a very long way from
 4 what was planned for, is it not?

5 **A.** I think there are some really -- there are obviously
 6 some really key differences between pandemic flu and
 7 coronavirus, and they lie in the characteristics of the
 8 disease, particularly in the ability to treat it. So
 9 there are treatments for flu. That was not the case for
 10 coronavirus. There is a fairly rapid accepted built
 11 route to a vaccine for novel flu. That wasn't the case
 12 for coronavirus and, as you've already referred to,
 13 there is a substantial amount of asymptomatic
 14 transmission for coronavirus, which doesn't exist at the
 15 same level for flu.

16 Those are characteristics. They give rise to a set
 17 of policy decisions which themselves had impacts that
 18 were not identified for that reason. I think that's the
 19 explanation I'm trying to give you. What I'm not
 20 attempting to say is that this risk assessment reflected
 21 exactly the reality that occurred in 2020.

22 **Q.** Ms Hammond, you make the positive assertion that this
 23 risk assessment process generated many of the impacts,
 24 so perhaps I may be permitted to put some suggestions to
 25 you.

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1 virus?

2 **A.** I think those are the key differences between the
 3 different risks.

4 **Q.** They are not inconsequential differences, are they?

5 **A.** No, I am not suggesting they are.

6 **Q.** They are massive. Therefore to say that therefore many
 7 of the impacts seen in the Covid pandemic were correctly
 8 identified doesn't really pass muster, does it?

9 **A.** I think they're not impacts, is what I would say. So
 10 I probably used a term of art in a way that's been
 11 unhelpful in this statement.

12 **Q.** Mass contact tracing was not anticipated or planned for?

13 **A.** Again, in the way I'm using the word, that wouldn't be
 14 an impact, that is a tool for managing --

15 **Q.** A countermeasure. Was it anticipated and planned for?

16 **A.** No.

17 **Q.** Were lockdowns anticipated or planned for?

18 **A.** Not on the scale envisaged. There's certainly
 19 discussion of some social distancing measures, school
 20 closure, but not what you would call a lockdown.

21 **Q.** Ms Hammond, you know very well that in Pandemic Flu
 22 Preparedness Board documentation, to which you were
 23 party, there was discussion now and then of the
 24 possibility of social restrictions. Was there any
 25 consideration of full national lockdowns?

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1 A. No, there wasn't, because --
 2 Q. Right.
 3 A. -- the pandemic flu scenario didn't make that
 4 an effective tool.
 5 Q. Was there any discussion of schools being closed on
 6 a national basis?
 7 A. Yes, there was, and for that reason a draft school
 8 closure power was included in the pandemic flu Bill
 9 which became the Covid-19 -- the coronavirus Bill --
 10 Coronavirus Act, forgive me.
 11 Q. For such a length of time that consideration would have
 12 to be given to whether or not children and pupils could
 13 sit national exams?
 14 A. I don't think the planning was that well developed.
 15 Q. No.
 16 A. But the potential for ministers wanting to take that
 17 decision had been identified.
 18 Q. What was envisaged or planned for or foreseen was
 19 a temporary closure of schools, was it not?
 20 A. Yes, driven in part by potential for absence rates in
 21 the teaching and support staff of schools, which might
 22 lead to the need to close them for safety.
 23 Q. There was debate and consideration and planning for
 24 workforce absence rates, which is the only example that
 25 you provide in that paragraph.

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1 Q. You know that process intimately, and you could not have
 2 not known that process coming here today.
 3 A. Forgive me, could you just repeat that point.
 4 Q. Yes. Are you suggesting to my Lady that you don't know
 5 enough about the reasonable worst-case scenario and the
 6 risk assessment process to be able to answer my
 7 question?
 8 A. I'm suggesting that I'm not an expert, and your question
 9 was what debate was there amongst the experts about the
 10 possibilities of symptomatic versus asymptomatic
 11 transmission, to which I don't know the answer.
 12 Q. No, my question was: what debate was there in the
 13 confines of the National Security Risk Assessment
 14 process, that page which we'll look at in a moment and
 15 in the assumptions, about asymptomatic or symptomatic
 16 transmission?
 17 A. I think the point I'm making, perhaps badly, is that
 18 that debate would have occurred between the experts
 19 assessing the risk.
 20 Q. Could we look, please, at INQ000147771, page 1. Ah.
 21 Would my Lady give me a moment? That's not the document
 22 I was expecting.

(Pause)

I may have put an extra --

25 LADY HALLETT: Could we take that one down, please.

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1 Was there any consideration, foresight or planning
 2 for total economic collapse, furlough scheme, for
 3 national support financially, and for the closing of
 4 businesses and, in effect, the economy?
 5 A. All of things flow from the planning for a lockdown, so
 6 the answer follows no.
 7 Q. Clinically, what debate was there about whether or not
 8 either of the next two possible pandemics, whether it
 9 was pandemic influenza or a new and emerging disease,
 10 would be symptomatic or asymptomatic, and therefore
 11 having a massive impact on transmissibility and spread?
 12 A. I think you would need to direct that question to the
 13 clinical experts, including the Chief Medical Officer.
 14 Q. What debate was there in the National Security Risk
 15 Assessment process, for which you took responsibility,
 16 and in the national risk assumptions concerning whether
 17 or not the next disease would be asymptomatic or
 18 symptomatic?
 19 A. I'm afraid I don't know. Individual risk assessment led
 20 by the experts. You can imagine there are tens of risks
 21 in the NSRA. As the director of CCS I didn't sit in
 22 discussion for all of them.
 23 Q. Ms Hammond, you yourself referred to the red box, the
 24 risk assessment process.
 25 A. Yes.

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(Pause)

1 MR KEITH: INQ000147771. That's what I said.
 2 Page 1, the 2019 National Security Risk Assessment.
 3 Was this the risk assessment in force in play at the
 4 time of the Covid pandemic?
 5 A. Yes.
 6 Q. Page 3, please. This is the foreword. In the third
 7 paragraph, could you zoom in, please:
 8 "The analytical framework ensures that our
 9 capabilities, plans and priorities are driven by
 10 evidence and expert judgement, and that risks are
 11 assessed in a consistent way. Crucially, the NSRA
 12 recognises that a large number of risks that the UK
 13 faces can be planned for generically: taking a risk
 14 agnostic approach ..."
 15 What does that mean?
 16 A. So that refers to the process of generating the National
 17 Resilience Planning Assumptions. They are formed by
 18 looking at the range of impacts assessed throughout the
 19 NSRA, and identifying essentially the most severe form
 20 of each, with the theory --
 21 Each risk?
 22 A. Of each impact. With the idea being that if you plan
 23 for the most severe impact that the risk assessment
 24 tells you you might see, you will be ready for lesser
 25

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1 manifestations of that impact. So crudely, if you plan
2 for 50,000 casualties and 10,000 occur, you should be
3 ready for that.

4 **Q.** Plan for the worst-case scenario and ignore the
5 particular characteristics of the potential disease that
6 may have a huge difference on its impact and therefore
7 on the planning?

8 **A.** I think what you're describing is the fact that there
9 are not multiple risk scenarios in here for each risk.

10 **Q.** All right.

11 Page 5, please, the contents. We can see there
12 a number of areas of risk, and towards the bottom of the
13 page on 134, human and animal disease.

14 Could we have page 6, please, the last paragraph:

15 "The [National Security Risk Assessment] does not
16 present an exhaustive list of all national security
17 risks, instead focussing on those perceived to be the
18 most serious. This approach allows risk owners and
19 planners to understand the common consequences of the
20 most serious risks ... and the UK to take a common
21 consequences approach to planning."

22 So by a common approach, a non-specific approach?

23 **A.** It's exactly what I've just described. Planning for the
24 top end impact assumptions.

25 **Q.** Top of page 7, you can see there a "Note to readers":

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1 **A.** No. I think the planning assumptions are the highest
2 end impacts taken from across the matrix.

3 **Q.** Page 10, methodological challenges -- sorry, "Risks
4 under review", "How to navigate the NSRA". So that
5 tells us that:

6 "... risks ... are regularly reviewed to ensure they
7 ... reflect the most plausible challenging scenario."

8 If you could zoom back out, please, you can see
9 part A deals with the summaries and part B the national
10 planning assumptions to which you referred.

11 **A.** Yes.

12 **Q.** Page 13, there is a list of risks, and in the middle of
13 the page or towards perhaps the second half of the
14 page -- my Lady, so that it's absolutely clear, some of
15 the risks which the United Kingdom faces, well, it's
16 self-evident, are serious and threatening, and knowledge
17 as to the fact that the United Kingdom understands what
18 those risks are could be used against it and, therefore,
19 they are wisely and properly redacted from this copy of
20 the document as irrelevant and sensitive.

21 But four particular types of risk which are
22 identified here are influenza-type pandemic,
23 antimicrobial resistance, emerging infectious disease,
24 major outbreak of animal disease.

25 Could we then go to page 135, which is the one with

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1 "Some of the risks have not changed in terms of
2 their likelihood ... since the 2015 NSRA or 2016 NRA,
3 however they have moved position on the matrix due to
4 methodological improvements made between iterations.
5 Low temperatures and heavy snow, storms, influenza-type
6 pandemics and animal disease are examples of risks which
7 have shifted due to methodology."

8 Page 8, you will see there a reference to
9 non-malicious risks, so that's what you were discussing
10 earlier, isn't it, Ms Hammond?

11 **A.** Hazards, yes.

12 **Q.** "Influenza type pandemic remains one of the most
13 critical risks facing the UK and is the driving risk
14 behind numerous National Resilience Planning
15 Assumptions ..."

16 Page 9:

17 "... risks must be interpreted and used in light of
18 other available and relevant information. Risk
19 management initiatives and strategic direction should
20 not be solely dictated by the position and/or colour of
21 a risk on the matrix ..."

22 What does that mean?

23 **A.** I think it means that you shouldn't only plan for the
24 most severe risks.

25 **Q.** But isn't that in reality what did happen?

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1 which we're most centrally concerned, influenza-type
2 pandemic:

3 "Human and Animal Disease ...

4 "Highlights

5 "Influenza-type pandemic remains the most severe
6 non-malicious risk in the NSRA, with the potential to
7 cause catastrophic impacts across a wide range of
8 sectors, hundreds of thousands of fatalities and
9 millions of casualties."

10 If you could scroll back out, please:

11 "Over the past 30 years, more than 30 new or newly
12 recognised diseases have been identified."

13 Are those diseases that are just influenza or is
14 that a general point, Ms Hammond?

15 **A.** I think that's more -- not just influenza, forgive me.

16 **Q.** "The emergence of new infectious diseases is
17 unpredictable but evidence indicates it may become more
18 frequent."

19 Then we can see this chart, "Likelihood" at the
20 bottom, "Impact" on the left: "Influenza-type pandemic",
21 a number 3 for likelihood and number 5 catastrophic for
22 impact?

23 **A.** Correct.

24 **Q.** 137, please. There are "Key uncertainties":

25 "There is significant uncertainty about the

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1 frequency with which an emerging infection may develop
2 the ability to transmit from person to person."

3 So that's an issue about transmissibility.

4 "Due to the nature of an emerging infectious disease
5 [so not a pandemic influenza] there is some uncertainty
6 as to whether a different emerging pathogen, including
7 one which was airborne [respiratory] would lead to ..."

8 I'm afraid I've lost the place now because of the
9 change in the page.

10 **A.** I think it said an outbreak which was similar.

11 **Q.** Thank you.

12 "... would lead to an outbreak similar to those seen
13 previously.

14 "The influenza-type pandemic scenario is based on
15 a 1918-like scenario, milder pandemics are more likely
16 than the figure quoted and will have a lower impact,
17 though ... with all risks, the NSRA focuses on the
18 reasonable worst-case scenario."

19 The NSRA, Ms Hammond, focused attention, by virtue
20 of impact and likelihood, on an influenza-type pandemic
21 based on the 1918 scenario; is that correct?

22 **A.** Based on the best expert opinion of what was the most
23 likely reasonable worst-case scenario, which included,
24 of course, experience of the past and used the 1918
25 experience as part of that assessment.

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1 from persistent but time-limited cause.

2 "Planning Assumption A

3 "... 32.8 [million] excess casualties.

4 "... 820,000 excess fatalities."

5 177 gives us the analogue for a new and emerging
6 infectious disease:

7 "Planning Assumption:

8 "Up to 2,000 casualties."

9 Given, Ms Hammond, the fact that the chart for new
10 and emerging infectious diseases had those arrows
11 showing the range could be a great deal broader than
12 what that box indicates, given the key uncertainties
13 which the text refers to, to possible catastrophic
14 impact of a new and emerging disease, why was the
15 planning assumption made that if we were struck by
16 a disease, the characteristics of which were not
17 apparent at all, the numbers of deaths would only be up
18 to 2,000 casualties?

19 **A.** Because that was the expert assessment based on
20 understanding of previous outcomes, some of which you've
21 referred to already, and the expert assessment of the
22 reasonable worst-case scenario for an influenza pandemic
23 was a much higher number, so that is what became the
24 planning assumption.

25 **Q.** After Covid, the Cabinet Office commissioned the Royal

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1 **Q.** Since when, of course, there had been MERS and SARS and
2 two major coronaviral outbreaks?

3 **A.** Of a much smaller scale, of course --

4 **Q.** Of course.

5 **A.** -- than that influenza pandemic.

6 **Q.** Page 140, MERS and SARS -- so we are dealing here with
7 then the other major risk, emerging infectious disease.

8 We can see on the top right the box, and the box shows
9 that the reasonable worst-case scenario is that star in
10 the middle, with 3 for likelihood, 3 for impact, so it
11 was middle of the range in terms of likelihood, middle
12 of the range for impact, and that star is the reasonable
13 worst-case scenario.

14 What do the arrows indicate, top left, top right and
15 bottom left?

16 **A.** The arrows as described in the text represent
17 uncertainty bounds, which I think essentially is, if you
18 like, a measure of confidence that the experts have in
19 making that judgement about the reasonable worst-case
20 scenario, ie there could be variation in either
21 direction.

22 **Q.** If you go to page 175, we will see the planning
23 assumptions for influenza pandemic, "Excess casualties,
24 and Fatalities":

25 "Non-contaminated casualties and fatalities arising

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1 Academy of Engineering to undertake an external review,
2 so a full formal external rule of this process. Was
3 that the first time there had been a formal review of
4 this process externally since it was started in 2009/10?

5 **A.** Yes, I believe so.

6 **Q.** Are you familiar with that review?

7 **A.** I've had an opportunity to see it as part of the
8 documents you provided.

9 **Q.** Would you agree with this proposition, that that formal
10 review of the process recommended in part that when
11 identifying risks a range of scenarios must be
12 considered and generated, to use their word, to reflect
13 the particular characteristics of the next disease and
14 the uncertainty that is always associated with disease
15 planning?

16 **A.** I'm sorry, your question was --

17 **Q.** Do you agree that they recommended, in recommendation 4,
18 that risk assessments should henceforth identify a range
19 of more specific scenarios?

20 **A.** I believe that is what they recommended, yes.

21 **Q.** And that decision-making should be driven by impact as
22 opposed to impact and likelihood because the risk of
23 a disease which may be less likely to occur but which,
24 if it does, could be catastrophic, cannot be ignored?

25 **A.** I think that is also their recommendation, if that's

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1 your question.

2 **Q.** Do you agree, therefore, that the risk assessment
3 process had those two strategic flaws in it?

4 **A.** I think they are excellent improvements to it, yes.

5 **Q.** Exercise Cygnus, to which you referred earlier, is at
6 INQ000056232.

7 **LADY HALLETT:** Sorry, how long ago was the Royal Academy of
8 Engineers' review?

9 **MR KEITH:** My Lady, the external review was commissioned in
10 January 2021 and the date -- if we have up INQ000068403,
11 please, again -- I think it's 1 September 2021.

12 **LADY HALLETT:** Thank you. That's fine, don't worry, don't
13 get it up.

14 **MR KEITH:** Operation Cygnus.
15 Did Operation Cygnus in October 2016 take place when
16 you were head of the CCS?

17 **A.** Just to correct that: Exercise Cygnus rather than
18 Operation.

19 **Q.** Sorry, what did I call it?

20 **A.** Operation.

21 **Q.** I'm so sorry, that's the second time.

22 **A.** A temptation in this world.

23 **Q.** Exercise Cygnus.

24 **A.** Yes, I'd been in post about eight weeks when it
25 happened.

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1 "... strategic decision-making processes ..."
2 And so on.
3 One of the major conclusions is at page 6, please:
4 "Key Learning.
5 "The analysis of the evaluation reports and the
6 organisations participating in the exercise indicate
7 that the UK's command & control and emergency response
8 structures provide a sound basis for the response to
9 pandemic influenza. However, the [United Kingdom's]
10 preparedness and response, in terms of its plans,
11 policies and capability, is currently not sufficient to
12 cope with the extreme demands of a severe pandemic that
13 will have a nationwide impact across all sectors."
14 So although the basis of Exercise Cygnus was
15 a pandemic influenza scenario, the key learning was that
16 the system was not sufficient to cope with extreme
17 demands of a severe pandemic.

18 **A.** That's correct, and that's the basis on which the
19 pandemic flu readiness programme was stood up.

20 **Q.** We'll come to that in a moment. Was this key learning
21 published?

22 **A.** Forgive me, I don't recall. This is a Public Health
23 England document rather than a CCS one. I think it was,
24 but I'd have to check that.

25 **Q.** I think 18 months after this report you spoke at

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1 **Q.** All right. This was what was called a Tier 1 command
2 post exercise. What is a command post exercise?

3 **A.** It means that, rather than doing live play, if I can
4 frame it that way, in the language of exercises, you're
5 essentially role playing what might happen, but not with
6 real people, not having real individuals being treated
7 in a hospital, for example.

8 **Q.** But it is a command post exercise rather than a tabletop
9 exercise, it's not just a paper exercise, people sit in
10 a room and they do what they might have to do in the
11 course of a real emergency?

12 **A.** Yes, they sit together round a table, they talk about
13 the decisions that might be facing them.

14 **Q.** All right.
15 Page 3, please, sets out the scope of the exercise,
16 the UK's preparedness and response to a pandemic
17 influenza outbreak. Command post exercise, second
18 paragraph:
19 "Designed to assess the UK's preparedness in
20 response to a pandemic influenza outbreak."
21 The objectives are at page 36:
22 "To exercise organisational pandemic influenza plans
23 at local and national levels ...
24 "... exercise co-ordination of messaging to the
25 public.

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1 a debate hosted by the Foundation for Science and
2 Technology. Do you recall that?

3 **A.** I do. I spoke after Professor Whitty, I think.

4 **Q.** You did. And you were asked: is the UK well prepared
5 for a repeat of the 1918 influenza pandemic? Do you
6 recall your answer?

7 **A.** No, I don't.

8 **Q.** You weren't entirely confident, were you, Ms Hammond,
9 that we were well prepared?

10 **A.** So after this exercise, we recognised there was
11 a programme of work to be done. 18 months later, that
12 work wasn't complete. So I think it would be completely
13 right to say I wasn't confident that that risk had been
14 mitigated.

15 **Q.** I'm just going to ask you one by one what was done in
16 relation to particular aspects of the recommendations.
17 So at page 6 -- we're not going to go to them all, they
18 recommended -- the exercise recommended an overarching
19 pandemic Concept of Operations, a central repository of
20 documentation. Was that done?

21 **A.** May I just read the recommendation for a moment?

22 **Q.** Yes, of course you may.

23 **(Pause)**

24 **A.** So I think central repository of information was put
25 into place on ResilienceDirect. The action that was

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1 planned but had not been completed was the review of the
2 pandemic influenza strategy, which is what I think would
3 have brought together the Concept of Operations point
4 made here. So elements of that, but not all of it.

5 **Q.** The report, the exercise referred to, on page 7, the
6 fact that individual organisations were relying upon
7 a corporate memory of the 2009 H1N1 swine flu response
8 which is currently being lost. Was anything done about
9 that loss of corporate memory?

10 **A.** Not specifically that I recollect.

11 **Q.** On page 9 at point 4, concerns were raised about whether
12 social care homes would cope with reverse triage, that's
13 to say the NHS sending patients into the care home
14 sector as opposed to treating them in hospital.

15 **A.** Yes.

16 **Q.** What was done about the possibility of social care homes
17 being overrun by patients from the NHS?

18 **A.** There was a specific workstream in the pandemic flu
19 programme which looked at surge resourcing for the adult
20 social care sector and how that would happen.

21 **Q.** Was that workstream affected in any way by
22 Operation Yellowhammer, the no-deal EU exit planning
23 operation?

24 **A.** I don't think so. The key product at the end of that
25 initial phase of work at least was guidance on how to

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1 struck?

2 **A.** Correct, and it generated a programme of work which, for
3 reasons I've set out in my evidence, hadn't been
4 completed by the time Covid arrived.

5 **Q.** In very general terms, why was that programme of work
6 not completed?

7 **A.** Elements of it were paused in order to refocus effort on
8 to Operation Yellowhammer.

9 **Q.** What was Operation Yellowhammer?

10 **A.** It was the cross-government planning effort for the
11 impacts of a no-deal exit from the European Union.

12 **Q.** One major matter arising from Exercise Cygnus was that
13 the National Security Council body to which you referred
14 earlier, the THRC subcommittee, commissioned something
15 called the pandemic flu readiness programme.

16 **A.** That's the programme of work I'm referring to.

17 **Q.** And that was under the auspices(?) of the Pandemic Flu
18 Readiness Board?

19 **A.** Correct.

20 **Q.** That committee, however, the NSC(THRC), was abolished,
21 was it not, in July 2019?

22 **A.** It was, and by that point, of course, this programme of
23 work had already been paused.

24 **Q.** So the body that brought into effect the Pandemic Flu
25 Readiness Board and its programme of work was abolished,

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1 manage that surge resourcing. That had been completed,
2 I think, before the start of Yellowhammer.

3 **Q.** Page 12 at A, 1.34:

4 "Meetings of the four health ministers and CMOs
5 should be considered best practice and included as part
6 of the response battle rhythm."

7 What was done by way of putting into place a formal
8 structure for meetings between the health ministers and
9 the devolved administrations and CMOs?

10 **A.** This is a lesson taken forward by DHSC rather than by
11 CCS. I know from conversations with colleagues there
12 that the four CMO forum certainly did exist, and
13 increasingly the health minister forum too, but I think
14 they will give you a better answer to that question than
15 I will.

16 **Q.** That general conclusion from Exercise Cygnus that the
17 preparedness and response in the United Kingdom, its
18 policies and capability, were not sufficient to cope
19 with the extreme demands of a severe pandemic; that
20 proved to be correct, did it not?

21 **A.** Yes.

22 **Q.** But that was the key learning from an exercise in
23 October 2016?

24 **A.** Sorry, is the question the date of the exercise?

25 **Q.** Yes. October 2016, three and a bit years before Covid

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1 and the work and the body itself -- the board and the
2 work -- was itself interfered with because of
3 Operation Yellowhammer?

4 **A.** That's right. Some of those workstreams had been
5 completed, some of that work did continue through
6 Yellowhammer, you'll have seen in my evidence that we
7 prioritised completion of the draft Bill which became
8 the Coronavirus Act or the basis for it, and we
9 prioritised particularly the work on managing excess
10 deaths which was also used in the coronavirus response.
11 So some work did continue, but further work on the
12 programme was paused for that reason.

13 **Q.** The work included work on surge and triage guidance, so
14 healthcare capability?

15 **A.** That had been completed, I think.

16 **Q.** Excess deaths, working out how many, what number of
17 excess deaths there would be under the risk assessment
18 process and making sure there was enough mortuary
19 capacity?

20 **A.** So the second half of your explanation but not the
21 first. The numbers had been worked out through the risk
22 assessment process.

23 **Q.** You're quite right. You were addressing the mortuary
24 capacity to reflect the number of excess deaths
25 identified in the risk assessment process?

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1 **A.** Correct, and those plans were also used in the
2 coronavirus response.

3 **Q.** The work absence in critical sectors? Workplace
4 absence?

5 **A.** So we had completed to my reflection a first round of
6 work on that, of assessing the resilience of particular
7 sectors. I think had the programme continued there
8 would certainly have been further actions under that
9 heading.

10 **Q.** But a significant part of the board's work was paused or
11 stopped altogether, and in any event for the reasons
12 that you explained earlier the process had not even
13 begun to identify the possible need for work on the
14 long-term consequences of shutting schools, lockdowns,
15 serious social restrictions, shielding, the collapse of
16 the economy, the need for financial support, in any
17 meaningful sense?

18 **A.** It hadn't, I don't think this programme would have
19 resulted in a lockdown plan, because it was based on
20 a flu scenario for which the lockdown -- a lockdown
21 would not have been an effective measure.

22 **Q.** The Pandemic Flu Readiness Board promulgated by the then
23 abolished National Security Council THRC committee, met
24 regularly between 29 March 2017 and November 2018. How
25 many times did it meet between November 2018 and the end

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1 in case I misunderstood? I'm talking about --

2 **LADY HALLETT:** We're talking about a period of two months,
3 November 2019 to January 2020.

4 **A.** Yes.

5 **LADY HALLETT:** With Christmas in between, is the point
6 Ms Hammond is making.

7 **A.** So it's a period of a few weeks.

8 **MR KEITH:** How many United Kingdom/devolved administration
9 meetings were there on pandemic flu readiness following
10 Exercise Cygnus, before Covid struck?

11 **A.** The devolved administrations came to the best of my
12 recollection every single Pandemic Flu Readiness Board,
13 I think that's 14 in that period, if I remember rightly.
14 There would have been other meetings with health
15 colleagues, I'm afraid you would need to ask for their
16 evidence on the frequency of those.

17 **Q.** How many times did the Scottish Government or the
18 Welsh Government or the Northern Ireland Executive
19 Office attend meetings with the Civil Contingencies
20 Secretariat to discuss pandemic preparedness?

21 **A.** Well, all of those boards plus a series of bilateral
22 conversations where we travelled to each of the devolved
23 administrations specifically to talk about pandemic flu
24 planning.

25 **Q.** There was one meeting with the Scottish Government on

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1 of November 2019?

2 **A.** I'm sorry, could you repeat the dates?

3 **Q.** Yes. Having met a number of times between March 2017
4 and November 2018, how many times did it meet between
5 November 2018 and November 2019?

6 **A.** I don't think it met at all. The reason for the
7 frequency of meetings in 2018 was that THRC was the body
8 overseeing Yellowhammer, the EU exit preparations.
9 There was then a change in the committee structure, and
10 that work was overseen by a different committee, EU exit
11 operations. So THRC stood down in that role at that
12 point.

13 **Q.** And after November 2019, how many times did the board
14 meet between then and the beginning of January 2020 and
15 the arrival of Covid?

16 **A.** When you say the board, forgive me, do you mean the THRC
17 or the pandemic flu board?

18 **Q.** Well, the THRC isn't a board, I meant the Pandemic Flu
19 Readiness Board, PRFB.

20 **A.** It met in November 2019 and then in January 2020.

21 **Q.** So the answer to my question is: it met no times between
22 November 2019 and the beginning of January 2020?

23 **A.** I think that's probably correct. There is a Christmas
24 period, of course, in the middle there.

25 I'm really sorry, could you repeat those dates, just

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1 27 March 2018, one meeting with the Welsh Government on
2 14 June 2018, and no meetings with the Northern Irish
3 Executive Office?

4 **A.** With the pandemic flu boards of course happening on
5 a regular basis.

6 **Q.** Were there any other meetings between those governments
7 and the CCS, the formal part of government, to talk
8 about pandemic preparedness?

9 **A.** Not that I can recollect.

10 **Q.** Right.

11 There was a body under the auspices of the
12 Department of Health and Social Care called the Pandemic
13 Influenza Preparedness Programme?

14 **A.** Correct.

15 **Q.** And it had a board called the Pandemic Influenza
16 Preparedness Board?

17 **A.** Yes.

18 **Q.** Do you know how many times it met between October 2018
19 and December 20?

20 **A.** I don't, I'm afraid. That would be a question for my
21 DHSC colleagues.

22 **Q.** Would you be surprised to know that it was once?

23 **A.** I would be neither surprised nor unsurprised.

24 **Q.** In all this planning, in all the risk assessment
25 procedures, in all the drawing up of the massive amount

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1 of policies and guidance and documentary information,
2 how much time is devoted to the issue of how planning
3 for a pandemic would impact upon the vulnerable, the
4 marginalised, those most affected potentially by
5 a pandemic?

6 **A.** I think that's a really important question, if I may
7 say. You can see in the risk assessments as drafted
8 there's clear recognition that pandemics have different
9 impacts on different groups. That's clearly recognised.
10 It's also recognised that's not predictable in advance,
11 even those different influenza strains have impacted
12 different groups differently. There's also recognition
13 in guidance that vulnerable groups need particular
14 consideration, so particularly those with pre-existing
15 health conditions.

16 What I think there isn't, if I may say, is the sort
17 of wide assessment of socio-economic vulnerabilities,
18 that I know your witnesses talked about this morning,
19 and how they would interact with a pandemic. So I think
20 specific vulnerabilities were considered, but not in
21 that wider socio-economic sense.

22 **Q.** Ms Hammond, so that we may be absolutely clear about
23 this, the only risk factors, the only elements
24 considered in the risk assessment process was clinical
25 risk, that is to say those persons who may clinically be

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1 think we did a piece of work to look at the totality of
2 socio-economic disadvantage.

3 **Q.** There was no consideration of socio-economic
4 disadvantage beyond comorbidities and prisons, was
5 there?

6 **A.** I think ... I don't think we did that piece of work.
7 I think that is fair.

8 **MR KEITH:** Thank you. I've no further questions, thank you.

9 **LADY HALLETT:** Thank you very much, Mr Keith.

10 **MR KEITH:** My Lady, in relation to the request from
11 core participants, may I ask you to give permission to
12 confirm your provisional indication that Mr Weatherby,
13 King's Counsel, may ask some questions of Ms Hammond?

14 And then the Cabinet Office have indicated kindly to
15 those behind me by way of a pre-Rule 10.2, it must be,
16 request that they wish the record to be correct and the
17 numbers for the resilience capability survey and they
18 would like me to put figures they say are accurate to
19 you and ask you if you recall, which I'm very happy to
20 do, that will avoid the need for the Cabinet Office to
21 ask that question itself.

22 Regarding the take-up rate of the resilience
23 capability surveys, these have not been uploaded into
24 the Inquiry's Relativity system, but they are exhibited
25 to Mr Hargreaves' third statement, and I'm afraid the

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1 more affected by a pandemic, those who suffer from
2 diabetes or heart disease, clinical features?

3 **A.** I think that's true of risk assessment but --

4 **Q.** You referred, with respect, to risk assessment then.

5 **A.** Indeed, sorry, and then I went more widely than that.
6 So just to give an example, perhaps, in the pandemic flu
7 programme there is a particular piece of work on the
8 prison population in a pandemic, for example, which
9 would fit within one of the definitions your experts
10 have given around socially disadvantaged groups.
11 I don't think there's a systemic look across the whole.

12 **Q.** So there was a consideration of those who, in a health
13 sense, those people who may be impacted by a pandemic,
14 who have comorbidities, and there was consideration of
15 people in prison?

16 **A.** That's an example.

17 **Q.** What other consideration was there of those who are
18 vulnerable or marginalised, or members of the ethnic
19 communities or disabled, or who might in any way be
20 affected by the impact of a pandemic on account of their
21 societal or economic position?

22 **A.** I think some of the groups you've listed there would
23 come within the definition of vulnerability that was
24 considered, so those with existing health conditions or
25 disabilities, but, as I say, at least in CCS I don't

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1 screen doesn't allow me to -- it does now.

2 In 2014 the take-up rate for local resilience forums
3 was 71% and in 2017 it was 74%. Is that -- perhaps you
4 would take it from your own office, the Cabinet Office:
5 are those the correct figures for the national
6 resilience capability surveys?

7 **A.** Yes, I think that's correct.

8 **MR KEITH:** So, my Lady, if you would like to hear from
9 Mr Weatherby.

10 **LADY HALLETT:** Certainly. To the extent, Mr Weatherby,
11 obviously they have not been covered by Mr Keith.

12 Questions from MR WEATHERBY KC

13 **MR WEATHERBY:** Just two short areas: learning lessons, and
14 then one short series of questions about the
15 relationship with the devolved administrations.

16 You have been asked questions about Cygnus and the
17 learning from Cygnus, and you've told us some of the
18 work that was done from Cygnus. We've heard from
19 Bruce Mann and Professor Alexander who say in
20 January 2020, in their view, preparedness in the UK for
21 pandemic flu was poor, their word, and for pandemic
22 newly emerging diseases was wholly inadequate, their
23 words.

24 Would you agree that whatever had been done from the
25 learning in 2016 had not significantly affected the

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1 preparedness of the UK for the pandemic that then
 2 struck?
 3 **A.** I think a lot of the work that had been done since 2016
 4 was indeed put to good use during the pandemic that
 5 struck, and we've talked about some examples around
 6 surge staffing, we've talked about work on managing
 7 excess deaths, we've talked about preparations for the
 8 Act. What is really clear is that that work didn't
 9 cover all of the things that were needed in coronavirus.
 10 **Q.** Yes.
 11 **A.** So it did make a difference, but not all of it.
 12 **Q.** Yes, okay. So it made a difference, but wholly
 13 inadequate nevertheless?
 14 **A.** I think wholly inadequate implies that the work that was
 15 done was not useful, and I think I'm suggesting to you
 16 that's not the case, but incomplete certainly.
 17 **Q.** Now, the issue of learning lessons in the Cabinet Office
 18 or the CCS is something that pre-dated -- problems with
 19 it pre-dated your involvement with the CCS; is that
 20 right?
 21 **A.** I'm not sure what issues you're referring to.
 22 **Q.** Okay. Well, you obviously became director in 2016?
 23 **A.** Yes.
 24 **Q.** In 2013, there had been the Pollock review which no
 25 doubt would have been known to you when you took your

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1 Professor Alexander put in their report is from the
 2 executive summary of the report, and I'm quoting:
 3 "The consistency with which the same or similar
 4 issues have been raised by each of the Inquiries is
 5 a cause for concern. It suggests that lessons
 6 identified from the events are not being learned to the
 7 extent that there is sufficient change in both policy
 8 and practice to prevent their repetition."
 9 That's from the summary, the executive summary of
 10 the Pollock review.
 11 So is that not something that you were aware of when
 12 you became director of it?
 13 **A.** I don't recollect that particular report. Of course
 14 that is three years before my arrival. I would say my
 15 experience in CCS, and with the wider resilience
 16 community, is that learning lessons is a very well
 17 embedded process and that, of course, learning a lesson
 18 implies you take some action in response to it.
 19 **Q.** Okay. So moving forward to 2021, the crisis
 20 capabilities review, which I think you have been
 21 referred to already, you're familiar with that, that
 22 concluded at paragraph 61 that the Cabinet Office is
 23 failing to consistently identify, learn and improve on
 24 its response to crises in any systematic way. Okay?
 25 Now, before you answer, can I just --

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1 position in 2016, because it was so significant?
 2 **A.** Could you repeat the name? It's not one I'm familiar
 3 with.
 4 **Q.** The Pollock review.
 5 **A.** The Pollock review?
 6 **Q.** Yes.
 7 **A.** Could you refresh me?
 8 **Q.** Yes. Dr Pollock produced a paper which was commissioned
 9 by the CCS and published by the Emergency Management
 10 College.
 11 **A.** Right.
 12 **Q.** About the fact that lessons identified in emergencies
 13 and major incidents from 1986 until his review, there
 14 had been a lack of following through on the learning.
 15 So the --
 16 **A.** Is that -- forgive me, I'm not familiar with that
 17 report --
 18 **Q.** You're not familiar with that?
 19 **A.** -- or at least the passage of time, I'm not. Is that
 20 referring to central government lessons or lessons
 21 learned by local responses?
 22 **Q.** I think it's overall in the civil contingencies
 23 framework.
 24 **A.** So the whole system from national to local?
 25 **Q.** That's my understanding. The section that Mr Mann and

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1 **A.** Of course.
 2 **Q.** -- be completely clear about this, it doesn't say that
 3 the Cabinet Office didn't learn or follow through, it
 4 was inconsistent in any systematic way. Is that
 5 something that you recognise? Is that conclusion
 6 something that you would agree with?
 7 **A.** I wouldn't agree with it in relation to CCS, where
 8 I think that was a really well-embedded, consistent
 9 doctrine, I'm not entirely clear whether CCS is the body
 10 being referred to in that finding.
 11 **Q.** Yes. Well, again, for completeness, the whole passage,
 12 I've not really got time to put it, but I'll give the
 13 reference, it's INQ000056240, page 26, paragraph 61. It
 14 indicates that CCS was better, because it was better
 15 resourced, but it was still inconsistent. Okay?
 16 **A.** Sorry, is your question do I agree with that?
 17 **Q.** Yes.
 18 **A.** It's very difficult to give you an answer when I don't
 19 have the timeframe comparison. If you mean better in
 20 comparison to 2013, that's before my arrival. I'm
 21 really sorry, I'm struggling without the reference to
 22 give you a precise answer.
 23 **LADY HALLETT:** I take it from "more resources" it means
 24 better than the rest of Cabinet Office?
 25 **A.** I'm afraid I don't know.

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1 **MR WEATHERBY:** Better resourced than. Yes, indeed, that's
2 what it does.

3 Okay, finally in this section, the 2022 CCA
4 review -- by, again, Bruce Mann but others -- indicated
5 that there was limited evidence in England of a learning
6 and continuous improvement culture in the resilience
7 community locally and nationally, and the reasons that
8 were given included a fundamental lack of desire to
9 disturb the status quo or to a perception that there was
10 nothing to learn from others.

11 Is that something that you would identify? Again,
12 it's a whole system, it's not CCS oriented, but is that
13 something you would identify with?

14 **A.** I really wouldn't. I really wouldn't. I mean, of
15 course there are going to be patches of better -- that
16 are better at that and patches that are going to be less
17 good, but my experience of that system is that it was
18 very invested in learning lessons and it did that very
19 rapidly after events occurred.

20 **Q.** Yes.

21 So, if I was to suggest that there was a cultural
22 barrier to change in this area, then what would you say
23 to that?

24 **A.** I wouldn't -- I wouldn't say I saw evidence of
25 a cultural barrier to change.

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1 **A.** If it was a pan UK issue.

2 **Q.** Yes, okay. I'm trying to work quickly, so I'm trying
3 not to be unfair to you. But again, working from
4 Bruce Mann and Professor Alexander at 191 of their
5 report, they make this point, that ConOps doesn't set
6 any specific arrangements for co-ordination between the
7 UK Government and the devolved governments where there
8 is a circumstance that affects all of them together.

9 **A.** I think that's because it's established practice that
10 COBR brings them in as needed.

11 **Q.** And in terms of SAGE, your role within CCS and the
12 Cabinet Office is one of liaison and co-ordination, and
13 in practice am I right that the Cabinet Office is
14 involved in activating SAGE?

15 **A.** That's right. SAGE is an advisory committee to COBR.
16 So Cabinet Office, along with the lead government
17 department and Number 10, would make the decision to
18 activate COBR and then activate SAGE if their advice was
19 needed.

20 **Q.** Yes. Again, there is no arrangements, or at least no
21 formal arrangements, to involve the Chief Medical
22 Officers or scientists from each of the devolved
23 administrations in that process, is there?

24 **A.** Forgive me, I think that's because SAGE is convened in
25 the same way as COBR, ie you bring together the people

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1 **Q.** Yes.

2 A different topic and briefly, in ConOps, the
3 Concept of Operations that you've already been shown,
4 where an emergency arises in one of the devolved nations
5 or jurisdictions, they are the lead?

6 **A.** Yes.

7 **Q.** Where there are arrangements in relation to
8 a whole-system disaster or incident that affects the
9 whole of the UK, is it right that ConOps doesn't include
10 any arrangements for co-ordination between the
11 UK Government and each of the devolved administrations?

12 **A.** No, I don't think that's right. That co-ordination
13 would happen through the COBR committee.

14 **Q.** Yes.

15 **A.** Which would include the devolved administrations.

16 **Q.** Okay, I've not put the question very well. In terms of
17 whether it might happen because you might think of it,
18 that may well be the case. But in terms of the ConOps,
19 the actual ConOps document, it doesn't cover that, does
20 it?

21 **A.** I think, if I am remembering correctly, the ConOps says
22 that you constitute COBR with the members that you need
23 to deal with the emergency that you've got. That would
24 include the devolved administrations.

25 **Q.** Yes.

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1 you need based on the emergency that you've got, and
2 that would include Chief Medical Officers from across
3 the UK.

4 **MR WEATHERBY:** Thank you.

5 **LADY HALLETT:** Thank you very much indeed, Mr Weatherby.

6 **MR KEITH:** My Lady, the representatives for Covid-19
7 Bereaved Families for Justice Cymru have indicated that
8 there are two broad areas of questions that they would
9 very much like CTI to put, because they had understood
10 that they would be covered in the course of my
11 examination. May I have your permission to put those
12 important questions in the two minutes remaining?

13 **LADY HALLETT:** You may.

14 **Further questions from LEAD COUNSEL TO THE INQUIRY**

15 **MR KEITH:** Ms Hammond, I would want you to concentrate,
16 please, on the position from the devolved
17 administrations' viewpoint concerning the risk
18 assessment process. Did the National Security Risk
19 Assessment process include or identify specific risks to
20 devolved nations as part of their approach to the
21 United Kingdom?

22 **A.** It didn't distinguish between, so it's a UK risk
23 assessment. The -- forgive me, may I add one sentence?

24 **Q.** I wasn't stopping you.

25 **A.** Sorry. Which is to say that I know the devolved

200

1 administrations themselves then produce risk assessments
 2 specific to their geographical area using the national
 3 risk assessment as the starting point.
 4 **Q.** We've seen on the organogram in fact, which you may or
 5 may not have seen, that there is a devolved risk
 6 assessment process --
 7 **A.** Exactly.
 8 **Q.** -- which sits under the Cabinet Office-driven UK risk
 9 assessment process?
 10 **A.** I think "sits under" might be implying a hierarchy, but
 11 "works with".
 12 **Q.** No hierarchy intended, that's how it appears on the
 13 schematic design.
 14 Were concerns ever brought to your attention by the
 15 Welsh devolved administration that the United Kingdom
 16 approach to risk assessment simply did not contain
 17 information of sufficient detail and relevance to the
 18 risk in Wales?
 19 **A.** I have no recollection of that issue being raised.
 20 **Q.** In relation to the national risk assessment which was
 21 refreshed in 2016, and whether or not experts were
 22 consulted for that purpose, were the respective
 23 experts -- were experts in the devolved nations
 24 consulted in any shape or form, either individually or
 25 as part of the expert challenge group to which you
 201

1 that away and answer it more precisely, if you'd like.
 2 **MR KEITH:** Perhaps if you would, and then perhaps you could
 3 inform us in due course, we'd be grateful.
 4 My Lady, that concludes the evidence today.
 5 **LADY HALLETT:** Excellent time on everyone's behalf, just.
 6 Thank you, everybody. Thank you very much,
 7 Ms Hammond, for your help today. I'm sorry it's been
 8 such a long stint for you, but I'm grateful to you.
 9 **(The witness withdrew)**
 10 **LADY HALLETT:** Just so that everybody knows, we're sitting
 11 at 11 o'clock on Monday but we may have a slightly later
 12 day as a result.
 13 Thank you.
 14 **(4.31 pm)**
 15 **(The hearing adjourned until 11.00 am**
 16 **on Monday, 19 June 2023)**
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1 referred, as being one of the bodies looking at the risk
 2 assessment process?
 3 **A.** I'm afraid I would have to go back to the papers to
 4 answer that question. I can't remember who all the
 5 experts would have been.
 6 **Q.** All right. Was the Welsh Government consulted or
 7 involved before the national risk assessment process was
 8 refreshed in 2016?
 9 **A.** In 2016?
 10 **Q.** Yes.
 11 **A.** Just to make sure I understand your question, do you
 12 mean in the production of the version of the risk
 13 assessment produced in that year?
 14 **Q.** Well, you have me there, Ms Hammond, because I'm reading
 15 out a question from somebody else. I think the question
 16 is designed to ask you: what degree the Welsh Government
 17 had in terms of being consulted or involved in the
 18 drawing up of risk assessments and in the publication,
 19 at least internally at official sensitive level, of the
 20 national risk assessment and then, after it, the
 21 National Security Risk Assessment?
 22 **A.** Okay. So I think I would have to check with the papers
 23 exactly who attended which meetings, but I think
 24 officials from the devolved administrations were very
 25 much part of that process, but I'm really happy to take
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