1 **Monday, 26 June 2023**
2 **(10.29 am)**
3 **LADY HALLETT:** Mr Keith.
4 **MR KEITH:** Good morning, my Lady. May I please call
5 Emma Reed.
6 **MS EMMA REED (sworn)**
7 **Questions from LEAD COUNSEL TO THE INQUIRY**
8 **MR KEITH:** Could you please commence by providing your name.
9 **A.** My name is Emma Victoria Reed.
10 **Q.** Ms Reed, whilst you give evidence, could I remind you to
11 keep your voice up -- I don't think there will be
12 a problem -- and also to make sure you speak clearly
13 into the microphone so that your evidence may be
14 properly recorded.
15 Have you kindly agreed to provide a statement to
16 this Inquiry?
17 **A.** Yes, I have.
18 **Q.** May we have, please, INQ000195847 up, please.
19 Does that appear to be your statement?
20 **A.** It does.
21 **Q.** If we have the last page, you provided a signature and
22 a statement of truth.
23 **A.** I did.
24 **Q.** My Lady, may that be published, please?
25 **LADY HALLETT:** Certainly.

1 **MR KEITH:** Ms Reed, you have been a civil servant I think
2 since April of 2003, and you've held a number of posts,
3 not just in the Department of Health and Social Care but
4 also the Cabinet Office and the Government Equalities
5 Office; is that correct?
6 **A.** Yes, it is.
7 **Q.** Were you appointed to the senior civil service in April
8 of 2013?
9 **A.** Yes, I was.
10 **Q.** From November 2014 until June 2015, were you one of the
11 two deputy directors in the Department of Health and
12 Social Care, leading on the response to the Ebola
13 outbreak?
14 **A.** Yes, I was.
15 **Q.** Most significantly, are you currently director of the
16 directorate in the Department of Health and Social Care
17 which is the directorate of Emergency Preparedness and
18 Health Protection?
19 **A.** Yes, I am.
20 **Q.** Have you been in that post since February of 2018?
21 **A.** Yes.
22 **Q.** Could you assist us, please, in broad terms, with the
23 nature of the functions discharged within that
24 directorate? We've heard a considerable amount of
25 evidence about the various functions in the

1 Department of Health and Social Care, and I therefore
2 want to ask you what that particular directorate is
3 concerned with. Is it, by way of commencement, the
4 directorate that discharges or plays its part in
5 discharging the duty on the Secretary of State for
6 Health and Social Care by virtue of being a Category 1
7 responder under the Civil Contingencies Act 2004?
8 **A.** Yes, but allow me to set out broadly where my
9 responsibilities in the directorate fall, and they
10 broadly fall into two different areas. I have
11 responsibility for health protection and health security
12 policy --
13 **Q.** Can I come back to that, Ms Reed?
14 **A.** Of course.
15 **Q.** There is a method to my madness, I wanted you to set out
16 generically the functions of the directorate before we
17 look at health protection and health security.
18 So one of the major functions of the directorate is
19 to discharge the duty on the Secretary of State by
20 virtue of being a Category 1 responder under the CCA; is
21 that correct?
22 **A.** It is, yes.
23 **Q.** Is another responsibility to discharge whatever
24 functions are imposed on the DHSC by virtue of being the
25 lead government department when it comes to health

1 emergencies?
2 **A.** Yes, it is.
3 **Q.** Is it also part of your directorate's functions to be
4 concerned in that risk assessment process --
5 **A.** Yes, it is.
6 **Q.** -- of which we have heard? And is it also your
7 directorate which liaises with bodies such as the
8 United Kingdom Health Security Agency and NHS England
9 and the Department for Levelling Up, Housing and
10 Communities, when it comes to assessing risk, managing
11 risk, preparing for health emergencies?
12 **A.** Yes, it is.
13 **Q.** Importantly, given the extent of the burdens on you, is
14 that why your directorate, the Emergency Preparedness
15 and Health Protection Directorate, has led the DHSC's
16 response to all the major incidents to which you speak
17 in your statement, monkeypox, the Novichok poisoning,
18 the heatwave of 2022, and so on and so forth?
19 **A.** Yes, it is.
20 **Q.** All right.
21 So you've referred to health protection, and also to
22 health security. What are they and what is the
23 difference between them?
24 **A.** So health protection and health security policies form
25 part of half of my responsibility. The types of

1 policies that we have responsibility for in that area
2 includes pandemic preparedness, emerging infectious
3 disease, antimicrobial resistance. They are essentially
4 about how the public health is protected but also what
5 threats, under infectious diseases, emerging diseases
6 and pandemics, may well be a risk to public health.
7 **Q.** So that's all under health protection?
8 **A.** And health security.
9 **Q.** Ah, they're together?
10 **A.** Yes, they are.
11 **Q.** All right. Your statement refers to the directorate
12 having three branches, and you distinguish between
13 health protection and health security, but are they in
14 fact the same area?
15 **A.** They are very closely related to each other, and sit
16 very closely adjoined.
17 **Q.** So which branch does the topic of pandemic preparedness
18 fall under?
19 **A.** Predominantly under health protection.
20 **Q.** Right.
21 Is there, in your directorate, a third branch called
22 the operational response centre?
23 **A.** Yes.
24 **Q.** What does that do?
25 **A.** So that covers the responsibilities you set out at the

1 beginning of the questions which relate to the discharge
2 of the Category 1 responder capability and is about how
3 we prepare for threats and hazards that impact on public
4 health, and how we respond also to those threats.
5 **Q.** So is it an emergency management centre? Does it deal
6 with crisis management?
7 **A.** It does. It delivers emergency preparedness, resilience
8 and response.
9 **Q.** Is the history, the etymology of the operational
10 response centre, that it was first created within Health
11 and Social Care to deal with the necessary preparations
12 for the no-deal EU exit, but latterly it is now the
13 crisis management centre in the Department of Health and
14 Social Care that deals with all emergency preparedness,
15 response and resilience issues?
16 **A.** That's not quite right. The department has had
17 a long-standing function that deals with emergency
18 preparedness, resilience and response, and that was
19 always part of the responsibility of this directorate
20 and was part of my responsibility when I took the post
21 in 2018.
22 In preparation for a no-deal exit we also developed
23 an operational response centre that was focused on those
24 particular capabilities for that threat, and following
25 the exit from the European Union we merged both of those

1 functions together to form what was then called the
2 operational response centre, that brings in EPRR
3 responsibility as well.
4 **Q.** I'm going to have to task you about your use of the word
5 "function". It's a word that --
6 **A.** I apologise.
7 **Q.** No, no, there is no apology required. What do you mean
8 when you say it had different functions? Do you mean
9 there were different rooms, different operational
10 response centres, different groups of people, or it was
11 the same group of people just doing two different jobs?
12 **A.** It was -- so by "functions" I mean a set of capabilities
13 of -- of -- ways of working that we use a manage
14 an emergency. In emergency response we had ones that
15 dealt with broader threats, and in the operational
16 response centre these were particular sets of products
17 and ways of working that were specifically focused on
18 no-deal exit.
19 **Q.** All right, so different jobs, but they were the same
20 people, they were just dealing with, at different times,
21 no-deal exit preparations or general EPRR responses?
22 **A.** No, they were different people. We maintained
23 a capability to make sure that we were ready for any
24 type of emergency as separate from the work we did to
25 prepare for a no-deal exit.

1 **Q.** All right.
2 **A.** They were under -- in the same part of my directorate,
3 but they were different sets of people.
4 **Q.** Right, that's clear, thank you.
5 My Lady's heard evidence about the high level risk
6 register that was held in the Department of Health and
7 Social Care, and a departmental board meeting which held
8 what was called a risk deep dive into major infectious
9 diseases within the department, how the department would
10 respond.
11 Could we please have INQ000022738 on the screen.
12 This is a document, Ms Reed, dated 28 September 2016, so
13 it's before your time, because, as you've told us, you
14 have been in post since February 2018.
15 If we look at page 2, please, would you just read
16 the middle bullet point within the red box.
17 **(Pause)**
18 **A.** Thank you.
19 **Q.** At the time that you took up your position as director
20 of the relevant directorate, to what extent did you
21 understand that steps had been taken to address that
22 plainly very serious and real concern? Were you told
23 what had been done to raise awareness of the risk and to
24 plan for the immediate mobilisation of a large number of
25 staff in the directorate?

1 A. I was not made aware of that particular commitment or
2 issue raised in 2016.
3 Q. Were you not told by anybody, "Ms Reed, congratulations,
4 you're the director of the directorate, you need to be
5 aware that the main departmental board for the entire
6 department, the DHSC, stated two years before there was
7 a very real concern that the entire directorate would be
8 rapidly overwhelmed in the event of a major pandemic,
9 and this is what we're doing about it"?
10 A. At the point that I took over the post, we did think
11 about the resourcing models and methods for escalating
12 and scaling up our resource if it was needed, but that
13 was never aligned to this discussion in 2016. It was
14 part of our regular resourcing considerations.
15 Q. Could we have the minutes of that departmental board
16 meeting at INQ000057271, please, page 6.
17 Again, I emphasise, before your time, but there are,
18 on page 6 -- I'm just going to refer you to them and
19 then give you time to read them -- paragraphs 25 and 26,
20 these words:
21 "It was more likely than not that even a moderate
22 pandemic would overrun the system."
23 So not the department, in fact, but the system, the
24 government.
25 "At the extreme, there would be significant issues

1 if it became necessary to track or quarantine thousands
2 of people."
3 Then, at 26, concerns are expressed about how
4 resilient the "somewhat fragmented system" would be,
5 that is to say the government system for preparedness.
6 So would you just like to just reflect on those two
7 paragraphs and then I'll ask you some questions.
8 **(Pause)**
9 A. Thank you.
10 Q. Do you recall when you took up post anybody briefing you
11 about the serious concerns expressed by the
12 Department of Health and Social Care's own departmental
13 board about whether or not there were systems in place
14 to track or quarantine thousands of people in the event
15 of even a moderate pandemic?
16 A. There was no discussion with me about quarantining.
17 Q. What about track and trace, any discussion about that?
18 A. There was no discussion with me about track and trace.
19 Q. All right. Then, in relation to paragraph 26, did
20 anybody at your very senior level in the department say,
21 "Ms Reed, we've got concerns about how fragmented the
22 system for preparedness in the United Kingdom has
23 become, this is something that your directorate is going
24 to have to grapple with"?
25 A. In the terms in which you set out, no. But the process

1 for how the system would respond to a pandemic -- and by
2 the system I mean organisations in health and social
3 care -- was both a factor of our pandemic flu readiness
4 programme but also one of the learnings from
5 Exercise Cygnus, so the intent of that paragraph and the
6 issue relating to system overload was something that
7 I was aware of, yes.
8 Q. In essence, these concerns were being addressed because
9 there were boards and systems and procedures otherwise
10 in place to try to make sure the system was better
11 prepared?
12 A. Yes.
13 Q. We'll look then at those boards in a moment.
14 An important part of your directorate's preparedness
15 arrangements was its -- and I'm now going to slip into
16 the terminology -- ownership of a 2011 pandemic
17 influenza strategy, was it not?
18 A. Yes. Yes.
19 Q. Because that was a strategy dealing with influenza
20 pandemic, a health emergency, and therefore, by
21 definition, something within the reach of the
22 Department of Health and Social Care?
23 A. Yes.
24 Q. Or the Department of Health, as it was then known.
25 Can you recall what you understood when you took up

1 your post about the efficacy, the appropriateness, the
2 adequacy of that strategy, whether it was a good
3 strategy, whether confidence was placed in it, whether
4 it needed refreshing, whether it needed updating or
5 wholesale revision? Can you recall what the state of
6 play was?
7 A. As I recall, the view was that the strategy included
8 important component parts that would be used for
9 a pandemic influenza, that it had been tested through
10 Exercise Cygnus and there were elements of that that
11 needed to be enhanced, and that there was a work
12 programme under way through the Pandemic Flu Readiness
13 Board to deliver that.
14 Q. Were you concerned by the fact that Exercise Cygnus
15 itself had concluded that the UK's plans, policies and
16 capability for preparedness were not sufficient to cope
17 with the extreme demands of a severe pandemic?
18 So you've referred to Cygnus and your answer is
19 essentially, "Well, I understand that Cygnus, [which had
20 taken place before your time] had addressed elements of
21 the strategy", but the Exercise Cygnus conclusion was
22 rather more serious than that, wasn't it?
23 A. It was very clear that there was a lot of work that the
24 department needed to do to improve its readiness for
25 a pandemic influenza. If the question you're asking is:

1 was I concerned about that? Yes, I was concerned about
2 that, but I was also aware that by the time I'd started
3 in my post in 2018, a programme of work had been
4 established to address those concerns.
5 Q. It was therefore of central concern to you that those
6 programmes should continue, because they were put into
7 place for a good reason, namely to meet the serious
8 concerns of this -- of the departmental board's
9 observations, the outcome of Exercise Cygnus, and
10 a clear understanding that the 2011 strategy needed at
11 the least some work doing on it?
12 A. Yes.
13 Q. All right.
14 That 2011 strategy was the only pandemic-scale
15 strategy, wasn't it?
16 A. It's the only one that was centrally run by the
17 Department of Health, yes.
18 Q. Well, pandemic is a health emergency, it goes to the
19 heart of your department's functions. Who else would
20 have an overarching health emergency-related strategy
21 for pandemic influenza?
22 A. I would expect that key organisations responsible for
23 delivering pandemic influenza response would also have
24 thought through and have plans in place on how they
25 would respond, so that would include NHS England, Public

1 Health England and local delivery partners.
2 Q. In the event of a national crisis, in the event of, as
3 it turns out, a catastrophic health emergency, the
4 Department of Health and Social Care is the lead
5 government department which drives forward what is
6 required to be done to prepare for and, initially at any
7 rate, respond to that crisis?
8 A. That's correct.
9 Q. So what other strategies for dealing with
10 a pandemic-scale catastrophe were there than this single
11 document?
12 A. The Department of Health owned the single document for
13 the strategy for pandemic influenza preparedness.
14 Q. Right. It was the only strategy document, was it not?
15 A. Yes.
16 Q. There was no strategy document for anything other than
17 an influenza pandemic?
18 A. That's correct.
19 Q. Could we have INQ000022708, page 14.
20 Three bullet points from the bottom, in
21 paragraph 2.21, there is a reference to the intrinsic
22 unpredictability of influenza pandemics.
23 Ms Reed, could you just have a read of that bullet
24 point, please.
25 **(Pause)**

1 A. Thank you.
2 Q. You are not by training an epidemiologist?
3 A. No.
4 Q. Why did no one in the directorate, with an eye to that
5 bullet point, ask himself or herself, "We have
6 a strategy for dealing with influenza pandemic, but
7 because influenza pandemics are intrinsically
8 unpredictable, and because we may be struck by
9 a pandemic that is not influenza but is another viral
10 respiratory outbreak that is equally as unpredictable as
11 influenza and therefore equally catastrophic, we need to
12 have plans for that eventuality"?
13 Why was that question not asked?
14 A. The preparedness we developed for pandemic influenza was
15 based on the reasonable worst-case scenario, so
16 effectively every renewal of that risk assessment did
17 ask whether -- what the scenario would be that we ought
18 to prepare for, and on successive risk assessments the
19 risk assessment was the pandemic we should prepare for
20 was a pandemic influenza.
21 Q. But those very same risk assessment processes referred,
22 of course, to the possibility or the risk of
23 a non-influenza pandemic, and those same processes
24 stated in terms that there were inherent variabilities,
25 that the next pandemic might or might not be influenza,

1 it might have the same characteristics, it could be just
2 as deadly or more so, it could have higher transmission
3 or less transmission, it could be just as severe or less
4 severe.
5 Where were the plans for dealing with those
6 eventualities?
7 A. Well, the plans that we developed and the mitigations we
8 built were based on the risk that we had been informed
9 was the most likely risk, that experts advised me and
10 colleagues that was the highest risk, and that was of
11 an influenza pandemic.
12 Alongside the influenza pandemic is a risk that
13 relates to emerging infectious disease, and in that risk
14 scenario we had prepared messages and responses that
15 would respond to that risk should that risk materialise.
16 Q. But you know very well, of course, that that risk, the
17 emerging infectious disease risk, was predicated upon
18 and assumed confinement to health setting outbreak, that
19 is to say it wouldn't extend probably beyond health
20 settings, and that there would be a very small,
21 relatively speaking, number of casualties and an even
22 smaller number of fatalities?
23 A. Yes, that's correct.
24 Q. Yes.
25 Could we look at page 57 in this document, please.

1 The 2011 strategy assumed -- and we can see at
2 paragraph 7.5 -- that "staff absence is likely to be
3 significantly higher than normal across all sectors",
4 levels of absence may vary due to the size, and then if
5 you could scroll back out, please, and in the middle of
6 the page, 7.4:
7 "... the Government will encourage those who are
8 well to carry on with their normal daily lives ... The
9 UK Government does not plan to close borders, stop mass
10 gatherings or impose controls on public transport during
11 any pandemic."
12 Any pandemic.
13 Between 2011, when this strategy was first made,
14 Ms Reed, and 2020, when the non-influenza pandemic
15 struck, are you aware in the Department of Health and
16 Social Care of any person at any time questioning that
17 statement, "the UK Government does not plan to close
18 borders, stop mass gatherings or impose controls"? Was
19 there any debate about the possible necessity of border
20 closings, self-isolation, quarantine, mass quarantine,
21 mandatory quarantine, or anything of that sort?
22 **A.** I'm not aware of any conversations on those areas of
23 mitigation, no.
24 **Q.** Could we have INQ000023131, please.
25 This is a pandemic preparedness meeting dated

1 November 2019, so on the eve of the pandemic, Ms Reed,
2 but about a year and a half after you had taken up your
3 post.
4 It's a meeting of a -- well, of, in fact, the
5 Department of Health and Social Care, so it's not,
6 I think, a -- it wasn't a PIPP meeting or a PFRB
7 meeting, we'll come back to those in a moment, it's just
8 a departmental meeting.
9 Page 5, I'll read out the relevant bit and then give
10 you a moment to find the part on the screen.
11 On the right-hand side -- don't, please, scroll in,
12 because I'll lose my way -- but on the right-hand side
13 there is a heading "Areas of Work not Prioritised for
14 the Next 6 Months:
15 "Adult Social Care -- The briefing paper which
16 outlined plans to augment adult social and community
17 care during a pandemic, was agreed by the former CMO
18 [Professor Dame Sally Davies], CSA and CNO in July 2018.
19 DHSC policy and social care team to work with [National
20 Health Service England and Improvement] to agree next
21 steps.
22 "Pandemic Influenza Public Health Communications
23 Strategy -- The content was signed off ... but needs
24 further work ... a Concept of Operations ... document to
25 outline the ... command structure and the

1 responsibilities of Departments ... needs to be
2 developed.
3 "Refresh of UK Pandemic Influenza Strategy -- Update
4 the content of the ... Strategy to ensure that UK
5 Pandemic Influenza preparedness and response policy is
6 accurate and up to date."
7 **A.** Thank you.
8 **Q.** These areas of xwork which were not prioritised were of
9 fundamental importance, were they not, to the
10 United Kingdom and the Department of Health and
11 Social Care's ability to be properly prepared for
12 a pandemic?
13 **A.** They were important pieces of work in the pandemic flu
14 readiness programme, yes. They were not the areas of
15 priority.
16 **Q.** Are you suggesting, Ms Reed, that the bringing up to
17 date and making accurate of the United Kingdom's sole
18 strategy for influenza preparedness was not a matter of
19 very considerable importance?
20 **A.** No, sorry, allow me to clarify. These pieces of work
21 were important as part of the pan flu readiness
22 programme and they were important pieces within that
23 programme. However, as I am happy to expand, at that
24 period of time, in readiness for the potential
25 disruption of a no-deal exit, my view at that time was

1 preparing for a no-deal exit took precedent(sic) over
2 completion of some of these pieces of work for a short
3 period of time.
4 **Q.** Did you or anybody else when confronted with -- and it
5 was a Cabinet direction, wasn't it?
6 **A.** Yes.
7 **Q.** Work must be -- to use the etymology, the terminology,
8 work must be prioritised, the euphemism for the
9 cessation or interruption or complete stopping of other
10 workstreams in order to be able to focus on preparations
11 for a no-deal EU exit, that came from the highest level,
12 did it not?
13 **A.** It did, yes.
14 **Q.** It did.
15 Did anybody in the Department of Health and
16 Social Care, which bore the primary responsibility for
17 getting the country ready for a health emergency, say,
18 "These important" -- you used the word vital, "These
19 vital parts of pandemic preparedness cannot afford to be
20 stopped"?
21 **A.** If I recall the process at that time, I was asked to
22 look at which areas of work we would prioritise and
23 de-prioritise in order to prepare for a no-deal exit,
24 and in thinking through which areas of work I would
25 de-prioritise and prioritise, I recall a submission

1 going to ministers to set out which areas of work
2 I would recommend that we prioritised and deprioritised.
3 On the case of adult social care particularly,
4 I think it may be helpful to add that my concern about
5 the impact of adult social care as a result of a no-deal
6 exit, a real and credible threat to that sector, was
7 that that sector needed to prepare for and ready itself
8 for a no-deal exit over the risk of a pandemic
9 preparedness.
10 **Q.** The concern that flowed from not being ready for
11 a no-deal EU exit in the adult social care sector --
12 **A.** Yes.
13 **Q.** -- was that there would be an interruption of services,
14 that's to say the availability of staff to work in the
15 sector, because of problems with employment and the
16 ability of individual members of the workforce to work
17 in the United Kingdom after an abrupt and traumatic
18 no-deal exit; also the supply of medicines probably?
19 **A.** That's correct.
20 **Q.** So the two areas were workforce availability and supply
21 chains?
22 **A.** I would say they're two of the areas of concerns.
23 **Q.** What were the others?
24 **A.** I think financial stability of that sector was
25 a particular concern before a no-deal exit, and at that

1 time we weren't certain what additional financial would
2 be on the sector as a result of a no-deal exit, so that
3 was an additional concern.
4 **Q.** Was it ever seriously considered by anybody in your
5 department that one of the consequences of an unprepared
6 no-deal EU exit would be the deaths of very large
7 numbers of inhabitants of care homes?
8 **A.** I think that the human aspect and risks associated with
9 that relating to a no-deal exit were considered.
10 I don't have the details of what the risk assessment
11 said of a no-deal exit, but the risk of harm to the
12 public was absolutely a consideration.
13 **Q.** In the risk assessment process, and the procedure was
14 updated, as you know, in 2016 and then 2019, what was
15 the assumed outcome of a severe influenza pandemic on
16 the United Kingdom in terms of fatalities?
17 **A.** If I recall, I believe the number to be about 8 --
18 800,000, I think, but I'm recalling, I might have that
19 number incorrect.
20 **Q.** Around 800,000 deaths?
21 **A.** **(Witness nods)**
22 **Q.** Of which, if the pandemic were to be particularly
23 dangerous to the elderly, a significant proportion of
24 those deaths would be in the care home sector, would
25 they not?

1 **A.** I would believe so, yes.
2 **Q.** Yes. So let me put the question again: in terms of the
3 balance between the possible outcomes of an unprepared
4 no-deal EU exit and the appalling loss of life attendant
5 upon a pandemic for which no preparedness had been
6 carried out, why did no one say "We cannot afford to
7 stop the pandemic preparedness"?
8 **A.** I think in response to your question, there's a couple
9 of points I think are important to make.
10 The first one is that the adult social care sector
11 had done some work in pandemic preparedness prior to the
12 pausate of the work.
13 Secondly, I think the work that was done for
14 Operation Yellowhammer was of benefit to our
15 preparedness for a pandemic influenza.
16 Then the third point I'd make is that, in
17 considering where to allocate resources, what I consider
18 is: what is a real and present and credible threat
19 versus the risk of a threat? And to try to strike the
20 balance of where resources are allocated, I retained
21 teamwork on pandemic preparedness, but I also allocated
22 resources to deal with the real risk of a disruption
23 through a no-deal exit.
24 **Q.** All right. May we then look briefly at the NSRA process
25 to which you've referred.

1 Can you recall what role you had in the
2 republication of, the re-issue of the NSRA process in
3 2019?
4 **A.** The National Risk Register's reassessment comes to my
5 team to lead the process for reviewing whether the risk
6 is still the same risk. One of my team led the work on
7 developing that risk assessment. I was aware of the
8 work at the time, that was led within my team.
9 **Q.** Not all the risks, indeed only a very small number of
10 the risks, fall within the reach of the Department of
11 Health and Social Care. Of course, disease is one of
12 them, perhaps the main one.
13 **A.** The department has a number of risks on the risk
14 register. Not all of the department's risks are -- fall
15 within the confines of my directorate's work. We deal
16 with emerging infectious disease risk and we deal with
17 pandemic risks, but there are risks that sit outside my
18 team in the other parts of the department.
19 **Q.** Do you accept, as Ms Hammond on behalf of the
20 Cabinet Office -- and of course the Cabinet Office and
21 the DHSC co-chair the Pandemic Flu Readiness Board --
22 would you accept in relation to the DHSC, as Ms Hammond
23 accepted in relation to the Cabinet Office, that the
24 DHSC would have been better prepared for a pandemic
25 if -- had the reasonable worst-case scenario been

1 closer, a lot closer to the realities of Covid than it
2 was?
3 A. Yes, I think it stands to reason that we would have
4 built a different set of responses and plans had the
5 risk that we were dealing with been a Covid risk.
6 Q. There is evidence before my Lady that Dame Deirdre Hine
7 in her review of the swine flu pandemic in 2009 had
8 expressed some concerns about the adequacy of the RWCS,
9 the reasonable worst-case scenario model.
10 Within the DHSC, as far as you're aware, were there
11 concerns ever expressed about the adequacy of the RWCS
12 model, and in particular the risk that by focusing on
13 the assumed worst-case scenario it could lead to
14 a tendency to stop thinking about how to prevent that
15 worst-case scenario from actually happening?
16 A. In the way in which you ask, nobody had raised with me
17 a concern about the process for developing the
18 reasonable worst-case scenario or that risk that we
19 don't do work on the lead-up to that risk occurring, and
20 I believe that with the emerging infectious disease
21 risk, we had complementary capabilities in two different
22 sets of scenarios which would have -- which would have
23 addressed where those risks would have taken us.
24 Q. But of course, as you now accept, the scenario for new
25 infectious disease was predicated on a very limited

1 outbreak with relatively very limited consequences?
2 A. Indeed, and the mitigations that we had in place for
3 managing that had been adequate for the outbreaks of
4 those emerging infectious diseases I experienced over
5 the five years of my appointment.
6 Q. Putting it another way, because the reasonable
7 worst-case scenario for a non-influenza outbreak was
8 described in such very limited terms, confined to health
9 settings, relatively small number of casualties, an even
10 smaller number -- tragic though they are -- of deaths,
11 much less was required of the department to mitigate for
12 that risk, because the risk, of course, had none of the
13 terrible catastrophic consequences that the Covid
14 pandemic resulted in?
15 A. Sorry, I --
16 Q. Yes. You didn't have to do very much by way of
17 mitigating the new and emerging infectious disease risk,
18 because the risk was described in a very limited way.
19 It didn't have the catastrophic or national consequences
20 that a severe influenza pandemic would have or as Covid
21 had.
22 A. I wouldn't agree with the statement that there was less
23 for us to be concerned with, with relation to
24 a high-consequence infectious disease risk. They are
25 extremely serious, and we worked very closely with

1 NHS England and Public Health England to ensure that the
2 plans were in place for managing that risk.
3 Q. I didn't suggest that you were less concerned. I said
4 what you had to do practically by way of mitigating the
5 risk was a great deal less than what you would have had
6 to have done had you been mitigating for a severe
7 national pandemic?
8 A. I think it's true to say that our work on pandemic
9 influenza was a greater responsibility for the
10 department, yes.
11 Q. That work was framed by that 2011 strategy which said in
12 terms: you don't need to worry about things like borders
13 or quarantining or self-isolation or mass test and
14 trace. Because none of it was envisaged, was it?
15 A. I would say that -- I wouldn't necessarily say that it
16 was framed by that. It was -- the work that we did on
17 pandemic influenza was framed by a series of documents,
18 by Exercise Cygnus, by the risk registers across that
19 period of time. So it was a number of different
20 documents, including the 2011 strategy.
21 Q. When Mr Hancock MP became Secretary of State for your
22 department in July 2018, that was after you had been
23 appointed to your post as director of the EPHP
24 directorate. He was provided with a document.
25 INQ000181825, please.

1 Ah, I've got the wrong reference, that's his witness
2 statement.
3 Could we have INQ000184105, instead, please.
4 "Introduction to Emergency preparedness, resilience and
5 response". So this was a paper which was prepared for
6 him, I think at his request, he wanted some more
7 information, about the -- well, England's emergency
8 preparedness, resilience and response.
9 Could we go down, please, to paragraph 12:
10 "Following a national-level exercise in 2016 and
11 a subsequent National Security Council (Threats,
12 Hazards, Resilience and Contingencies) meeting in
13 February 2017, a cross-Government Pandemic Flu Readiness
14 Board ... was established to develop and manage the UK's
15 preparedness for a flu pandemic ... The first year of
16 the programme included the following work streams ..."
17 Then over the page, please:
18 "- Response of the adult social care and community
19 healthcare system.
20 "- Coping with excess deaths ...
21 "- Communicating legal, moral and ethical
22 considerations."
23 That led to the MEAG committee being set up.
24 "- Keeping different sectors working with reduced
25 staff numbers."

1 If that could be shrunk, please.
2 Then, at paragraph 13, reference to "'mass casualty'
3 planning".
4 Do you recall assisting in the process by which
5 Mr Hancock was briefed in relation to the general state
6 of preparedness?
7 **A.** I am not familiar and cannot recall specifically adding
8 to this briefing. I can say, and can recall, that when
9 new ministers arrive I do support Clara Swinson in
10 producing an assessment of the very current situation of
11 risks and threats that the department faces as part of
12 new ministerial briefing, but I can't specifically
13 recall contributing to this particular one.
14 **Q.** At paragraph 12, the first few words are:
15 "Following a national-level exercise in 2016 ..."
16 Would that have been a reference to Exercise Cygnus,
17 do you think?
18 **A.** Looking at the reference to the Pandemic Flu Readiness
19 Board, I would assume it was in relation to
20 Exercise Cygnus and not Exercise Alice.
21 **Q.** Yes, because it was as a direct result of
22 Exercise Cygnus that the then Prime Minister directed in
23 the NSC(THRC) meeting that a board be set up and
24 a programme of work devised for the Pandemic Flu
25 Readiness Board?

1 **A.** That's correct.
2 **Q.** Looking back, are you surprised that there is no
3 reference in this paragraph to the conclusions of
4 Exercise Cygnus, which you described earlier yourself as
5 being concerning, to the effect that the UK's
6 preparedness and response in terms of its plans,
7 policies and capability were not sufficient?
8 **A.** No, I wouldn't say that I was surprised that it didn't
9 go into more detail in this note. From my brief reading
10 of this note, my assessment is that this was a very
11 early briefing given to our Secretary of State to set
12 out the range of threats and hazards that the department
13 faced.
14 In 2018 there had been a series of challenging
15 incidents over the last five years of my role, 32 major
16 incidents, not including anything relating to Covid. So
17 it's very important at the very start of
18 a secretary of state's tenure that they're clear about
19 our risk assessment and their Category 1 responder
20 requirements. I would have expected reference to the
21 high-level risks on pandemic influenza and emerging
22 disease, but in the context of the wider threat
23 landscape.
24 **Q.** What was the highest risk in the entirety of the
25 government's risk assessment procedures?

1 **A.** When it came to hazards, it was pandemic influenza.
2 **Q.** What was the lead government department for pandemic
3 influenza?
4 **A.** The Department of Health and Social Care.
5 **Q.** So are you not, therefore, somewhat surprised that there
6 was no reference to the fact that the greatest hazard
7 risk in the entirety of the government's book of risks
8 was a pandemic influenza and that the national level
9 exercise of Exercise Cygnus, which dealt with the
10 possibility of an influenza pandemic, had reached the
11 conclusions that it did in such serious terms?
12 **A.** I would not have expected that document at that time to
13 have included more information on that risk than it did.
14 It is also useful to recognise that there had been
15 a poisoning in Salisbury, there had been breast cancer
16 screening incidents, so it was in a context of a number
17 of different incidents that had occurred. I would
18 expect the risk register to have been referred to, as it
19 was in this document.
20 **Q.** May we then discuss in a little more detail some of the
21 exercises. You were concerned, because you were one of
22 the two deputy directors within the department leading
23 on the response to the Ebola outbreak, so you were
24 concerned very much with how the country -- the
25 department did respond?

1 **A.** Yes.
2 **Q.** To what extent -- and I should say that -- was that
3 outbreak 2014/15, so not when you were director of the
4 EPHP, you weren't appointed to that post until
5 February 2018, it was whilst you were in a different
6 post?
7 **A.** That is correct.
8 **Q.** All right.
9 To what extent were you concerned with taking on the
10 recommendations in the report on the Ebola outbreak once
11 the outbreak was over?
12 **A.** Are you talking about at the immediate time or in my
13 current post?
14 **Q.** No, at the immediate time. So following the outbreak
15 obviously there was a certain amount of learning and
16 reports were produced dealing with the outbreak and what
17 could be learned from them, and making recommendations
18 as to the future. To what extent were you concerned
19 with that process?
20 **A.** I was involved in the lessons learned processes, there
21 were a number of different lessons learned processes
22 post the Ebola outbreak, and I moved to different roles
23 that were unconnected in this area in the intervening
24 period. So the work was continued by my colleagues.
25 **Q.** So you were involved in the lessons learned processes

1 but only for a while?
2 **A.** Some of the lessons learned processes. There was
3 a number of lessons learned processes.
4 **Q.** Right. You said the work was continued by your
5 colleagues because you moved to different roles. To
6 what extent were you concerned? For how long were you
7 involved in the lessons learning process?
8 **A.** I'm recalling that some of the lessons learned processes
9 were operational lessons learned, and some of them were
10 more detailed lessons learned, a series of sessions.
11 I was not involved in the more formal lessons learned
12 processes, if I can recall.
13 **Q.** The reason I ask, Ms Reed, is that, as you will no doubt
14 recall, one of the lessons, lesson 8, from the Ebola
15 report was that appropriate levels of PPE should be
16 maintained for ongoing infectious disease preparedness.
17 A second lesson, lesson 16, was that consideration
18 needed to be given to the development of the relevant
19 powers to allow stepped interventions from port through
20 to community, so, in a sense, social restrictions or
21 closing of borders or management of people and
22 gatherings.
23 Can you recall what steps were taken to pursue those
24 issues, to draw up further papers or develop the
25 thinking on PPE and social interventions?

1 **A.** So thinking about the PPE aspect of your question, PPE
2 and appropriate levels of PPE were part of the
3 mitigations that were recommended on the back of the
4 emerging infectious disease risk. Ebola is an emerging
5 infectious disease, it's a high-consequence infectious
6 disease, and would therefore have been dealt with under
7 the mitigations for that particular risk.
8 **Q.** Can I just pause you there?
9 **A.** Yes, of course.
10 **Q.** Is that a reference back to what you said earlier, which
11 is that of the two risks, health or disease-related
12 risks in the risk assessment process, you've got
13 influenza pandemic, with its assumed catastrophic
14 consequences, and then you've got the much narrower new
15 and emerging infectious disease risk, with the assumed
16 much narrower consequences, and therefore reference
17 to PPE would be a reference to the PPE required in
18 a health setting or in a much narrower way?
19 **A.** That is correct. Ebola would have been classed as
20 an emerging infectious disease and would have been
21 treated as an emerging disease with the mitigations that
22 would be appropriate for the management of
23 high-consequence infectious disease. And with that,
24 your question around PPE, is that PPE advice that would
25 be given to us would be based on how you have that

1 intensive treatment regime for a high-consequence
2 infectious disease and what would be the appropriate PPE
3 required to manage those diseases.
4 **Q.** What about lesson 16 and the consideration of powers
5 that might be required to adopt interventions in the
6 community, so restrictions on movement or public
7 gatherings or border controls and so on? Do you recall
8 what work was done on those issues?
9 **A.** I don't recall the work that was done on those issues.
10 I am aware that there was a view that border
11 restrictions wouldn't be the appropriate response for
12 an emerging infectious disease or pandemic influenza.
13 **Q.** Of course, that's why it was the lesson in the report.
14 But was this not something that, at least subsequently,
15 as the director of the directorate, you would have seen
16 the outcome of the work done to put that recommendation
17 into place?
18 **A.** I'm aware of work that Public Health England and
19 latterly Health Security Agency have been doing around
20 border measures. I'm not aware of any work that was
21 done to restrict border access.
22 **Q.** Exercise Alice was in 2016, wasn't it, and it was
23 an assumed large-scale outbreak of MERS coronavirus?
24 **A.** Yes.
25 **Q.** That's correct. Was that an exercise in which the

1 Department of Health and Social Care was a participant,
2 an organiser, or just an observer?
3 **A.** The exercise was run by Public Health England and the
4 Department of Health and Social Care participated in
5 that. I wasn't in post at the time.
6 **Q.** But there were a number of recommendations made as
7 a result of the report following on that exercise, were
8 there not?
9 **A.** That's correct.
10 **Q.** Those recommendations included issues such as developing
11 plans for or at least considering the need for
12 quarantine, self-isolation, the collection of data from
13 contacts, an enlarged process of community sampling --
14 of course, again, this was regarded as
15 a high-consequence infectious disease, it was a more
16 limited outbreak -- do you know what happened with those
17 lessons and the putting into place of practical measures
18 to give effect to them?
19 **A.** Yes. There were two piece -- bodies of work that were
20 set up to lead pieces of work on how to respond to those
21 actions. One was developed by NHS England, they set up
22 a high-consequence infectious diseases programme. The
23 Department of Health was a participant to that piece of
24 work. And Public Health England set up a programme of
25 work to also respond to the recommendations and the work

1 on high-consequence infectious disease.
2 As I understand it, NHS England's board continues,
3 and we still play an active role on that, and PHE's
4 commitments have been embedded within their programme of
5 work at UKHSA.
6 **Q.** Both those workstreams, Ms Reed, were clinically
7 related, weren't they? They were to do with how the NHS
8 clinically would deal with the impact of
9 a high-consequence infectious disease outbreak and how
10 Public Health England would deal, I suppose,
11 semi-clinically, with the outcome of an outbreak.
12 Where was the work done by the DHSC by way of plans
13 for quarantine, self-isolation, enhanced community
14 sampling and collection of data?
15 **A.** I would say that the recommendations were both clinical
16 and operational, and that the clinical and operational
17 elements of them were led by NHS England and Public
18 Health England, with bodies that we were on to support.
19 In your -- answer to your question about where the work
20 on contact tracing was led, that was within Public
21 Health England.
22 **Q.** Did the DHSC, as far as you are aware, take forward,
23 produce papers or policies or guidance or spend time
24 thinking about any of those issues within its own
25 department?

1 **A.** So the advice on clinical and operational matters would
2 be the responsibility of NHS England and Public Health
3 England, so we would look to those bodies to provide us
4 with advice. I am not a clinician and I'm not well
5 placed to write those papers. I would seek advice from
6 colleagues across the health and social care
7 organisations that can.
8 We were very aware of the level of readiness in the
9 health and social care system to deal with an emerging
10 infectious disease. There were, at -- off memory,
11 approximately eight or nine in the five years of my
12 appointment, and so I was very aware of the response
13 capability to high-consequence infectious disease and
14 had run a number of incidents to see how that operated
15 in practice.
16 **Q.** Those recommendations were not formulated by way of
17 directions to NHS England or Improvement or to Public
18 Health England, they were generic recommendations or
19 lessons: X, Y or Z must be done.
20 So, given that it wasn't the NHS England or the PHE
21 who were told to respond in their own way, within the
22 limits of their own functions, to these areas of
23 concern, why wasn't the DHSC itself responding, doing
24 what it could to improve the overall system of
25 preparedness for a health emergency by addressing these

1 particular issues?
2 **A.** I would say that it is within the remit of those
3 organisations to lead the response that was required to
4 those recommendations. That is set in the remit letters
5 and the responsibilities that those organisations hold
6 to deliver adequate preparedness to an outbreak of
7 an infectious disease and a response to public health.
8 That is enshrined within the responsibility of those two
9 bodies to do.
10 **Q.** Exercise Cygnus.
11 **A.** Yes.
12 **Q.** You're aware, because we've been debating it, that the
13 overall outcome of Exercise Cygnus was that the UK's
14 plans, policies and capability were not sufficient to
15 cope with the extreme demands of a severe pandemic. How
16 often, as far as you're aware, was that conclusion
17 considered within your department once you took up post
18 18 months later?
19 **A.** Sorry, could you repeat the question?
20 **Q.** Yes. How often was active consideration given to
21 whether or not that general conclusion from
22 Exercise Cygnus was being dealt with? How often were
23 meetings held where employees in the department would
24 say, "Right, well, that was the serious conclusion from
25 the exercise. How well are we doing in terms of

1 addressing those concerns, of making sure that the plans
2 and the policies and the capability are now sufficient"?
3 How often was active consideration given to making sure
4 that that worrying feature was being adequately
5 addressed?
6 **A.** I would say on a regular number of occasions in
7 different ways. That -- the concern that was raised in
8 Cygnus was a feature of our risk and our risk register.
9 That was discussed at every level of the department on
10 a quarterly basis. We had boards that were looking at
11 the readiness of the health and social care system to
12 respond to that, that was chaired by my Director
13 General, Clara Swinson. We had quarterly conversations
14 to look at cross-government readiness and whether we
15 were addressing the recommendations of that report.
16 So -- and also regular meetings with our
17 permanent secretary. So I think the question about how
18 we were responding to our state of readiness was asked
19 on a regular occasion.
20 **Q.** How many recommendations came out of Exercise Cygnus?
21 **A.** 22, and four learning recommendations.
22 **Q.** By June 2020, how many of those recommendations did the
23 DHSC itself identify had not been fully completed?
24 **A.** Off my recollection, I would say that eight of them had
25 not been fully completed -- had been partially

1 completed, and about six of them had not been completed
2 at all.
3 Q. That was, you're quite right, the conclusion of a DHSC
4 meeting, workstream, another workstream, to consider to
5 what degree the department or to what degree the
6 recommendations from Exercise Cygnus had not been
7 completed, and that was a conclusion reached in
8 June 2020, was it not, Ms Reed?
9 A. That sounds about the right date, yes.
10 Q. All right, take it from me then.
11 **LADY HALLETT:** Can I just ask what you mean by not fully
12 completed, not completed at all?
13 Completed means done, completed. So I would have
14 thought not fully completed means work had started but
15 it hadn't finished. Not completed at all, I don't
16 understand.
17 A. Okay, allow me to expand. Some of the recommendations
18 had different component parts to them, and so there may
19 be an element of a part that had been completed. So,
20 for example, we had completed some work on surge
21 guidance, and that had been completed, but the second
22 half of that, around socialising that with -- or testing
23 that with health and social care organisations, that
24 part of it was not completed.
25 **LADY HALLETT:** But that would come under the category of not

1 completed.
2 A. I think that's a fair conclusion to reach, yes, my Lady.
3 **LADY HALLETT:** So what do we mean by six were not completed
4 at all? Do we mean no work had started?
5 A. No, I wouldn't say that no work had started. Work had
6 started on all of the recommendations, but there were
7 some elements of those that had been completed.
8 So I would agree with your conclusion that they
9 weren't completed, but work had begun on all of them.
10 **LADY HALLETT:** Or they hadn't got very far?
11 A. It varies across the recommendations, my Lady.
12 **LADY HALLETT:** If you have a recommendation that says "We
13 must get more PPE, this is a highly infectious disease,
14 it's got terrible consequences, we must get" -- whose
15 responsibility is it to get the PPE?
16 A. I would suggest that that would be my responsibility.
17 **LADY HALLETT:** Who would ensure that your responsibility was
18 carried through, apart from you?
19 A. That would be the responsibility of my
20 permanent secretary and the departmental board.
21 **LADY HALLETT:** So after Ebola you had a recommendation for
22 more PPE, was it?
23 A. I can't recall the recommendation from Ebola, my Lady.
24 **LADY HALLETT:** I think there was one in relation to PPE.
25 A. If there was a recommendation that related to PPE being

1 acquired for an emerging infectious disease, as
2 I understand it the PPE stockpiles for emerging
3 infectious disease have been adequately built, I haven't
4 had anything to tell me to the contrary. So I'm not --
5 it's -- unfortunately before my time I can't confirm
6 whether or not and how the recommendations for Ebola's
7 PPE were delivered, but I can say that that hasn't been
8 raised to me as an issue, that there isn't adequate PPE
9 for an emerging infectious disease.
10 **LADY HALLETT:** Thank you.
11 **MR KEITH:** Can I assist you, Ms Reed?
12 Lesson 8 from Ebola was that further work would be
13 required between the Department of Health, NHS England
14 and Public Health England to determine the most
15 appropriate levels of PPE that should be maintained for
16 ongoing infectious disease preparedness.
17 But for the reasons that we have been debating,
18 namely that the assumed consequences of infectious
19 non-influenza disease were set so low, were so narrow,
20 in terms of being confined to healthcare settings, and
21 very low levels of casualties and fatalities, not very
22 much PPE was required to meet what was thought to be
23 necessary for a high-consequence infectious disease.
24 But no consideration was given at all to the need for
25 PPE for a non-influenza pandemic.

1 That's the sum of it, isn't it?
2 A. The risk assessment we were building our mitigations for
3 were a pandemic influenza and emerging infectious
4 disease, and in both of those cases, with advice from
5 experts and specialists, we were advised what PPE we
6 needed for both of those risks. If you start from the
7 premise of the risk you're mitigating, you build the
8 appropriate mitigation for those risks. So it is the
9 case that we had appropriate PPE for those two
10 scenarios, but not for a Covid pandemic, which was not
11 the risk we were managing.
12 Q. Going back to the recommendations, the recommendations
13 from Cygnus, 14 of which had not been fully completed,
14 whatever that means, eight partially, perhaps six not
15 fully, fully completed, that was not a situation in
16 June 2020 which took anybody by surprise, was it?
17 A. No. The recommendations that hadn't been completed were
18 part of our ongoing programme of work, and, as
19 I mentioned earlier, some elements of our programme
20 needed to be paused, and so there were elements of those
21 programmes that hadn't been completed.
22 I would also say that there are a number of
23 recommendations in Cygnus that it's not really
24 conceivable for us to say that we have ever fully
25 completed. So the first recommendation is that our

1 emergency preparedness must follow best practice. Well,
2 by definition we never complete that, because the
3 process is about continuous learning. So I'd never feel
4 comfortable being at the point of saying that we've
5 absolutely completed that activity. The way that some
6 of the recommendations were phrased were such that they
7 were about ongoing work and continuous development. So
8 I think it would be difficult for us ever to get to the
9 point that we'd say all 22 of those had been completed.
10 **Q.** The point, Ms Reed, though, is this, isn't it: as at
11 June 2020, the body that was looking at how many of the
12 recommendations were implemented couldn't have been
13 taken by surprise, it must have been apparent to
14 everybody who was responsible for implementing the
15 implementations, from 2016 through to 2020, that the
16 recommendations were not being implemented; it just was
17 not being done, for a variety of reasons, which you've
18 attempted to explain? It just wasn't done.
19 **A.** There were a number of recommendations that weren't
20 completed, that's absolutely correct.
21 **Q.** You knew that the recommendations were not being
22 implemented. 2016 was four years before this committee
23 reported as to the number which weren't being
24 implemented.
25 **A.** That's correct.

1 **Q.** If we could have, please, on the screen INQ000022792,
2 which is the report into Exercise Cygnus, page 6. At 1,
3 amongst the recommendations which were never implemented
4 in full was this one:
5 "The development of a Pandemic Concept of
6 Operations ..."
7 Correct?
8 **A.** That's correct.
9 **Q.** Page 8, at 3, work to be done on how the public would
10 respond to a pandemic, that is to say whether it would
11 self-isolate, whether it would cope with the demands of
12 mandatory quarantining, how it would respond to social
13 restrictions; correct?
14 **A.** I can't say with certainty whether any of the work was
15 done on this particular recommendation. I don't think
16 it is concluded.
17 **Q.** Now, the only thing that was done, Ms Reed, wasn't it,
18 was that a committee was set up called MEAG, of which
19 my Lady has heard, the Moral and Ethical Advisory Group,
20 which would give advice in the event of a pandemic on
21 some of the moral and ethical questions that might
22 arise?
23 **A.** Yes.
24 **Q.** But the work done, the behavioural work done as to how
25 the public would deal with social restrictions and

1 non-pharmaceutical interventions and how in practice the
2 country would be enabled to deal with the consequences
3 of a catastrophic pandemic were not addressed at all,
4 were they?
5 **A.** No.
6 **Q.** Page 9:
7 "An effective response to pandemic influenza
8 requires the capability and capacity to surge resources
9 into key areas, which in some areas is currently
10 lacking."
11 The NHS did put into place, at your department's
12 urging, plans for surge capacity, and we saw that
13 of course when the pandemic struck, but very little work
14 was done in relation to how the adult social care sector
15 would cope with a mass influx of patients in a pandemic.
16 **A.** I wouldn't agree that there was no work done in that
17 space. There was a lot of engagement with LRFs and some
18 guidance was issued to adult social care providers in
19 May of 2018 that addressed the question of surge.
20 I would not say that that work was completed, and
21 I would be very clear to say that there was more that we
22 needed to do about community surge. But it was not the
23 case that no work was done.
24 **Q.** Page 11, there was some feedback in the course of
25 Exercise Cygnus from local resilience forums to the

1 effect that there are just "too many plans" and "there
2 is a question about how up to date all the plans are and
3 whether there are contradictions between [them]".
4 What was done in order to rewrite the plans? To
5 produce something, perhaps in a single document,
6 something that was coherent and clear to the LRFs? Was
7 that ever done?
8 **A.** No, it wasn't completed.
9 **Q.** Page 12, some of the feedback was to the effect that
10 LRFs, the local resilience forums, "would have
11 difficulty operating their plans and capabilities at
12 this scale [of response]".
13 "More focus and co-ordination on pan flu
14 preparedness [is] needed nationally, departmentally and
15 within Resilience and Emergencies Division Operations
16 Centre itself."
17 Now, of course you don't speak for the Resilience
18 and Emergencies Division of the Department for Levelling
19 Up, Housing and Communities, nor for the Cabinet Office,
20 but was that focus and co-ordination carried out, as far
21 as you were aware?
22 **A.** I am aware that the Ministry for Housing engaged
23 extensively with local resilience forum around their
24 readiness in pandemic influenza. I'm aware the
25 Cabinet Office engaged extensively with local resilience

1 forums on their resilience standard and their level of
2 preparedness.
3 Of course it's also important to note that
4 NHS England and Public Health England are represented on
5 the local resilience forum, so I also engaged with the
6 health system that sits on local resilience forum. It
7 was not co-ordinated and that was definitely one of the
8 recommendations that we were -- we didn't deliver, which
9 I regret, around that co-ordination and the bringing
10 together of advice. But we did engage with local
11 resilience forums and at the local level.
12 **MR KEITH:** My Lady, is that a convenient moment?
13 **LADY HALLETT:** Certainly. I shall return at 12 o'clock.
14 **(11.45 am)**
15 **(A short break)**
16 **(12.00 pm)**
17 **MR KEITH:** Ms Reed, what are health sector security and
18 resilience plans?
19 **A.** They would be plans that organisations who are
20 Category 1 responders and have responsibility under the
21 Civil Contingencies Act need to have in place to ensure
22 that they can discharge that duty.
23 **Q.** So they are plans which you put into place to make sure
24 that everyone can know or you can be assured that your
25 preparedness and continuity arrangements are in order,

1 as they are obliged to be under the Civil Contingencies
2 Act 2004, as a Category 1 responder?
3 **A.** Yes.
4 **Q.** Can we have INQ000187694, please, which is the 2016
5 plan, page 3, paragraph 1:
6 "Within the health sector, there are generally good
7 levels of resilience, with good preparedness and
8 business continuity arrangements in place."
9 **A.** Yes.
10 **Q.** At paragraph 5:
11 "The health sector can be impacted by the majority
12 of risks in the National Risk Assessment ... it is
13 essential that within the health sector, national
14 planners are ... planning against the common
15 consequences ... Given the diversity and
16 interconnectedness within the health sector, and the
17 extent to which it needs to respond to the consequences
18 of emergencies in other sectors, emergency preparedness,
19 resilience and response planning ... adopts an
20 'All Risks' approach."
21 So this is the DHSC saying "We have measured
22 ourselves against a security and resilience assurance,
23 these are our plans for preparedness and continuity, we
24 [going back to paragraph 1] think there are generally
25 good levels of resilience, with good preparedness and

1 business continuity arrangements in place", it's you
2 signing off on how you're doing, paragraph 1?
3 **A.** Yes, but this is not a -- this is not a static status,
4 it is something that we continually look at, the health
5 and social care sector's resilience for emergency
6 preparedness.
7 **Q.** Of course, so this is just for 2016?
8 **A.** Yes, I'm not familiar with this document.
9 **Q.** All right.
10 So every year or every two years these plans are put
11 into place or these documents are prepared, and they're
12 not static, are they, they take account of whether or
13 not there is good resilience and whether there has been
14 an outbreak or whether there has been an exercise and
15 whether you've responded to an exercise or whatever it
16 might be. They're not fixed, set in place. They take
17 account of the reality of how well the department is
18 doing.
19 **A.** The department and its delivery organisations.
20 **Q.** Arm's length --
21 **A.** Yes.
22 **Q.** And its arm's length bodies?
23 **A.** Yes.
24 **Q.** Could we then, please, have 2017/18 health sector
25 resilience plan, INQ000105273. Page 3.

1 So, Ms Reed, this health sector security and
2 resilience plan was after Exercise Cygnus. The first
3 one I showed you was before the report in
4 Exercise Cygnus.
5 Could you go, please, down to the bottom of the
6 page -- or, rather, halfway down the page. There we
7 are, stop there.
8 So this plan, a year and a half later, from the
9 earlier plan, is after Cygnus has reported in the terms
10 that it did about the systemic insufficiency of the
11 plans, policies and capability in the health sector,
12 amongst others, to cope with the extreme demands of
13 a severe pandemic, but the wording in this plan is
14 identical:
15 "... there are generally good levels of resilience,
16 with good preparedness and business continuity
17 arrangements in place."
18 The identical words to the plan 18 months before.
19 So it wasn't static -- sorry, it was static. The plan
20 uses the identical wording from the earlier plan. So
21 how could it possibly have taken account of that severe
22 conclusion from Exercise Cygnus, and the fact that the
23 workstreams which came from Cygnus were not by and large
24 being pursued through to their fruition?
25 **A.** I'm not familiar with this document and this document

1 was produced before my time in the organisation, so
2 I cannot -- I cannot make an assessment of the decision
3 to draft that sentence as it is. Looking at this
4 document for -- for what I can see it to do, is it is
5 looking across the totality of the threats and hazards
6 landscape, so all of the threats that are captured in
7 the National Security Risk Assessment, I think that my
8 perception would be that at that time the concern of
9 pandemic influenza was in a state of readiness, but this
10 is looking at general levels of resilience and
11 preparedness across all the risks in the National Risk
12 Register.
13 **Q.** Ms Reed, in the field of health emergency, in the field
14 of the Tier 1 risk faced by the United Kingdom, there
15 had been since the earlier sector resilience plan,
16 Exercise Cygnus, which had concluded in the way with
17 which you are very familiar. How could a proper,
18 adequate sector resilience plan conclude in this way
19 using the identical wording that its earlier plan had
20 used before Exercise Cygnus had reported?
21 **A.** I can't comment on the drafting of this paper --
22 **Q.** Because this was before your time?
23 **A.** -- it was not -- before my time. I would not say that
24 in the specific risk of pandemic influenza we were fully
25 prepared or that there was good levels of resilience.

1 I would say generally across the threat and hazards
2 landscape there is a good level of resilience and a good
3 degree of preparedness.
4 **Q.** Was there a sector resilience plan prepared by you,
5 however, after you were in post?
6 **A.** I don't believe there was, no. I don't recall producing
7 one, no.
8 **Q.** All right.
9 My Lady, there's a document which we have on our
10 system which hasn't in fact been disclosed for a variety
11 of reasons, I'm not quite sure why, to core participants
12 and to the witness, and therefore I'm not in a position
13 to be able to bring it up on the screen, and it's not
14 right that I should because it will take everyone by
15 surprise.
16 But I want to ask you, Ms Reed, do you recall
17 a sector resilience plan for 2018 and 2019 being
18 prepared whilst you were and remain in post?
19 **A.** I don't recall a plan being produced, no.
20 **Q.** All right.
21 If that plan were to use these words "there are
22 generally good preparedness and business continuity
23 arrangements in place", that would seem to indicate that
24 the wording had still not been materially altered, even
25 by 2018/19, when you were in post?

1 **A.** I can't comment on the text, I'm not familiar with the
2 document. If the text is the same as the previous
3 versions, that would imply that it hadn't been changed.
4 That would not be my view of the pandemic risk, but it
5 would be my overarching view of our state of readiness
6 for wider threats and hazards.
7 **Q.** All right.
8 The Pandemic Flu Readiness Board, we've covered the
9 workstreams which were meant to be addressed by the
10 Pandemic Flu Readiness Board. Bringing those threads
11 together, the board was established in --
12 **A.** 2017.
13 **Q.** -- in March, following Exercise Cygnus. It was
14 established by order of the National Security Council
15 Threats, Hazards, Resilience and Contingencies committee
16 in the order of the then Prime Minister?
17 **A.** Yes.
18 **Q.** It had a number of workstreams, some of which were
19 completed?
20 **A.** Yes.
21 **Q.** Some were part completed, some were not completed at
22 all. We needn't go into the detail of it. But that
23 Pandemic Flu Readiness Board, which was a board chaired
24 jointly by your department and the Cabinet Office,
25 didn't sit at all, did it, between November 2018 and

1 November 2019?
2 **A.** That's correct.
3 **Q.** You've already explained and other witnesses have
4 explained that that was because of the necessary
5 preparations for a no-deal exit, Operation Yellowhammer
6 interfered in this process. But why did the fact that
7 the particular workstreams were in some places being
8 paused or not completed mean that the board itself
9 didn't have to meet between November 2018 and
10 November 2019? Why was Operation Yellowhammer
11 a sufficient explanation for why the board didn't meet
12 as opposed to why some of its workstreams were not being
13 seen through to their conclusion?
14 **A.** I would say that the reason for that is that our
15 prioritisation of resources in working on pandemic flu
16 were prioritised at the delivery of key elements of the
17 programme rather than in the secretariating of a board.
18 So I prioritised our work on the Bill and on work to do
19 with excess deaths and MEAG rather than board
20 secretariating functions. So the work continued but we
21 didn't run a board.
22 **Q.** You were the prime civil servant, along with Ms Hammond,
23 on that board?
24 **A.** Yes.
25 **Q.** You effectively co-chaired it?

1 A. Yes.
2 Q. You knew the board was not sitting and did not sit for
3 a whole year.
4 A. That's correct.
5 Q. Did you not think to yourself, "The risk of a pandemic
6 has never gone away, these are important workstreams
7 which the Prime Minister ordered to be done, they are
8 things that matter, they reflect the conclusions of
9 Exercise Cygnus, they are important aspects of getting
10 this country ready for the Tier 1 risk, the greatest
11 risk in the entire risk assessment process, I think we
12 should be sitting"?
13 A. I -- no, I don't. I think that what I took as
14 a judgment was, firstly, that resources were needed to
15 support the response to the real threat of disruption
16 from a no-deal exit and, secondly, that I prioritised
17 work that needed to be completed on capabilities that
18 actually were used in the Covid situation, which
19 included the Pandemic Flu Bill. Those pieces of work
20 could continue outwith a board structure.
21 Q. Now, there are a number of things that the board did see
22 through to fruition. There was the drafting of
23 a Bill --
24 A. Yes.
25 Q. -- which was the draft pandemic Bill, which became the

1 Coronavirus Act.
2 A. Yes.
3 Q. Only in relation to the emergency regulations in England
4 was that Act used, was it not, when Covid struck,
5 because Scotland, Wales, Northern Ireland all used
6 earlier emanations of the Public Health Act, did they
7 not?
8 A. I would have to check my records to see which piece of
9 legislation --
10 Q. All right.
11 A. That would be an issue for the devolved administrations.
12 Q. MEAG --
13 A. Yes.
14 Q. -- was put in place, the Moral and Ethical Advisory
15 Group, and that gave valuable assistance, of course,
16 during the pandemic on the moral and ethical issues.
17 Another piece of work that was done was the board
18 authorised, drafted and prepared and published something
19 called the National Resilience Standards. That was
20 a standard, a test, a check, if you like, for local
21 resilience forums, so that they knew to what standard
22 their own preparedness plans had to be judged by?
23 A. Yes.
24 Q. I put it to Ms Hammond, but I ought to put it to you
25 because I think the National Resilience Standards for

1 Local Resilience Forums came, at least in part, from the
2 Department of Health and Social Care, did they not?
3 A. If I recall, it was a piece of work that was led by the
4 Cabinet Office working in partnership with the
5 department responsible for local government, but we will
6 have supported that work.
7 Q. All right. Are you aware that until 14 November 2019,
8 just before the pandemic struck, the National Resilience
9 Standards for Local Resilience Forums across the
10 entirety of England and Wales made no reference to any
11 need to judge their work by reference to the plans that
12 might be required for an influenza pandemic?
13 A. That would be a matter for the Cabinet Office and the
14 department for housing and local government.
15 Q. All right.
16 The PIPP board or the PIPP programme, what was that?
17 A. That was a programme that was led by my Director
18 General, Clara Swinson. The responsibility of that body
19 was to look at the delivery of the health and
20 social care elements of pandemic preparedness. So it
21 was a more internal health and social care-focused
22 programme.
23 Q. Was there a long period during which it did not meet, or
24 at least the board for the Pandemic Influenza
25 Preparedness Programme did not meet?

1 A. As I recall, it also did not meet during the period of
2 end 2018 to 2019.
3 Q. Again, because of Operation Yellowhammer?
4 A. As I understand it, yes.
5 Q. Do you agree that no pre-pandemic exercise in which your
6 department was either an observer or a participant and
7 no outbreak report and no DHSC policy or guidance paper
8 considered the issue of the vulnerabilities and
9 inequalities of parts of the community and how they
10 might be affected by the plans that you were drawing up
11 for a pandemic influenza?
12 A. No, I wouldn't agree with that statement. I think there
13 was consideration taken for the impact to vulnerable
14 people of a pandemic influenza.
15 Q. Clinical vulnerability, Ms Reed, it was clinical
16 vulnerability, it was obviously, in the event of
17 a pandemic, the pandemic and our responses to the
18 pandemic will have an impact clinically on those who are
19 at greatest risk from the disease. Was there any
20 consideration of anything other than clinical
21 vulnerability?
22 A. I believe that there were considerations of wider
23 inequalities of -- for those individuals who would
24 potentially find it difficult to access health and
25 social care systems.

1 You mentioned earlier also the moral and ethical
2 committee that considered issues around concerns from
3 different faith groups about the approach to vaccination
4 and shielding, so there were areas where thinking about
5 protected characteristics were a consideration in our
6 planning and preparing.
7 There was no systemic assessment of protected
8 characteristics impact, but individual work programmes
9 were considering impacts on vulnerable people.
10 **Q.** The work programmes to which I now understand you may be
11 referring, was that the work done to ensure that if
12 individuals want treatment, clinical treatment, steps
13 needed to be taken to mitigate differential impact by
14 ensuring that health communications will be available in
15 a range of languages?
16 **A.** There was work undertaken to think about how we reach
17 communities where English is not the first language.
18 I would say that it is writ within the principles of how
19 we deliver our work that we consider health inequalities
20 at a national and local level and so communications
21 would, in themselves, think about people who may not be
22 able to access information where English isn't their
23 first language.
24 **Q.** Ms Reed, other than the obvious point that some people
25 may be more clinically vulnerable to a pandemic, the

1 only consideration in this whole ten-year period given
2 to the position given to members of ethnic minority
3 groups or vulnerable sectors of society, by way of your
4 pandemic planning, was making sure that health
5 information would be available in a range of languages;
6 is that the sum of it?
7 **A.** I don't believe that to be true, we considered equality
8 impact assessment as part of the -- as the 2011
9 strategy, we considered an impact assessment as part of
10 the pandemic Bill preparedness that you mentioned
11 earlier. In guidance that went to local resilience
12 forums they talked about people who would struggle to
13 access mainstream healthcare, which included those who
14 were homeless and disenfranchised. So there was work to
15 do that. It wasn't systemic -- systematic, I apologise,
16 but there was work to consider vulnerable people.
17 **Q.** The work that was done, and you've just referred to it,
18 was a consideration -- there was a paper called the
19 Equality Duty paper, which came out around about the
20 same time as the 2011 strategy, there was nothing
21 thereafter, which considered the legal obligation
22 imposed on the government generally under the
23 Equality Act 2010, known as *The public sector Equality*
24 *Duty*. Is that the duty to which you're referring?
25 **A.** Yes.

1 **Q.** Right. That was a broad omnibus consideration of the
2 power or the duties of the government under the
3 Equality Act. Where was a single paper referring to
4 what the impact would be on the particular parts of
5 society to which I've made reference of either
6 a pandemic or your planning?
7 **A.** There was no single piece of paper with that on it.
8 **Q.** Right. Do you accept from me, evidence through me,
9 evidence from the government's own Equality Hub, and its
10 director, Mr Bell, who has given a witness statement to
11 my Lady, which says:
12 "Reasonable and proportionate searches have been
13 conducted ... I can confirm that this department was
14 involved in no work related to the United ...
15 government's response to civil emergencies, including
16 a pandemic. There was no contribution to the design or
17 preparation of any policy response on behalf of
18 the United Kingdom government in the event of
19 a pandemic."
20 Just no work was done on this topic at all, was it?
21 **A.** There was no overarching assessment of the impact of the
22 pandemic preparedness strategy on inequalities since the
23 publication of the strategy in 2011.
24 **Q.** Thank you.
25 **A.** Had there been a revision, we would have done that.

1 **MR KEITH:** All right. Those are all my questions,
2 thank you.
3 My Lady, that concludes the evidence of Ms Reed.
4 **LADY HALLETT:** So no Rule 10?
5 **(Pause)**
6 **MR KEITH:** There were applications but permission has been
7 denied.
8 **LADY HALLETT:** Thank you very much.
9 Thank you, Ms Reed, thank you for your help.
10 **THE WITNESS:** Thank you.
11 **(The witness withdrew)**
12 **MS BLACKWELL:** My Lady, good morning. The next witness is
13 Rosemary Gallagher MBE. May she be sworn, please.
14 **MRS ROSEMARY GALLAGHER (sworn)**
15 **Questions from COUNSEL TO THE INQUIRY**
16 **MS BLACKWELL:** Is it Ms or Mrs Gallagher?
17 **A.** It's Mrs.
18 **Q.** Thank you.
19 Mrs Gallagher, thank you for the assistance that you
20 have so far given to the Inquiry and thank you for
21 coming to give evidence today.
22 Please keep your voice up, speak into the
23 microphones so that the stenographer can hear you for
24 the transcript. If I ask you a question that isn't
25 clear, please ask me to repeat it and I will.

1 If you need a break before our usual time of
2 breaking -- which I think will be 1 o'clock today,
3 my Lady?
4 **LADY HALLETT:** Or maybe 1.15, depending on how we go.
5 **MS BLACKWELL:** Or maybe 1.15 -- thank you -- then please
6 just say so.
7 Is it correct, Mrs Gallagher, that you are the
8 professional lead for Infection Prevention and Control,
9 or IPC, and nursing sustainability lead at the Royal
10 College of Nursing, a role that you have held since
11 2009?
12 **A.** Yes.
13 **Q.** Thank you. In terms of your professional career to
14 date, you were a senior nurse in infection control at
15 Stoke Mandeville Hospital from 2002 to 2008. In 2009
16 you represented the Royal College of Nursing as a member
17 of the Pandemic Influenza Clinical and Operational
18 Advisory Group, dealing with the H1N1 swine flu
19 pandemic, and from June to October of 2015 you assisted
20 the World Health Organisation on behalf of the RCN with
21 the MERS outbreak in Saudi Arabia. Between 2014 and
22 2016 you led the RCN response to the Ebola viruses
23 disease outbreak in West Africa, and in November 2018
24 you joined the emergency preparedness, resilience and
25 response (EPRR) clinical reference group of NHS England

1 at the request of its director, Stephen Groves.
2 **A.** That's correct.
3 **Q.** You have provided two witness statements. May we put up
4 first, please, INQ000177809. Can you confirm that
5 that's your first witness statement, Mrs Gallagher?
6 **A.** That's correct.
7 **Q.** Thank you. Now INQ000183414.
8 Thank you. Is that the second statement that you've
9 provided?
10 **A.** That's correct.
11 **Q.** Thank you very much.
12 My Lady, could we have permission for those to be
13 published?
14 **LADY HALLETT:** You have.
15 **MS BLACKWELL:** Thank you. We can take that down.
16 I'm going to begin, please, by asking you to
17 describe to us the role and function that you hold at
18 the Royal College of Nursing.
19 **A.** So I am a registered nurse --
20 **Q.** Yes.
21 **A.** -- and I provide strategic leadership on behalf of the
22 Royal College of Nursing on matters relating to
23 infection prevention and control. I provide specialist
24 infection prevention and control advice to the college,
25 to our members and our stakeholder organisations that we

1 work with. My role is a UK-wide role, and I'm one of
2 a team of about 13 professional leads that work together
3 to cover many areas of nursing practice.
4 **Q.** Right, and it being a UK-wide role, how do you ensure
5 a tailored approach to the particular needs of each of
6 the devolved nations, for instance?
7 **A.** So the RCN has -- covers the four regions of the
8 United Kingdom, and my role often involves both
9 proactive and reactive work. With the proactive work,
10 we engage with the four countries, the four regions of
11 the Royal College of Nursing, and as far as possible
12 with our relevant organisations in the countries as
13 well. For reactive work, we would respond according to
14 the need and what it was that I could support them with.
15 **Q.** Thank you.
16 Moving then to your role with the EPRR clinical
17 reference group, a role that, as we've established,
18 you've held since November of 2019. Could you provide
19 us with an overview of what that group does, and in
20 particular what your role is within that group?
21 **A.** I was asked to be on the group as a nurse.
22 **Q.** Yes.
23 **A.** Not specifically in relation to my experience with
24 infection prevention and control, though that was
25 thought to be advantageous in terms of some of the

1 discussions that took place in the meetings, and
2 I shared that role with a colleague who represented
3 public health nursing.
4 As a member of the EPRR we were there to represent
5 our discipline of nursing and to provide nursing input
6 and advice on discussions that were on the agenda at
7 that time.
8 **Q.** Right, thank you.
9 At paragraph 17 in your witness statement, you tell
10 us that:
11 "Pandemic preparedness [with the group] focused only
12 on influenza and was not a significant regular agenda
13 item at meetings of [the group] ..."
14 And that:
15 "The need to consider other potential infections
16 with pandemic potential was made public by the Chief
17 Medical Officer ... for England in July of 2019 and this
18 position was supported by the RCN due to the experience
19 that it had gained through its planning to support
20 Saudi Arabia with [the] MERS CoV [outbreak]."
21 You also say, Mrs Gallagher, that, additionally,
22 Disease X was added as a new category to the World
23 Health Organisation's emergency priority list in 2019,
24 but that the UK continued to focus on influenza, despite
25 the experience of MERS in the Middle East, and Severe

1 Acute Respiratory Syndrome, SARS, and the potential for
2 a new coronavirus to emerge.
3 So the Chief Medical Officer had given advice in
4 July 2019, the World Health Organisation had made
5 Disease X -- given it a place on the emergency priority
6 list in the same year, and yet the group upon which you
7 sat was giving pandemic influenza only a priority in its
8 discussions, and even that wasn't a regular agenda item.
9 Were you concerned about that?
10 **A.** The overarching pandemic planning did not feel as if it
11 reached into the EPRR group, whose agenda focused on
12 much more recent incidents, and our response and our
13 learning from those. So it was an ad hoc agenda item
14 but not a regular item, and I'm unsure exactly how the
15 EPRR group fed directly into the governance systems for
16 pandemic planning.
17 **Q.** Did you personally have any concerns prior to January of
18 2020 that the focus within the group was too narrow,
19 given as it only appeared to consider pandemic
20 influenza?
21 **A.** The RCN had raised concerns regarding the opportunities
22 for other organisms with pandemic potential that we
23 needed to consider. The -- if I recall the discussions,
24 it was more of an agenda item rather than an opportunity
25 to feed back, it was more feedback on where the pandemic

1 planning was going.
2 **Q.** The Inquiry has heard an explanation or justification
3 from those who were focused, perhaps too narrowly, on
4 pandemic influenza that in fact plans could be and
5 should be adapted?
6 **A.** Yes.
7 **Q.** So the fact that pandemic influenza led to a certain
8 level of planning was able to be seized upon and used
9 during the course of the Covid pandemic.
10 Do you agree that clinical preparedness plans are
11 capable of being adapted for different infectious
12 diseases?
13 **A.** I believe that if you have the principles right in
14 relation to pandemic planning, that you can use those as
15 a platform to adapt as situations evolve. It won't --
16 you cannot have a specific plan for every specific
17 organism, but it's important that we get the foundation
18 structures right.
19 **Q.** Thank you.
20 The Inquiry has heard from Professor Dame
21 Sally Davies, former Chief Medical Officer, and in her
22 witness statement to the Inquiry she has said:
23 "I have previously expressed the view that whilst
24 the [World Health Organisation] has said the UK was well
25 prepared for a pandemic, those preparations assumed

1 a pandemic of influenza. This reflected a longstanding
2 bias in our preparations in favour of influenza and
3 diseases that had already occurred, with, we now know,
4 an underestimation of the impact of novel and
5 particularly zoonotic diseases."
6 Do you agree with that?
7 **A.** I do.
8 **Q.** Yes.
9 In his evidence to this Inquiry, Jeremy Hunt has
10 said that in his view there was a groupthink that the
11 United Kingdom knew that this stuff, as he described it,
12 the best, and that we had no need to look further afield
13 to other countries in order to try and learn from their
14 experience.
15 In particular, he said:
16 "... I don't think people were really registering
17 particularly Korea as a place that we could learn from."
18 Did you observe this type of groupthink as
19 described?
20 **A.** I did.
21 **Q.** Yes, and did you raise your concerns in relation to that
22 with anybody or any organisation?
23 **A.** In response to the work that we did with Saudi Arabia,
24 and also in relation to the work we did on Ebola, we
25 raised significant concerns around the different needs,

1 for example, for personal protective equipment that may
2 differ from influenza. So the concerns that we raised
3 came out of our experience supporting other incidents
4 and were fed directly back to those involved.
5 **Q.** Right, well, I want to ask you about your personal
6 involvement with incidents representing the Royal
7 College of Nursing.
8 In your witness statement, you tell us that the
9 Royal College of Nursing was invited to be part of the
10 Pandemic Influenza Clinical and Operational Advisory
11 Group, or PICO, and that was as part of the response to
12 the H1N1 swine flu --
13 **A.** That's correct.
14 **Q.** -- in 2009. Tell us about your experience in that
15 group, please.
16 **A.** So as part of the pandemic response in 2009, the college
17 was approached to provide representation to the PICO.
18 It was a clinical subgroup that I understand provided
19 advice to SAGE at the time. Other members of the PICO
20 included other medical royal colleges and those with
21 other relevant areas of expertise.
22 We discussed situations or drafts of guidance that
23 were being developed, and we met weekly. I shared that
24 role with two colleagues within the Royal College of
25 Nursing to ensure that we provided the correct level of

1 representation, that included my colleague who led on
2 health and safety, and the professional lead for
3 community and primary care at that time, so we
4 considered all care settings.
5 I found the PICO an excellent group. It allowed for
6 multi-professional discussion and scrutiny of proposed
7 guidance. The end result of that discussion would be
8 agreement on a specific position, or to approve the
9 guidance moving forward.
10 **Q.** So you would describe this as an example of clinical
11 stakeholder engagement working well?
12 **A.** Yes.
13 **Q.** What you tell us, Mrs Gallagher, at paragraph 40 in your
14 witness statement is that:
15 "We were able to feed in our expertise and
16 intelligence and represent the needs of the [Royal
17 College of Nursing's] membership to inform the
18 development of clinical guidance and guidelines
19 concerning the response to pandemic flu."
20 Then you go on to say:
21 "This was a very different experience to the
22 approach taken by the [United Kingdom] government during
23 the Covid-19 pandemic."
24 How so?
25 **A.** My experience in the early stages for Module 1 is that

1 the opportunities for engagement of stakeholders from my
2 position, from the Royal College of Nursing, was
3 extremely limited, so this was a very -- it had the
4 perception of a very hierarchical response. Given that
5 it was a command and control situation, however, we had
6 the experience of knowing that stakeholder engagement
7 could be implemented and worked very well in previous
8 pandemics.
9 **Q.** Well, indeed, Dame Deirdre Hine in her review following
10 the swine flu outbreak, at paragraph 6.60 in her report,
11 says:
12 "Further engagement is needed between health
13 departments, professional bodies and employers to
14 further develop clinical advice and provide support to
15 staff during a pandemic."
16 Is it your experience, Mrs Gallagher, that that
17 lesson was or wasn't carried forward and incorporated
18 into preparedness planning for the Covid-19 outbreak?
19 **A.** So the Royal College wasn't specifically involved in
20 pandemic planning. Our experience does not reflect
21 stakeholder engagement. And I would just like to add
22 that it's not just the development of clinical guidance
23 or guidelines that requires stakeholders to be involved.
24 Nursing is the largest part of the healthcare worker
25 workforce, and actually we have a key role in

1 implementing guidance and guidelines. So it's
2 absolutely vital that we are around the table to be able
3 to identify opportunities or risks to that proposed
4 guidance.
5 **Q.** But that didn't happen?
6 **A.** No.
7 **LADY HALLETT:** Sorry, when didn't it happen?
8 I've got a feeling that you were moving on to when
9 the pandemic really was acknowledged as having hit, so
10 in other words response rather than --
11 **A.** So I was referring to the very early days, up until the
12 middle of January, because I'm aware Module 1 only
13 covers that short time period.
14 **MS BLACKWELL:** All right, but in relation to pandemic
15 planning --
16 **A.** Yes.
17 **Q.** -- there was a lack of engagement with the Royal College
18 of Nursing?
19 **A.** That's correct, yes.
20 **Q.** You tell us in your witness statement about playing
21 a clinical advisory role during the Ebola viruses
22 disease outbreak?
23 **A.** Yes.
24 **Q.** Can you tell us what that involved, please.
25 **A.** So the Ebola epidemic in West Africa was extremely

1 challenging, and a request was made for UK nurses to go
2 out and support the delivery and action in West Africa.
3 This request, from a nursing perspective, was led by the
4 public health -- by Public Health England.
5 **Q.** Yes?
6 **A.** -- and I was asked to provide professional support to
7 the nurses that were leading that response.
8 This was really about where the RCN could add value,
9 as somebody put it, at a time when everybody was running
10 towards the fire. We are able to sit back and reflect
11 on what is needed from a professional and regulatory and
12 indemnity perspective, and to support those nurses who
13 may be interested in going to West Africa under those
14 conditions to really understand what it is that they
15 need to do and the level of competency and capability
16 that is needed to do that sort of role.
17 **Q.** Was it possible, in your experience, for lessons to be
18 learned by the government in pandemic planning from the
19 time of the Ebola viruses outbreak until Covid-19 hit at
20 the beginning of January 2020?
21 **A.** Yes, one of the most useful lessons for us,
22 unfortunately, occurred when a healthcare worker in
23 Spain acquired Ebola virus disease as a result pf caring
24 for a patient in hospital in Madrid. Now, that
25 healthcare worker was not involved in providing direct

care. There were many, many lessons that were identified as a result of a European nursing summit with -- through our relationship with the European Federation of Nurses, to identify lessons around how we can best protect healthcare workers from what we call high-consequence infectious diseases now, such as Ebola.

Now, we were not preparing for a pandemic of Ebola, this was very much a local situation, but it highlighted significant lessons around how infection control policies were written and the need to engage with clinical staff. It identified lessons around what -- not just what type of personal protective equipment was needed but how we support staff to be educated on how to put these on and take these off safely. It also highlighted many lessons around confidence and communication and transparency that was needed by the healthcare workers.

Q. I wanted to ask you about the culture of transparency and learning. What do you say, in relation to that, should have been carried forwards and perhaps wasn't?

A. We fed the lessons back from the experience of that meeting in Madrid directly. At the time I was part of a Department of Health communications group that actually worked very well, again with other stakeholders around the table, where we were able to feed in both

intelligence from within the UK around how some vulnerable groups were feeling stigmatised, as cases started to be imported into the United Kingdom, but, on this occasion, more importantly, about the lessons we learnt from Madrid.

So that worked very well. However, I have no knowledge of what happened with those recommendations and that report after it was delivered.

Q. All right, thank you.

Moving forward to MERS CoV, could you outline your role, please, during the outbreak in the Middle East in 2015.

A. Yes. A request came in to Public Health England through the global -- through GOARN, which was a global network, requesting support in Saudi Arabia, particularly in relation to the spread of MERS CoV within hospitals. There was real concern that healthcare workers were becoming infected with MERS, and MERS did have some sustained transmission between people at that time. We were asked to effectively identify nurses that would go -- that would be willing to go to Saudi Arabia to support education and training on infection prevention and control.

We undertook an assessment of the situation and were actually very concerned about potentially just going out

to seek nurses to respond to this, and we asked if it would be possible to undertake an assessment in person so that we could identify whether it was appropriate for nurses to be -- to go there, number one, but also to identify what risks might be present, both culturally, clinically, you know, a holistic view, and it was on that basis that we were asked to visit -- when I say "we", myself and a colleague in Public Health England -- to visit and undertake that assessment, and the subsequent ask, given our expertise, was then to look more widely at potential transmission of MERS CoV and how infection prevention and control might support that.

Q. Right, and you tell us at paragraph 36 in your witness statement that you believe, in your extensive experience of that outbreak:

"... significant lessons should have been learnt from the experience with MERS CoV. For example, the Gulf Co-operation Council's IPC guidance specifically addressed the airborne spread of MERS CoV and the requirement for the use of RPE."

A. Yes, that's correct.

Q. You go on to say in a following paragraph:

"The Covid-19 pandemic has shown that there was too much of a focus on preparing for a flu pandemic and not enough consideration was given to how such plans would

need to be adapted to deal with a respiratory infection pandemic, where the primary mode of transmission was not necessarily via 'traditional' droplet transmission."

And:

"... that airborne transmission needed to be properly factored into IPC Guidance concerning the level of PPE required for health and care workers exposed to patients with Covid-19."

A. That's correct. We had the experience of MERS CoV in Saudi Arabia and we additionally had the South Korean experience as well, both of which showed that transmission within healthcare facilities was entirely possible in addition to community spread of infection.

Q. What is the difference between PPE and RPE?

A. So RPE stands for respiratory protective equipment, and it is one form of personal protective equipment. Personal protective equipment is a broad term that in healthcare would cover items such as gloves, aprons, respiratory protective equipment, for example.

PPE is designed to protect the wearer from a hazard, so in the case of a pandemic of whatever cause, that would be the infectious agent or the biological hazard that is present at that moment in time.

Q. Are there lessons that you believe could have been learned from countries dealing with MERS CoV regarding

1 the stockpiling and use of RPE?
2 A. Yes. To -- when you're -- in my view, if you are
3 planning for a pandemic, we need to consider all
4 eventualities. So we need to consider both potentially
5 the use of surgical masks, but they are not personal
6 protective equipment, and consider the need for
7 respiratory protective equipment for an infection that
8 is spread through the respiratory route predominantly.
9 Not exclusively but predominantly.
10 It's my view that there was inadequate consideration
11 given to not just the use of respiratory protective
12 equipment for a prolonged period of time but exactly
13 which elements of the health and care system would need
14 to use respiratory protective equipment if we had
15 widespread infection.
16 Q. Right. So not just for hospital settings?
17 A. No, the NHS is more than buildings, so the NHS
18 considers -- the NHS has hospitals and healthcare
19 facilities but also community teams, community nurses,
20 district nurses, GP practice nurses, for example; all
21 make up part of the NHS. So NHS care goes beyond
22 hospitals.
23 Q. Right, thank you.
24 I want to ask you now about the level of engagement
25 that the RCN had in the preparation of Exercise Cygnus,

1 which we know began to be prepared in 2014 but in fact
2 didn't take place until 2016.
3 Was the RCN involved in any sense in either the
4 preparation or the carrying out of that exercise?
5 A. Not to the best of my knowledge.
6 Q. Do you know whether or not the RCN was invited to be
7 involved in the preparation or carrying out of the
8 exercise?
9 A. No.
10 Q. Corporate memory. You tell us in paragraph 34 of your
11 witness statement that you have concerns about the loss
12 of corporate memory.
13 A. Yes.
14 Q. You say:
15 "There was ... a palpable change in culture, in the
16 years immediately preceding the Covid-19 pandemic,
17 brought about by the successive administrations. This
18 seemed to manifest in an attitude where engagement with
19 stakeholder organisations seemed to be less of
20 a priority."
21 Can you expand upon that, please. What did you mean
22 by a "palpable change in culture"?
23 A. So as I've described, our experience supporting the
24 incidents of MERS and Ebola were very positive
25 experiences in terms of the engagement and the value

1 that professional nursing was held in, so far as we
2 could support that. At the time, around 2017, we were
3 also part of an antimicrobial resistance programme board
4 that was managed by Public Health England, that, again,
5 had a variety of stakeholders, including the RCGP, the
6 Royal Pharmaceutical Society, around the table.
7 Once that was disestablished, about a year later,
8 stakeholder engagement was significantly reduced and
9 really remained that way until the pre-pandemic period.
10 Q. All right. Just taking that into account and moving
11 back for a moment to Exercise Cygnus, do you believe it
12 was a mistake for the Royal College of Nursing not to be
13 involved in that exercise?
14 A. Yes, but I would go further and say it was a mistake not
15 to involve other professional organisations alongside
16 ourselves as well.
17 Q. Thank you.
18 May we put up, please, a paragraph of the report
19 that's been provided to the Inquiry by
20 Dr Claas Kirchelle. Thank you.
21 It's at INQ000205178, and we're looking at
22 paragraph 112.
23 I want to seek your opinion on this paragraph,
24 please, Mrs Gallagher:
25 "There were also ongoing concerns about [Public

1 Health England's] ability to act as an independent
2 advocate for public health from within the
3 Department of Health (from 2018 Department of Health and
4 Social Care ...). In 2014, the British Medical
5 Association ... warned that 'the requirement to adhere
6 to civil service rules and regulations is having
7 an impact on [PHE staff's] ability to do their work.
8 Particular concerns have been raised about (...) the
9 ability to publicly discuss or criticise public health
10 policies'. In surveys, local authorities noted that PHE
11 could do more to 'acknowledge the pressures and
12 constraints facing Local Authorities in its work with
13 them' and 'be more vocal around issues such as welfare
14 reform and austerity and what this means for the health
15 of our nation'. A later witness seminar also
16 highlighted that the increasingly rapid turnaround of
17 civil servants across government departments had created
18 a lack of specialist interlocutors and understanding in
19 Whitehall."
20 In your view, Mrs Gallagher, did Public Health
21 England become less able to effectively advocate for
22 public health and public health budgets in the period
23 preceding January 2020? Are you able to give us your
24 opinion on that?
25 A. What I can say is that the Royal College of Nursing was

1 very concerned around the reduced funding for Public
2 Health England and the impact that that was having on
3 local authorities and local health protection teams to
4 support population health initiatives in that time.
5 From my perspective, obviously from an infection
6 prevention and control position, the conversations
7 continued in terms of business as usual, but not
8 necessarily in relation to how we could move -- work
9 forward to increase population health and respond to
10 incidents at pace.
11 **Q.** All right, thank you. We can take that down now.
12 Finally on the issue of stakeholder engagement,
13 before we leave this topic, please could we display
14 INQ000148405, and it's page 5, paragraph 15 of
15 Professor Kevin Fenton's witness statement, he being the
16 president of the Faculty of Public Health.
17 If we could look over the page, please -- in fact
18 let's look at paragraph 15 on page 5. Thank you. Could
19 we highlight that, please:
20 "Generalist specialists in public health,
21 particularly those working in health protection at
22 regional and local levels, have been under-represented
23 in the development of national pandemic policy, strategy
24 and guidance and there is opportunity for this to be
25 addressed in the future through the UKHSA-hosted Centre

1 for Pandemic Preparedness. There was a significant
2 missed opportunity for broader engagement in planning
3 across local resilience forums and local health
4 resilience partnerships which require closer working and
5 mainstreaming of planning, training and exercising of
6 pandemic response arrangements."
7 From your viewpoint, working within the Royal
8 College of Nursing, do you agree with those sentiments?
9 **A.** I do.
10 **Q.** Thank you very much. We can take that down, please.
11 By early 2019, is it your view, Mrs Gallagher, that
12 there were sufficient structures in place for raising,
13 escalating and addressing concerns on behalf of
14 frontline staff amongst the UK preparedness bodies?
15 **A.** I don't think I can answer that question, because we
16 weren't specifically involved in preparedness.
17 **Q.** All right. So because of your lack of involvement at
18 all, it's not possible for you to comment on that
19 question?
20 **A.** No. Could you repeat the question again for me, please.
21 **Q.** Yes. It was whether or not you considered that there
22 were sufficient structures in place for escalating and
23 addressing concerns on behalf of your frontline staff,
24 with the United Kingdom preparedness bodies.
25 **A.** No, that wasn't in place, we weren't able to contribute

1 to that.
2 **Q.** All right, and indeed, as you've already said, there was
3 a complete lack of engagement with the Royal College of
4 Nursing in terms of preparedness, so there was no option
5 or potential for --
6 **A.** No.
7 **Q.** -- raising those issues on behalf of your frontline
8 staff?
9 **A.** No.
10 **Q.** You tell us in your witness statement that, in terms of
11 your role at the Royal College of Nursing -- and indeed
12 you've confirmed this this morning -- that it was as
13 part of a UK-wide organisation.
14 Did you have any concerns in relation to how EPRR
15 had been dealt with in any of the devolved nations in
16 terms of the frontline staff there?
17 **A.** No. I -- I only attended the EPRR group which was based
18 in England.
19 **Q.** Yes.
20 **A.** However, we did, if it was available at the time, take
21 intelligence or feedback from our members in relation to
22 what was relevant to feed in to the EPRR group. To the
23 best of my knowledge, the agenda items that were
24 discussed, the lessons there would have been learnt,
25 would have been shared with the four countries.

1 **Q.** Yes.
2 **A.** But I wasn't party to those discussions.
3 **Q.** All right.
4 I want to come on to discuss workforce resilience
5 issues which are crucial to a pandemic. What is the
6 relationship, Mrs Gallagher, between the resilience of
7 health systems and the resilience of the workforce
8 within healthcare and social care?
9 **A.** So the resilience of the health and care workforce is
10 absolutely essential in order to be able to deliver
11 healthcare services that meet the public's needs. We
12 know that we went into the pandemic with a significant
13 shortage, we were about 50,000 nurses short before we
14 went into the pandemic, and therefore that immediately
15 put us at risk when we needed to surge capacity to
16 support patients who were infected, either at home or in
17 hospitals.
18 **Q.** Had the RCN, in your view, consistently highlighted over
19 a number of years the absence of effective workforce
20 planning for nursing?
21 **A.** They had.
22 **Q.** What was the reaction of the government to that being
23 highlighted?
24 **A.** The RCN has campaigned and lobbied for many, many years
25 around what we now call staff safe -- safe staffing for

1 effective care. The RCN has participated in significant
2 research with our European counterparts around the
3 impact of insufficient numbers of registered nurses,
4 for example, on patient care and the implications for
5 patient safety. The RCN has responded to all the
6 consultations and also comprehensive spending reviews
7 highlighting the importance of investment in the nursing
8 workforce.
9 **Q.** Has this been handled differently across the different
10 nations? What I'm coming to is asking you about the
11 fact that the Welsh Government have implemented the
12 Nurse Staffing Levels (Wales) Act, which was passed in
13 March of 2016, and does that mean that health boards and
14 NHS trusts in Wales must have regard to the importance
15 of providing appropriate numbers of nurses in all
16 settings?
17 **A.** That's correct.
18 **Q.** In Scotland, the Health and Care (Staffing) (Scotland)
19 Act of 2019 has been passed, setting out requirements
20 for safe staffing across both health and care services,
21 but the implementation of that, in fact, was delayed due
22 to Covid-19?
23 **A.** That's correct.
24 **Q.** So is that still pending, as far as you're aware?
25 **A.** As far as I'm aware, but I'm not leading that piece of

1 work, so --
2 **Q.** All right.
3 You also tell us in your witness statement that in
4 Northern Ireland members took industrial action in
5 December 2019 and January 2020 over safe staffing and
6 pay.
7 **A.** Yes, they did.
8 **Q.** So just immediately going into the pandemic?
9 **A.** Yes.
10 **Q.** All right.
11 So does this still remain a concern of high priority
12 for the RCN across the four nations?
13 **A.** Yes, absolutely. I mean, there are clearly differences
14 across the UK in terms of how workforce and the need for
15 an appropriate workforce level is implemented across
16 the UK.
17 **Q.** Right, thank you.
18 I'd like to display, please, the witness statement
19 of Jeremy Hunt, please, just to underline this point,
20 page 15, paragraph 66. Could we highlight this, please.
21 "As I have written elsewhere, one of the things
22 I learned in my time as Health Secretary and wish I had
23 understood better at the outset was the importance of
24 workforce planning. This was not something
25 I implemented while Secretary of State because it took

1 me some time to appreciate the full picture. I was also
2 not advised to place more emphasis on this because the
3 NHS had a longstanding habit of relying on immigration
4 to fill any gaps. However, with a two million shortage
5 of doctors globally according to the World Health
6 Organisation, this was not a sustainable position in the
7 long term."
8 Now, the former Secretary of State for Health and
9 Social Care doesn't mention nursing there --
10 **A.** No.
11 **Q.** -- he uses the shortage of doctors as an example, but
12 would you say, Mrs Gallagher, that the issue was just as
13 important in relation to nursing and workforce planning?
14 **A.** Absolutely. We know we have a global shortage of
15 nurses, as identified in the triple impact report, so
16 this is a global problem, and the reliance on overseas
17 nurses is a real cause of concern for the Royal College
18 of Nursing.
19 **Q.** Thank you.
20 **LADY HALLETT:** I think, Ms Blackwell, we are going to pause
21 there, because we have a strange noise that I know --
22 **MS BLACKWELL:** Oh dear.
23 **LADY HALLETT:** -- may need fixing. I don't know if you are
24 conscious of it. Initially I thought it was thunder,
25 but ...

1 **MS BLACKWELL:** Right.
2 **LADY HALLETT:** Forgive us, you're going to have to come back
3 this afternoon, Mrs Gallagher. I hope it's not too
4 inconvenient for you. I shall return at, I'm being
5 told, 1.45.
6 **MS BLACKWELL:** Fingers crossed. Thank you.
7 **(1.03 pm)**
8 **(The short adjournment)**
9 **(1.45 pm)**
10 **LADY HALLETT:** I'm assured the problem has been resolved.
11 **MS BLACKWELL:** I do hope so. Thank you, my Lady.
12 Mrs Gallagher, just before we broke, we were
13 discussing workforce resilience issues and the
14 importance of workforce planning, and I'd like to turn
15 now to look at public health and local infection
16 control.
17 At paragraph 65 in your witness statement, you tell
18 us that:
19 "Funding for public health services and
20 interventions (ie the frontline public health services
21 funded by local authorities) in England has not been
22 consistent and has suffered under austerity measures."
23 And you say that:
24 "The public health grant has been cut by more than
25 a fifth (22% [in fact]), since 2015/16. Consequently,

this has meant that local authorities are unable to provide vital functions that promote well-being and prevent ill health and the reductions in outreach services such as smoking cessation [and other health matters] which impacts population health and chances.

You go on to say that:

"It is the [Royal College of Nursing's] contention that this historic underfunding of public health [has] undermined the capacity of local public health teams to effectively improve health and reduce inequalities and respond to the Covid-19 pandemic."

From a nursing perspective, then, how does a reduction to the public health grant and public health spending affect pandemic preparedness at the local level? Is it just a matter of resilience, or are there other effects to the cutting in the budgets?

A. In terms of population health and having a population that is as well as it can be to not suffer unnecessarily from the impact of an infectious disease, population health is absolutely vital, and throughout the life course. So, for example, we know we have far fewer health visitors at the moment that support mothers and also support young children, and that is vital in terms of local communities.

In terms of operational management of the pandemic,

that's -- that, at a local or regional level, would be supported by the health protection teams, and they are absolutely vital in having good relationships, collaborative relationships with provider organisations such as NHS trusts, but also in supporting care homes.

Now, health protection teams came under Public Health England, they're now under the UKHSA, and their roles have continued but, with the changes in the landscape, those roles and relationships have changed over time. So it's a bit of both, if you like.

Q. All right, thank you.

Professor Philip Banfield from the British Medical Association has provided a witness statement to the Inquiry in which he says that reforms to the public health system in England in particular led to a fragmented system and that the 2012 Health and Social Care Act fractured in many places the links between public health specialists and NHS colleagues, which in turn impacted upon pandemic response.

Do you agree with that?

A. I do.

Q. All right.

What role does community infection prevention and control have to play in pandemic planning and emergency response?

A. So the role of community infection control teams has changed over time. When I was in clinical practice we provided support from the acute trust to our community partners and provided them with an infection control service, but in other areas they have dedicated infection control teams. So there is variation across the system on how advice is provided.

We know that when the Lansley reforms, the changes to the NHS -- the Health and Social Care Act was implemented, that we lost many community infection control teams as staff moved under the umbrella of local authorities away from their original employers, and that gap, if you like, placed increased pressure on health protection teams, but also had an effect on local relationships and resilience locally.

Q. May we put up, please, the statement of Professor Kevin Fenton at paragraph 11, pages 3 to 4, and highlight that, please. Thank you.

Here he says:

"Health protection teams, which moved from the Health Protection Agency ... to [Public Health England] ... saw successive reductions in funding and capacity over the pre-pandemic years and lack of investment in regional emergency preparedness, response and resilience ... teams. A direct result of these changes

was a reduction in the amount of professional exposure that the public health specialist generalist workforce had to health protection duties and continuing professional development outside of PHE. There was also a reduction in the exposure that NHS staff in general had to important public health issues associated with health protection, especially in community settings. This is likely to have contributed to a poor understanding of the role of the wider public health agenda around pandemic preparedness, and more specifically the role of local authority public health teams and wider system partners in pandemic preparedness and response. Community infection prevention and control ... is a key element of pandemic planning and local health protection more generally, but guidance is unclear on commissioning responsibilities, funding streams, and standards for high-performing local integrated services. It is largely understood that provision for community IPC was a significant casualty of the 2012 reforms and the Faculty considers the creation of Integrated Care Systems, with local authority Directors of Public Health and UKHSA as key partners, an opportunity to rectify the current problems. The use of Contain Outbreak Management Funding ... during the pandemic to temporarily increase

1 IPC capacity in many systems provides proof of concept
2 of what can be achieved through concerted effort and
3 funding enhancements."
4 Do you agree with Professor Fenton's suggestion that
5 guidance on commissioning responsibilities, funding
6 streams and standards for high-performing local
7 integrated services is unclear?
8 **A.** From my experience, yes.
9 **Q.** Do you also consider that the provision for community
10 IPC was a significant casualty of the reforms? I think
11 as you've just referred to.
12 **A.** Yes, I do.
13 **Q.** All right.
14 Towards the end of that paragraph, Professor Fenton
15 suggests that the use of the COMF during the pandemic to
16 temporary increase IPC capacity demonstrates the concept
17 of what can be achieved; do you agree with him in that
18 regard?
19 **A.** I do. In order to sustain the benefits that have been
20 achieved through this, however, I would also focus on
21 a need for standardised training as a foundation,
22 a cornerstone for health protection teams, because there
23 is no standardised education currently for health
24 protection practitioners.
25 **Q.** How would that best be achieved?

1 **A.** There are a number of ways in which education can be
2 commissioned and delivered. For me, the starting point
3 would be to identify the needs of health protection
4 practitioners, who are not all nurses at all, many do
5 not have a nursing background, and to support them to
6 identify what is needed in order for them to deliver
7 their role in practice.
8 **Q.** Thank you.
9 **LADY HALLETT:** Just before you go on, may I interrupt.
10 Can you explain, I appreciate it's not your
11 expression, Mrs Gallagher, "specialist generalists"
12 sounds a bit contradictory to me.
13 **A.** Sorry, that's me.
14 **LADY HALLETT:** Is it? Oh, no, I think it's in this report
15 as well.
16 **A.** Oh, I see.
17 **LADY HALLETT:** What is a specialist generalist?
18 **A.** I'm not quite sure actually.
19 **LADY HALLETT:** Right.
20 **MS BLACKWELL:** We will provide a definition for my Lady.
21 **LADY HALLETT:** Thank you. I hope it makes sense. At the
22 moment it doesn't.
23 **A.** I think I know what it means, but I wouldn't like to
24 say.
25 **Q.** Right.

1 In terms of the problems created in public health
2 provision, the Inquiry has heard from Professors Marmot
3 and Bambra that those difficulties that arose, those
4 highlighting of inequalities that developed, hit certain
5 areas of the country hardest and hit people who were
6 suffering from particular inequalities even harder,
7 living in those areas.
8 Is that something that you recognise, and if so, is
9 the difficulty with inequalities, and that caused by
10 funding or lack of workforce planning or some of the
11 issues that we've looked at, is that something that the
12 Royal College of nurse was alive to prior to the onset
13 of the pandemic?
14 **A.** Certainly in relation to the impact of the pandemic,
15 we're very aware of the effect of inequalities both on
16 our nursing workforce but also on those that required
17 care or were most affected by the pandemic.
18 The second part of your question, in relation to
19 workforce --
20 **Q.** Yes.
21 **A.** -- could you just repeat that for me, please.
22 **Q.** Yes, what I'm asking is whether or not the fact that
23 inequalities hit in particular areas, as Professors
24 Marmot and Bambra have told the Inquiry, and whether or
25 not that was exacerbated by either workforce issues or

1 public health funding cuts or a combination of both, and
2 if that is something which the Royal College of Nursing
3 recognises, was that something that was apparent prior
4 to the onset of the pandemic in 2020?
5 **A.** Certainly the Royal College is very aware of the impact
6 of inequalities, from a public health perspective.
7 Then, obviously, whatever impacts on our public health
8 ultimately affects our hospitals and the demand for
9 hospital services, so the two are very closely related.
10 The issue of black and ethnic minority staff in
11 terms of their experience in the workforce is well
12 documented by the Royal College of Nursing.
13 **Q.** Is that something to which the Royal College of Nursing
14 was alive prior to the pandemic?
15 **A.** Yes.
16 **Q.** The onset of the pandemic.
17 **A.** I would -- yes.
18 **Q.** All right.
19 Moving on to social care, please, you describe in
20 your statement at paragraph 48 that there was not
21 a whole systems approach to pandemic planning,
22 particularly with regard to social care, and you say
23 that from your perspective:
24 "This was evident at the start of the pandemic,
25 during efforts to rapidly scale up acute capacity, when

1 some community staff were being redeployed into the
2 acute sector without sufficient thought being given to
3 the services that needed to continue in the community.
4 For example [and this is an example that you give in
5 your statement], the [Royal College of Nursing] heard
6 reports that community nursing staff were being asked to
7 go and work in hospitals when community services needed
8 to be augmented at the same time to ensure essential
9 services such as child protection and end of life care,
10 could continue."
11 You identified this as a problem. Was this
12 a problem that had persisted prior to the pandemic or
13 was this something that came to light only when the
14 pandemic hit and the staff, as you say, were being
15 pulled from hospitals into the care sector and back
16 again and vice versa?
17 **A.** Certainly you would expect to need to move staff in
18 a case of need --
19 **Q.** Yes.
20 **A.** -- in the case of a national incident. The pandemic
21 highlighted, really, the impact of doing such actions,
22 and there was real concern regarding how we would
23 maintain care for our patients in the community, and we
24 have many more patients in community settings than we do
25 in hospital settings, for example.

1 The RCN has raised concerns over a number of years
2 around a reduction in the community nursing workforce
3 and the implications for that, not just in terms of
4 community care but the knock-on effect of care in
5 hospitals.
6 **Q.** Right. As far as you are aware, was there any planning
7 in terms of the movement of staff from hospitals into
8 adult social care and workforce planning in any of the
9 pandemic planning that was undertaken?
10 **A.** As I recall, as we took place -- part in Operation Pica
11 around 2018, the need to consider the movement of staff
12 and the different demands in different care sectors at
13 different times was on that agenda.
14 To the best of my memory, I don't recall in-depth
15 discussions on what the real impact of that might mean,
16 particularly from a nursing perspective.
17 **Q.** In your view, was there adequate operational guidance in
18 place for managing a pandemic within the social care
19 sector prior to Covid-19 hitting?
20 **A.** I'm not aware of any, but we weren't involved in the
21 pandemic planning.
22 **Q.** Yes, of course.
23 **A.** Yeah.
24 **Q.** Certainly none was brought to the attention of the
25 RCN --

1 **A.** Not that I recall.
2 **Q.** -- nor was there any invitation given to the RCN to
3 involve itself in any such guidance being prepared?
4 **A.** Not that I recall.
5 **Q.** All right.
6 I'd like to ask you now, please, about the value of
7 healthcare-acquired infection operational guidance,
8 which you deal with at paragraph 53 in your witness
9 statement.
10 Now, there was the publication in 2012 by the Health
11 Protection Agency of certain guidance, and you recall
12 that the guidance was updated in 2016, I think, as
13 an internal document but that that update wasn't
14 published; is that right?
15 **A.** Yes, that's a verbal report that I had. I've not seen
16 the 2016 updated guidance.
17 **Q.** Right.
18 You say in your witness statement that the fact that
19 this operational guidance wasn't published, that's
20 the 2016 update, I think:
21 "... meant that NHS teams, as well as care homes and
22 community settings, did not have up-to-date information
23 on the roles and responsibilities of Health Protection
24 teams, and this would have impacted directly on local,
25 regional and national incidents, including responding to

1 HCIDs such as Covid-19."
2 **A.** Yes. The -- as I recall, the operational guidance was
3 a recommendation that came out of the Stoke Mandeville
4 report in 2016 -- 2006, apologies, where there was
5 criticism around the role of the Health Protection
6 Agency local team at that time and how they intervened
7 to support the NHS trusts.
8 The guidance is around roles and responsibilities,
9 and relationships between health protection teams, acute
10 trusts and community providers is really important for
11 dealing with local or regional issues, and therefore,
12 when it comes to a national incident, it's absolutely
13 essential.
14 The 2012 guidance focuses on healthcare-acquired
15 infection because Stoke Mandeville was predominantly
16 around clostridioides difficile healthcare-acquired
17 infection.
18 However, for me this represents good governance and
19 essentially having your house in order to have
20 operational guidance in place that can be referred to
21 and is already in place.
22 **Q.** Has the RCN been vocal in expressing its concern about
23 a lack of guidance in this area?
24 **A.** I don't believe we've written anything formally, but
25 certainly questions have been asked over the years since

1 it was developed and at a time when it would have been
2 reasonable to update it.
3 Q. Yes. One of the aspects that you bring to the forefront
4 in your witness statement is the concern that has been
5 regularly raised by the RCN at national fora, including
6 the Care Quality Commission's stakeholder group for
7 non-hospital organisations, that the CQC had not
8 delivered on its regulatory responsibilities in relation
9 to IPC, to the extent of ensuring effective systems.
10 Is that something which has regularly been raised by
11 the RCN over the years?
12 A. So when I attended the CQC meetings on behalf of the
13 Royal College of Nursing I did raise this at those
14 meetings, and I also took the opportunity, I can't
15 recall which meeting specifically, but to raise this as
16 part of concerted efforts to support the reduction in
17 healthcare-associated infections that didn't just focus
18 on hospitals.
19 Q. Right. In particular, I think, one of the concerns of
20 the RCN was that a focused inspection was requested of
21 the CQC in adult social care and to strengthen
22 non-hospital-based IPC provisions. You say in your
23 witness statement that:
24 "Despite [that], the RCN is not aware of
25 consideration being given to providers, such as

1 care homes, being assessed in pandemic planning with
2 regard to meeting the fundamental requirements of the
3 Code of Practice or their ability to escalate issues if
4 required."
5 Is that right?
6 A. That's correct. The theory behind our ask is that if
7 care homes are well prepared for business as usual, then
8 when it comes to an incident they are much better
9 prepared to respond and consider how they will manage,
10 should that occur.
11 Q. Was social care non-compliance something that you'd
12 raised with the Department of Health and Social Care
13 before 2020?
14 A. Non-compliance with regard to the code of practice --
15 Q. Yes?
16 A. -- do you mean?
17 We raised concerns around the level of compliance,
18 I would say, rather than non-compliance with the code of
19 practice, which every provider of health and care has to
20 meet in a proportionate way to their role. So there is
21 a different expectation for care homes than there is,
22 for example, to a large acute hospital.
23 The essential expectations around having good
24 policies and procedures and education in place would be
25 fundamental to their response in a pandemic.

1 Q. Right, thank you.
2 We've touched upon PPE and RPE, and you tell us in
3 your witness statement that, as far as the RCN is
4 concerned, there was a lack of -- or insufficient
5 stockpiling of RPE that was needed. That's also
6 a reference, is it not, to FFP-3 face masks, which
7 I think you've already described to us, the critical
8 nature of those?
9 You say that without a sufficient stockpile of that
10 equipment, not only for hospital settings but also for
11 community nursing, nursing staff are putting their own
12 lives and the lives of their families and patients at
13 risk.
14 But in addition to the availability of such PPE, is
15 it also necessary for those who are going to be
16 utilising it to know how to fit it properly?
17 A. Yes.
18 Q. That involves staff training in fit testing.
19 From an RCN perspective, is there or indeed was
20 there at the onset of the pandemic sufficient capability
21 within staff who might need that PPE to be able to fit
22 it properly? Had the training been in force and in
23 place?
24 A. If I might go back a little step --
25 Q. Certainly.

1 A. -- briefly. The failure to consider a pathogen that had
2 pandemic potential that would require the extended use
3 of respiratory protective equipment was not duly
4 considered, and it is my view that that had an effect on
5 how large the stockpile was of respiratory protective
6 equipment as opposed to face masks.
7 If you take that to the next degree, then I would
8 have expected consideration of the need to cascade
9 fit testing to be in place as part of pandemic
10 preparedness.
11 When a pandemic or an incident first starts, it's
12 absolutely critical that we also take a precautionary
13 approach to what it is we are dealing with until the
14 science tells us otherwise, and that would also have
15 implications for how much respiratory protective
16 equipment we would need. It's clear now that those
17 systems for escalating fit testing, and also the system
18 for having standardised respiratory protective
19 equipment, was not in place, and by that I mean the
20 demand for respiratory protective equipment resulted in
21 many different types of masks being available, and masks
22 fit people differently. So whilst your face may fit one
23 type of mask, it may not fit the other. So this then
24 necessitated multiple attempts or multiple -- the
25 multiple -- multiple requirements to fit test staff on

numerous occasions because of the numerous types of masks that were required.

So I don't believe that the system was well set up to consider this as part of pandemic planning.

Q. All right. So just to summarise your evidence, a lack of foresight in terms of the requirement for RPE, a lack of stockpiling for RPE, and then a lack of fit testing for the various RPE facilities?

A. Yes, or having systems in place to cascade fit testing. You can, for example, introduce a train the trainer system, where you can cascade to staff. Most trusts would not routinely -- well, I can't think of any trust, actually, that would routinely educate or train all its staff to be fit tested all the time in RPE. However, we did learn from H1N1 and Ebola that there would be a need to expand and escalate fit testing and the use of RPE as part of those experiences.

Q. In your witness statement, you discuss framing vulnerability as a clinical category in pandemic plans and guidance. In your view, were structural health inequalities factored into the government's pandemic planning?

A. No. I don't believe so.

Q. Why do you say that?

A. So the structural health inequalities that I would

consider of key importance to take into account would have included inequalities within the healthcare workforce, as well as the vulnerabilities and inequalities experienced by our population, and that has undoubtedly changed since the last pandemic.

Q. How has that changed?

A. So we know that our levels of non-communicable diseases have increased, so diseases such as diabetes, obesity, for example, those have really escalated since the 2009 pandemic, therefore there have been shifts in our populations that we would need to keep considering as part of our pandemic planning.

Q. All right.

Frontline workforce and planning for minority ethnic members of the workforce. Paragraph 63 of your report, you say that:

"In its written submission to the ... Treasury Comprehensive Spending Review ... [in] (September 2020) ... the [Royal College of Nursing] highlighted the overrepresentation of BAME staff at bands four to six, which represent those professionals providing care on the frontline, warning that they may be at increased risk of exposure to the viral load of Covid-19."

And you also highlighted the fact that:

"... as the pay bands increase, data shows larger

increases in the number of white staff at each pay grade compared to the increase of in ethnic minority staff."

Was the risk of a disproportionate impact on minority ethnic staff mitigated against within pandemic planning as far as the Royal College of Nursing is concerned?

A. In my opinion, no, but as I've stated before, we weren't involved in pandemic planning.

Q. But you haven't seen anything or had anything brought to your attention in your position to indicate that it was so considered?

A. Not that I recall. The language used in most strategic documents tends to refer to at-risk groups --

Q. Yes.

A. -- or, as you've said, other clinical vulnerabilities linked to medical conditions, but not inequalities as described by Professor Marmot, for example.

Q. Thank you.

Finally, Mrs Gallagher, turning to lessons learned for future pandemics. You've mentioned stakeholder engagement earlier in your evidence this morning. What do you say is missing and what needs to be done in order to better ensure a level of preparedness, certainly so far as your organisation is concerned, with stakeholder engagement going forwards?

A. I would say that we need to revisit what we think stakeholder engagement means. There may be assumptions that stakeholder engagement could be something as simple as sending out a draft document to review and comment on, but the view of the Royal College of Nursing is that meaningful stakeholder engagement would entail involvement at the beginning rather than being a recipient at the end of a long process.

We would also consider stakeholder engagement to be absolutely vital to allow us to really consider the impact of what we have learnt now in terms of vulnerabilities. So, for example, by engaging with other royal colleges or other organisations, which has been such a valuable lesson for us during the pandemic. So, for example, the inclusion of organisations such as the British Occupational Hygiene Society or speech and language therapists or others that can bring a combined view together with ours on how we operationalise or manage specific incidents or view guidance.

Q. Thank you.

Finally, is there any recommendation that you would like to bring to the attention of the Inquiry so far as transparency is concerned?

A. Transparency is absolutely vital to support communication. In my experience, I have found that

1 healthcare professionals and the general public are very
2 understanding that guidance and advice changes as
3 an incident or a pandemic evolves, and they are very
4 forgiving of changes in guidance and advice. But they
5 need to understand why. So we are able to bring people
6 with us if we can do that, and bringing in the public
7 and our healthcare workers with us at a time of national
8 crisis is absolutely vital.
9 **Q.** So transparency and information provision?
10 **A.** Yes.
11 **MS BLACKWELL:** Yes, thank you.
12 My Lady, those are all the questions that I have.
13 You have provisionally provided permission for Covid-19
14 Bereaved Families for Justice to ask a specific question
15 around a meeting of the Chief Nursing Officers back in
16 2014, according to the sheet that I have.
17 May they ask those questions now, please?
18 **LADY HALLETT:** They may. Ms Munroe.
19 **Questions from MS MUNROE KC**
20 **MS MUNROE:** Thank you, my Lady.
21 Good afternoon, Mrs Gallagher.
22 **A.** Good afternoon.
23 **Q.** In your witness statement at paragraph 29 -- I should
24 have said, my name is Allison Munroe and I ask questions
25 on behalf of Covid-19 Bereaved Families for Justice.

1 In your statement at paragraph 29 -- we don't need
2 to bring it up -- you make reference to a meeting on
3 22 October 2014 between the Chief Nursing Officer and
4 regional CNO nursing teams. It's a meeting you yourself
5 did not attend.
6 **A.** That's correct.
7 **Q.** But you say that from discussions that flowed from that
8 meeting, there were concerns about whether or not the
9 voices of nurses were being heard, and that issue of
10 stakeholder engagement that you've spoken about at
11 length this afternoon and earlier this morning.
12 Can you assist us, please, were there wider concerns
13 about the engagement with the Chief Nursing Officer and
14 the RCN, and did you see any improvements following on
15 from that meeting in 2014?
16 **A.** The feedback I had as a result of that meeting, which
17 I wasn't present at, was that the information that was
18 provided, and this was in relation to the Ebola
19 outbreak, had been positively received and that there
20 was ... that it had been taken on board around the need
21 for nursing to be engaged in this response.
22 I don't -- I don't recall any issues in relation to
23 relationships, there were good professional working
24 relationships at that time, but clearly because this was
25 in response to an incident that was occurring at

1 a moment in time, the meeting was called at quite short
2 notice, to the best of my memory.
3 **Q.** You've said there were good working relationships. You
4 have been referred to paragraph 34 of your statement
5 again earlier, before the luncheon adjournment, where
6 you speak about certain significant changes that
7 happened in the healthcare system and the culture around
8 about the time 2018 to 2019.
9 Now, with regards to the Chief Nursing Officer,
10 Dame Ruth May succeeded Jane Cummings in January of
11 2019. To what extent did that change have an impact, if
12 at all, on the pan professional working and
13 communications between the CNO and the RCN?
14 **A.** To the best of my knowledge, there was no detrimental
15 effect at all when Dame Ruth May took over her position
16 of CNO. Most of the -- my experience before that had
17 been to work to the Deputy Chief Nurse in Public Health
18 England, who then held a strategic relationship with the
19 Chief Nursing Officers team in the NHS. From my
20 perspective, the change in CNO leadership didn't cause
21 any issues at all.
22 **MS MUNROE:** Thank you very much.
23 Thank you, my Lady.
24 **LADY HALLETT:** Thank you, Ms Munroe.
25 **MS BLACKWELL:** That concludes Mrs Gallagher's evidence.

1 **LADY HALLETT:** Thank you very much indeed for your help,
2 Mrs Gallagher.
3 **THE WITNESS:** Thank you.
4 **(The witness withdrew)**
5 **MS BLACKWELL:** My Lord, may I please call Professor Dame
6 Jenny Harries. Would you take the oath, please.
7 **DAME JENNY HARRIES (affirmed)**
8 **Questions from COUNSEL TO THE INQUIRY**
9 **MS BLACKWELL:** May I begin by thanking you for the
10 assistance that you've so far given to the Inquiry. You
11 have produced an extensive witness statement.
12 May we have it on the screen, please. It's
13 INQ000148429. Can you confirm that that's your witness
14 statement, please, Dame Jenny.
15 **A.** It is.
16 **Q.** Thank you. We can take that down.
17 We have also had two witness statements from
18 Professor Isabel Oliver, who is the Interim Chief
19 Scientific Officer. The first statement on 17 May 2023,
20 which is at INQ000194054, and then a supplementary
21 statement at 12 June 2023, at INQ000212902. May we have
22 permission, please, to publish Dame Jenny's witness
23 statement and the second of Professor Isabel Oliver's
24 statements, please, today?
25 I can inform my Lady that the first witness

1 statement of Professor Oliver will be published at
2 a slightly later date.
3 **LADY HALLETT:** Thank you.
4 **MS BLACKWELL:** Thank you.
5 Please keep your voice up during questions,
6 Dame Jenny. If I ask anything that you don't
7 understand, please ask me to repeat it and I will.
8 I'm going to begin by taking you through your
9 professional qualifications and previous roles and
10 relevant experience so far as it is relevant to our
11 Inquiry.
12 So you are now chief executive of the United Kingdom
13 Health Security Agency, since its formation in April of
14 2021, and head of the NHS Test and Trace since May
15 of 2021.
16 You, prior to joining the UKHSA, were the Deputy
17 Chief Medical Officer for England between 2019 and 2021,
18 and prior to that you were the regional director of the
19 south of England at Public Health England from 2013 to
20 2019, and prior to that you were the Interim Deputy
21 National Medical Director between 2016 and 2017.
22 You have also worked as a director of public health.
23 You are a medical physician with specialist training in
24 public health medicine. You have formal qualifications
25 in medicine and pharmacology, a Master's degree in

1 public health and also one in business administration.
2 You have a postgraduate diploma in health economics
3 evaluation and a postgraduate certificate in strategic
4 planning and commissioning.
5 You are a fellow of the Chartered Management
6 Institute, a visiting professor of public health at the
7 University of Chester, and honorary fellow of both the
8 Faculty of Occupational Medicine and the Royal College
9 of Paediatrics and Child Health.
10 You are a member of the Joint Committee on
11 Vaccination and Immunisation, national advisory
12 committee on the NHS Constitution, NHS England Clinical
13 Priorities Advisory Group and Women's Health Taskforce.
14 In particular you were the national programme
15 director for Ebola screening and the UK returning
16 workers programme in 2014 to 2016, and you were the SRO
17 of the subsequent development of the High Consequence
18 Infectious Disease Programme, and prior to the Covid-19
19 pandemic you contributed to various significant health
20 protection incidents, including Zika in 2016, the
21 Hurricane Irma response in 2017, the Novichok poisonings
22 in 2018 and the first cases of monkeypox in the
23 United Kingdom in 2018.
24 During the Covid pandemic, you chaired the SAGE
25 Social Care Working Group, led clinical work on the

1 initial shielding programme, and acted for SRO for
2 co-ordination of the subsequent Enhanced Protection
3 Programme for those who remain more clinically
4 vulnerable to serious outcomes from Covid-19:
5 **A.** Broadly, yes. Can I just clarify a couple of points?
6 So the roles where you said I -- it started with
7 membership of the JCVI, those are previous roles,
8 they're not current, and that's important, I think.
9 The most important qualification, which you probably
10 didn't read out, was a fellowship of the Faculty of
11 Public Health. That's probably the most important one
12 for now.
13 Then I would also just like to flag, just for
14 clarity, I am a Welsh resident, and I realise there
15 might be conversations around UK countries, and
16 I trained in Wales, and to flag actually that I've spent
17 more of my time professionally working in local -- as
18 you've said, as a director of public health in the
19 regions than I have nationally. So where that is
20 relevant I'm assuming it will be okay for me to add that
21 commentary.
22 **Q.** Thank you.
23 Let's deal first, please, with the background and
24 history of public health bodies in England, starting
25 with the Health Protection Agency, which was established

1 in April of 2003. To help put things in historical
2 context, is it right that the HPA was the public health
3 body in operation in England during the SARS outbreak in
4 late 2002, but that outbreak, of course, was not
5 contained until July of 2003, the swine flu outbreak in
6 2009 and 2010, and the MERS outbreak in the Kingdom of
7 Saudi Arabia in June of 2012?
8 **A.** Yes.
9 **Q.** The HPA was an executive non-departmental arm's length
10 public body sponsored by the Department of Health which
11 was accountable to the Secretary of State for Health and
12 the Minister of State for Public Health, but which was
13 operated separately to the Department of Health?
14 **A.** Yes.
15 **Q.** Could we display, please, INQ000187830, which is in fact
16 a sheet which helpfully description the different
17 organisational models of national statutory bodies.
18 At page 1, paragraph 2, we see described an
19 "Executive non-departmental public body":
20 "[Those] bodies are normally established [by]
21 primary legislation. They carry out a wide range of
22 administrative, commercial, executive and regulatory or
23 technical functions which are considered to be better
24 delivered at arm's length from ministers."
25 Existing examples given there are the Care Quality

1 Commission and the independent regulator of NHS
2 foundation trusts.
3 We'll just leave that on screen for the moment,
4 please.
5 You set out in your witness statement the five main
6 roles of the HPA, which were: advising government on
7 public health protection policies and programmes;
8 delivering services and supporting the NHS and other
9 agencies to protect people from infectious diseases,
10 poisons, chemicals, radiological hazards; providing
11 an impartial and authoritative source of information and
12 advice for professionals and the public; responding to
13 new threats of public health; and providing a rapid
14 response to health protection emergencies, including the
15 deliberate release of biological, chemical, poison or
16 radioactive substances.
17 So can we see, Dame Jenny, that the HPA's principal
18 role was related to health protection?
19 **A.** **(Witness nods)**
20 **Q.** There are three core strands of public health, are there
21 not: health protection, health improvement and
22 healthcare, public health?
23 The change that took place when HPA was replaced by
24 Public Health England in 2013 to 2021 was brought about
25 in part to make a cohesive change to the three core

1 strands in public health; is that right?
2 **A.** It is. My understanding -- I wasn't actually in the
3 Health Protection Agency myself.
4 **Q.** Yes.
5 **A.** My understanding was, along with a number of other
6 public bodies at the time, that the intention was to try
7 and, as you say, streamline this, I think partly or if
8 not mainly for efficiency reasons. But actually in
9 the -- for Public Health England there was a wider remit
10 as well, which I think as you have been speaking through
11 the Inquiry were very aware around inequalities and the
12 importance of people's lives, their work, how they live
13 on a daily basis and how important that is for health
14 protection. So actually bringing together the health
15 improvement elements alongside the health protection
16 gave a potential opportunity to protect on all of those
17 fronts in one organisation.
18 **Q.** To help put things again in a historical context, Public
19 Health England was in operation during the global
20 outbreak of Ebola from 2013 to 2016, the MERS outbreak
21 in South Korea in 2015, and of course the start of the
22 Covid pandemic in January 2020.
23 **A.** Yes.
24 **Q.** Public Health England was established as an executive
25 agency of the Department of Health. So returning to our

1 fact sheet, and if we look, please, at paragraph 4 of
2 page 1, we can see that an executive agency is:
3 "A national body created administratively, not
4 legally distinct from its 'home' Department. Examples
5 including the Medicines and Healthcare products
6 Regulatory Agency (MHRA)."
7 And of course Public Health England.
8 So it was operationally independent but legally part
9 of the Department of Health, the Department of Health
10 and Social Care?
11 **A.** It was, but actually in looking at your -- at that
12 statement, of course I think the description of the
13 non-departmental public body uses regulatory as
14 a distinctive element, and in fact we say -- we can see
15 here that MHRA is a regulatory agency. So I think what
16 that probably signals is that, in theory, there is a lot
17 of difference and in practice there potentially isn't.
18 **Q.** Well, one of the differences between the way in which
19 the HPA was created and run and Public Health England is
20 created and run is that there was a direct link, wasn't
21 there, there was a direct legal link between Public
22 Health England and its home department, the
23 Department of Health?
24 **A.** Yes, that's correct, but the HPA also eventually will
25 have reported back up to Parliament, I think, for its

1 use of public money. So, as I say, I think the
2 distinctions are there. They're clearly not entirely
3 distinguished, even in this statement, and in practice
4 I think they are less differential than perhaps is
5 assumed from this.
6 **Q.** As far as PHE's functions were concerned, they were
7 wide-ranging and, as you have already told us, one
8 intention was to bring together the three strands of
9 public health. Its key functions, set out in your
10 statement at paragraph 80, include:
11 "... fulfilling the Secretary of State's duty to
12 protect the public's health from infectious diseases and
13 other public health hazards.
14 "b. Improving the public's health and wellbeing.
15 "c. Improving population health through sustainable
16 health and care services.
17 "d. Building the capability and capacity of the
18 public health system.
19 "e. Developing and publishing the evidence base for
20 public health ..."
21 Is that right?
22 **A.** It is. I think probably in all of those it says
23 somewhere "in partnership", because clearly one
24 organisation can't do all of that, and that was a key
25 component of PHE's work.

1 Q. All right. Well, in relation to pandemic preparedness
2 and resilience, is it correct that PHE's functions
3 included but were not limited to surveillance, the rapid
4 assessment of the first cases and early alerting,
5 testing and contact tracing, providing guidance on
6 border and infection control, the exchange of
7 information with international contacts, designing and
8 running simulation exercises, and managing the pandemic
9 flu stockpile?
10 A. Yes. I think just -- on two of those points, which I'm
11 sure we'll come on to, on testing and contact tracing
12 I think it's -- we should not assume that is mass
13 testing and mass contact tracing, which I think we will
14 come on to.
15 Q. Yes.
16 A. And in managing the stockpile, it is very definitely
17 management and procurement rather than decision on.
18 Q. All right, thank you. We will be turning to look at
19 that later on in your evidence.
20 Then bringing public health agencies up to date, we
21 now know that the Public Health England organisation was
22 replaced by the UK Health Security Agency, that change
23 took place in 2021, and it became operational towards
24 the end of that year, October 2021.
25 It's right, isn't it, that during the Covid-19

1 pandemic the government decided to separate out again
2 the national health improvement, healthcare public
3 health and health protection functions?
4 A. Yes.
5 Q. Yes, so the health improvement functions of Public
6 Health England moved into a new structure called the
7 Office for Health Improvement and Disparities, or the
8 OHID, which sits within the DHSC?
9 A. Yes.
10 Q. The healthcare public health functions of Public Health
11 England transferred to the OHID, NHS England,
12 NHS Improvement and NHS Digital, and the health
13 protection capabilities of Public Health England and NHS
14 Test and Trace were combined into the new UKHSA,
15 a pandemic preparedness and response super-body which
16 has a permanent standing capacity to prepare for,
17 prevent and respond to infectious diseases and other
18 threats to health?
19 A. That's right.
20 Q. Thank you.
21 So the UKHSA is an executive agency of the DHSC --
22 A. Yes.
23 Q. -- is that right? Thank you. We can take that down,
24 please, now.
25 I want to look in a little bit more detail, please,

1 at the changes made to England's public health
2 structures by the Health and Social Care Act of 2012.
3 Would you agree that in 2012 there was a complex
4 restructuring of health and public health services in
5 England, including the -- abolishing the HPA and
6 transferring its functions to the PHE, which involved
7 the merging of 5,000 staff from over 120 different
8 organisations. I mean, that in itself is quite a task.
9 A. Yes. I mean, I think there's a series of different
10 organisational moves which have involved very large
11 numbers of staff and very complex systems working,
12 including the last one.
13 Q. Thank you. Also the abolition of strategic health
14 authorities and primary care trusts, which were replaced
15 with a number of clinical commissioning groups.
16 A. Yes.
17 Q. The creation of a new arm's length commissioning body,
18 NHS England, which came into force?
19 A. Yes.
20 Q. Also the Secretary of State for Health was given
21 a statutory duty to take steps to protect the health of
22 the people of England, meaning that at a national level
23 accountability for health protection would rest with
24 central government?
25 A. Yes.

1 Q. And importantly, giving local authorities responsibility
2 for improving the health of their local populations,
3 which was previously, I think, the responsibility of the
4 primary care trusts?
5 A. Yes.
6 Q. The government's rationale for that change was that many
7 of the wider determinants of health, for example
8 housing, economic development, transport, could be more
9 easily impacted by local authorities who had overall
10 responsibility for improving the local area for their
11 populations and who were well placed to take a very
12 broad view of what services would impact positively on
13 the health of their local populations and maximise
14 benefits?
15 A. Yes, I mean, it returned to the sort of 1970s model,
16 a medical officer for health for the community, which
17 I think was important, and if you look at where the
18 evidence is now, after a little bit of a sticky start,
19 I think that's where most people think a director of
20 public health should be: in the local authority.
21 Q. Yes, the directors of public health in England were also
22 given a new ringfenced budget and a duty to publish
23 annual reports, I think, that could chart local
24 progress. They were intended to be strategic leaders
25 for public health, and health inequalities, in local

1 communities, working with the local NHS across the
2 public, private and voluntary sectors, and new proposed
3 local statutory health and well-being boards.
4 In your view, Dame Jenny, that has been a successful
5 implementation?
6 A. It was a painful birth, I think, and I say that having
7 taken my own team, when I was a director of public
8 health in Norfolk & Waveney, over to the local authority
9 and worked as chief officer in local authority and PCT.
10 It wasn't welcomed by all and there were some losses,
11 which we might come on to. But I think broadly now, and
12 particularly actually since the last three years, it's
13 been very clear that many of those public health
14 director colleagues have really risen to the challenge
15 and are very respected senior leaders in their
16 communities.
17 Q. Would you agree that the 2012 reforms across the board
18 relating to mainly the creation of Public Health England
19 but the other matters that we've touched upon received
20 mixed reviews from the public health community?
21 A. I think that's a fair comment.
22 Q. Okay. The Inquiry has heard from
23 Professor David Heymann, who was a non-executive chair
24 of both the HPA and PHE, and also from
25 Professor Whitworth, the biosecurity expert, who were

1 both of the view that it was beneficial to have health
2 protection and health improvement under one roof, the
3 one roof of one organisation, because of the
4 cross-learning to be had between those areas, and the
5 synergy, as they described it, that was created between
6 them as a result. But on the other hand, others have
7 raised concerns about the structural reforms and
8 problems that have arisen, which we're going to look at
9 now, if we may.
10 A. If I might just add, though, I think whichever way you
11 divide public health it goes in multiple different
12 directions, so there is no straight line which works
13 perfectly, and what perhaps you haven't mentioned is the
14 potential advantage of the organisation we have now,
15 which is actually to build up on the science side, which
16 I think has been a little bit suppressed in the last
17 year, so totally supportive of the directors of public
18 health but actually, when we get to what can we do to
19 prevent a pandemic --
20 Q. Yes.
21 A. -- it wasn't well placed.
22 Q. No. Well, we're going to look at the scientific side
23 and how that has been perhaps improved by the UKHSA.
24 But remaining for a moment, please, with Public
25 Health England, because that's the organisation that was

1 in force in the run-up to the pandemic, and really
2 throughout the majority of the timescale that Module 1
3 is looking at.
4 I want to look at five potential drawbacks:
5 confusion over EPRR responsibilities, independence from
6 government, funding issues, capacity issues, and
7 fragmentation of public health services.
8 In his report to the Inquiry, Dr Claas Kirchelle has
9 said:
10 "What sounded complicated on paper proved
11 complicated in practice. The blurred statutory overlap
12 between local authority, Secretary of State, and Civil
13 Contingencies Act duties could create significant
14 operational confusion over prime protection
15 responsibility during emergencies ..."
16 Dame Jenny, do you agree that there was some
17 confusion perhaps over roles in emergency preparedness,
18 resilience and response arising out of what is described
19 as a complicated overlapping or blurred state of
20 statutory responsibilities?
21 A. Yes, but I don't think it was a perfect system before
22 either, and so I think what you're potentially getting
23 is a central view out rather than an outside view in,
24 but I do -- I agree in principle that it was confused,
25 partly because of a number of different new changes,

1 people have to get used to them, partly because of the
2 movement, which, we've just said, I think, everybody
3 supports, of the director of public health into the
4 local authority.
5 Q. Thank you.
6 Dr Claas Kirchelle also has told the Inquiry in his
7 report:
8 "Although it absorbed many pre-existing structures,
9 PHE also differed from its predecessors in key ways. In
10 addition to its combination of health protection and
11 promotion functions, PHE broke with the post-1950s
12 English tradition of statutory non-departmental public
13 health bodies that were set up by Parliament by being
14 integrated as an executive body within the
15 Department of Health. This not only resulted in far
16 greater political control over PHE activities by
17 ministers, but also meant that all employees were civil
18 servants and subject to the Official Secrets Act --
19 a cause of concern amongst public health workers ..."
20 Do you agree with that as a description, and do you
21 agree that the very close political connection between
22 the organisation and government was a cause of concern
23 amongst public health workers?
24 A. I recognise the cause of concern and I recognise the
25 perception, I don't necessarily agree with the content.

1 **Q.** All right. Why not?
2 **A.** Well, I mean, I myself at times have been accused of
3 going to the dark side. This is the standard thing.
4 And it's very difficult because, as I pointed out when
5 I did, I was a director of public health one day in
6 a community and then, on the other side, the next, I'm
7 just the same person with exactly the same professional
8 skills and ambitions. There is a different way,
9 necessarily, of working in government to try and achieve
10 the outcomes, and I think the most important thing, as
11 we'll probably see with other systems, is you need the
12 trust of the people you're working with, and those
13 relationships, and I think that is important to
14 organisational change.
15 **Q.** To what extent did being an executive agency of Public
16 Health England affect its ability to act as
17 an independent advocate for public health and decide its
18 own public health priorities?
19 **A.** So I think there are two answers to that. One is in
20 reality and one is in perception, as I've said. So
21 there was very definitely a strong perception. I can
22 remember when I joined the organisation from --
23 you know, having not been in this area of work at all,
24 was that government was trying to stop everything being
25 published. So the minute you stopped to try to align

1 comments so it didn't confuse the public, it was
2 perceived as "government won't let us publish science",
3 and it was entirely incorrect, and in fact there was
4 a very specific clause inserted in the rule that said
5 there is a right for Public Health England -- and we've
6 retained it in the UK Health Security Agency -- to speak
7 the truth about the science.
8 But there's also how you use that to enable good
9 public health outcomes and sometimes it's better for the
10 public, for the political context, you'll get better
11 outcomes if you manage that type of relationship, and
12 you almost have to be in it to understand it, and
13 I think that's one of the problems.
14 **Q.** So is it important in your view for public health
15 advisers to be independent of the government, or at
16 least appear to be independent of the government?
17 **A.** So I like to think -- I am a civil servant -- this is
18 where I have to throw whichever hat I'm wearing up in
19 the air -- but I'm also bound by General Medical Council
20 regulations, and I stick to them very firmly, but at the
21 end of the day I'm bound by my moral compass, which is
22 very definitely set on delivering public health
23 outcomes.
24 So I -- there is a debate here about, if you are
25 away from government, whether you can achieve good

1 outcomes or whether it's better to be closer. But
2 I think the key point is you need both, that's the
3 really important thing, and you need the connections
4 between them.
5 **Q.** How important is it for an organisation such as Public
6 Health England to be able to set its own strategic
7 priorities, and is that possible with such a close
8 connection with government?
9 **A.** I think it is important, because I'm sure, you know,
10 a lot of the conversations that have been happening so
11 far in this Inquiry are very much about who is raising
12 which issues, are they being heard, and that is part of
13 that strategic direction, and in most cases they are the
14 experts in the topic and need to do that. Nevertheless,
15 the point you make is they will be to some extent moved
16 by whatever the departmental initiatives and priorities
17 are, and they are part of that machinery. So there is
18 a balancing act.
19 **Q.** Thank you.
20 Moving on to funding, please, could we display
21 INQ000 -- ah, we have it already, paragraph 108. You're
22 ahead of me, thank you very much.
23 This is, again, from Dr Kirchhelle's report and
24 I just want to focus for a moment on the public health
25 budget, please:

1 "Functioning of the new local and national English
2 public health structures was compromised by austerity
3 politics [in his view]. At the local level, the
4 abolition of PCTs [primary care trusts] meant that
5 overall public health performance was strongly dependent
6 on local authority capabilities to commission and
7 deliver effective services. Ministers had promised to
8 ringfence the public health budget for local
9 authorities. However, an in-year cut of £200 million in
10 2015 was followed by further reductions over the next
11 5 years. According to the Local Government Association,
12 this amounted to a real term reduction of the public
13 health grant from over £3.5 billion in 2015-16 to just
14 over £3 billion in 2020-21."
15 That's a difference of 14%.
16 "Other estimates by the Institute for Public Policy
17 Research spoke of an even more dramatic reduction of
18 £850 million in net expenditure between 2014/2015 and
19 2019/2020 with the poorest areas in England experiencing
20 disproportionately high cuts of almost 15 percent.
21 Resulting pressures on local public health were
22 exacerbated by an overall 49 percent real term cut in
23 central government funding for local authorities between
24 2010/11 and 2016/17 and a resulting practice of
25 'top slicing' whereby authorities reallocated ringfenced

1 public health budgets to other services broadly
2 impacting health and well-being such as trading
3 standards or parks and green spaces. In 2010, *Healthy*
4 *Lives, Healthy People* had promised to give 'local
5 government the freedom, responsibility and funding to
6 innovate and develop their own ways of improving public
7 health in their area'. Freedom and responsibility had
8 been granted -- but funding was often lacking."
9 Thank you, we can take that down.
10 Dame Jenny, do you agree that the ringfenced public
11 health budget reduced over time due to austerity?
12 **A.** Yes. I mean, those figures -- and, I mean, I recognise
13 some of them, obviously I've read the report, but
14 I think they just need to be taken in context. If there
15 are 152 top tier local authorities and a 200 million cut
16 in a year, we just need to think that's just about
17 a million, and we're -- so it's an important million for
18 that local population --
19 **Q.** Yes.
20 **A.** -- but just to put that in context and hold that tight.
21 Nevertheless I do agree with you and I know that
22 directors of public health were under significant
23 pressure. Local authorities were actually often much
24 more efficient at commissioning services, so they could
25 almost generate savings from that and get just the same

1 public health outcomes, but nevertheless they were
2 significantly under pressure.
3 **Q.** But as well as having the opportunity to generate income
4 themselves, the public health budget was reduced even
5 further, wasn't it, by local authorities dipping into it
6 due to cuts to their overall funding from central
7 government, as set out in the piece that we've just
8 seen?
9 **A.** Yes, and rather than use the word "generate", I might
10 just say that there was a lesser -- a lower loss, if you
11 like, rather than -- it wasn't a generation --
12 **Q.** Yes --
13 **A.** -- it was just --
14 **Q.** -- all right.
15 **A.** -- (inaudible) more efficiently, just for clarity.
16 So I think the way the public health grant was
17 managed, it went through Public Health England
18 effectively, it came out as a top figure from local
19 authorities. It wasn't possible, often, to see -- and
20 we can -- I think may acknowledge that for health
21 protection -- exactly the detail of what was being spent
22 where.
23 **Q.** Yes.
24 **A.** And it was a very sensitive area for obvious reasons.
25 But I think it's fairly reasonable to assume that local

1 authorities were translating where lives were being
2 protected through the lens which they had at that time.
3 **Q.** Do you agree that the poorest areas in England
4 experienced disproportionately high cuts?
5 **A.** I can't comment on that objectively without seeing the
6 numbers, but my understanding is that that's the case.
7 **Q.** How did the funding cuts impact on the work of the
8 directors of public health and local authorities
9 generally when it came to EPRR functions, do you think?
10 **A.** So I think it's fair to say, I mean, even at the start,
11 before any of the budgetary changes, whether because of
12 perceptions of people, for example, in clinical roles
13 not wanting to move to local authorities, or whether for
14 other reasons, the changes, people -- actually lots of
15 staff were lost in that move, so there was some skill
16 loss, and then increasingly, as people went across, some
17 of the -- initially, not now, but some of the directors
18 of public health roles started to move down the
19 hierarchy within the local authority and some of the
20 more, if you like, the expensive roles, so some of the
21 ones -- perhaps the clinical roles, would be lost. So
22 I think it is fair to say, and I'm pretty confident it's
23 evidenced, that some of the health protection skills
24 were denuded from -- particularly from the smaller local
25 authorities, where you would perhaps have one director

1 of public health, one consultant and one other. Really
2 quite small.
3 **Q.** Yes. In fact your colleague Professor Oliver tells us
4 at paragraph 93 in her witness statement that:
5 "Over the period from 2009 to 2013, regional EPRR
6 resourcing in terms of whole time equivalent capacity
7 and relative seniority and that of other teams
8 supporting EPRR functions reduced."
9 She says that consequently this impacted on the
10 ability of regional teams to undertake EPRR functions
11 including engaging in multi-agency pandemic preparedness
12 work, and that reductions in funding also impacted on
13 the HPT workforce which would have had a further impact
14 on EPRR capacity.
15 **A.** Yes, just for clarity, though, those comments relate to
16 the Health Protection Agency EPRR capacity, not the
17 local authority, which is what I was referring to
18 before.
19 **Q.** Right. But do you agree --
20 **A.** But I agree.
21 **Q.** -- with what she says in terms of the --
22 **A.** Yes.
23 **Q.** -- reduction in capacity.
24 Yes.
25 **LADY HALLETT:** If you're moving on -- actually you have one

1 more, haven't you, for the five?
2 **MS BLACKWELL:** Yes, sorry, that was dealing with capacity
3 issues and I'm just going to deal, if I may -- were you
4 inviting me to take a break, my Lady?
5 **LADY HALLETT:** When you're ready.
6 **MS BLACKWELL:** Thank you.
7 Fragmentation of the public health system. I'll
8 just deal with this briefly if I may.
9 Professor Philip Banfield of the BMA has told
10 the Inquiry that reforms of the public health system in
11 England in particular led to a fragmented system, with
12 the 2012 Health and Social Care Act fracturing in many
13 places the links between public health specialists and
14 NHS colleagues.
15 Is that something that you recognise, Dame Jenny?
16 **A.** I recognise it as a recurrent theme every time there is
17 a change in the system, and it happens always when
18 there's an NHS change as well, so it's almost if you're
19 working on the front line, you have to throw your rope
20 out to the person you knew last week and see which
21 organisation they've landed in. So I do recognise it
22 but it's not that uncommon. I think it was particularly
23 difficult over that period.
24 **Q.** Do you agree that community infection prevention and
25 control suffered as a result of the fragmentation?

1 **A.** So that was some of the clinical capacity that I was
2 mentioning. It was a declining resource anyway,
3 I think, so IPC nursing -- I know I personally persuaded
4 two of my nurses to come across to the council with me.
5 Most places were not that lucky, they mostly stayed in
6 the NHS, and actually there was -- there is and was
7 a strong need for them in the community.
8 **Q.** Finally, do you have any comments on how the structural
9 changes might have impacted on staff morale and working
10 conditions, including pay, based on your own experience
11 as regional director of the south of England PHE?
12 **A.** So within the PHE at the time?
13 **Q.** Yes.
14 **A.** So I think pay -- pay was a standard terms and
15 conditions, so to speak, for different
16 multidisciplinary, but that was not the issue, with one
17 exception, I think, which was for EPRR staff, where the
18 regional layer went, then people were -- then people
19 were -- there was a reconstruction, if you like, and
20 a formal consultation, and several people moved down
21 a rank rather than stayed in their existing roles. So
22 I think that did prove demoralising for many of them.
23 But I think the uncertainty around it, and, as
24 I say, just trying to find out whether the other end of
25 your rope needed to land is unsettling. People

1 generally want to get on and do the job that they are
2 trained to do.
3 **Q.** And it created its own pressure?
4 **A.** Yes.
5 **MS BLACKWELL:** Thank you.
6 My Lady, is that a convenient point?
7 **LADY HALLETT:** Thank you very much. I shall be back at
8 3.15.
9 **(3.00 pm)**
10 **(A short break)**
11 **(3.15 pm)**
12 **LADY HALLETT:** Yes, Ms Blackwell.
13 **MS BLACKWELL:** Thank you, my Lady.
14 At paragraph 139 in your statement, Dame Jenny, you
15 explain that the PHE centres and regional teams worked
16 with the NHS and local authorities as well as with other
17 agencies involved in local public health systems across
18 all of the three domains of public health.
19 What did the health protection teams do? What were
20 their functions?
21 **A.** So the health protection teams were part of each PHE
22 centre, and it's actually the same teams we use now.
23 They would have a lead CCDC, a communicable disease
24 consultant, who would work and link with the director of
25 public health in a local authority. So if, for example,

1 you had some sort of health protection incident, then
2 usually the director public health -- one would alert
3 the other, depending on how the situation had arisen,
4 and they would work out between them how they needed to
5 go about it. If there was a longstanding health
6 protection issue, I can think -- smelly quarries or
7 something like that, then they would call on resource
8 from the centre of Public Health England to get
9 specialist input.
10 **Q.** You also say that regional directors played an important
11 role in providing a local perspective in PHE's work at
12 a national level. Can you provide an example of how
13 that might have worked?
14 **LADY HALLETT:** Before you do, could you speak more slowly?
15 Like many of us, and I'm also guilty, you speak very
16 quickly, and I know it's been a very long day for our
17 wonderful stenographer, so ...
18 **A.** My apologies.
19 **LADY HALLETT:** Not at all, please don't apologise.
20 **A.** I will try and speak more slowly.
21 So in response to your question, as a regional
22 director for the south of England, I had two centre
23 directors who would report to me, each of whom had
24 several health protection teams, and if, for example,
25 let's say it was a capacity issue, they were having

1 problems with recruitment, we would be reporting that
2 back in to the executive management team, nationally, to
3 alert to the fact that there may be some risk in
4 a health protection provision. Alternatively, if they
5 were doing good work and had had some success in
6 a particular issue, then that was an opportunity to be
7 sharing that work.
8 But obviously it also gave an opportunity to feed
9 back on the local political side as well and how
10 different directors of public health were working in
11 their patches.
12 **MS BLACKWELL:** Thank you.
13 There were a number of changes to the structures of
14 the regions and therefore to the management and delivery
15 of EPRR functions over the course of our module time
16 period. What was the impact of those structural changes
17 to the PHE regions and to the regional teams?
18 **A.** So this started with the Health Protection Agency
19 problems, and I think there were something like
20 28 strategic health authorities when it started off and
21 gradually they all got removed and then we went into PHE
22 regions.
23 The difficulties of coterminosity, or lack of it,
24 was a major problem, and therefore, as numbers went
25 down, with resource cuts across, obviously, local areas

1 but Public Health England teams as well, then those
2 individuals were trying to support more local resilience
3 fora, directors of public health and local health
4 resilience partnerships.
5 So generally it meant you were less able perhaps to
6 put the same amount of input as you would have done, and
7 support, into those different areas.
8 **Q.** Professor Fenton, from the UK Faculty of Public Health,
9 who we have already looked at, said:
10 "Health protection teams, which moved from the
11 Health Protection Agency ... to [Public Health England]
12 ... saw successive reductions in funding and capacity
13 over the pre-pandemic years and a lack of investment in
14 regional emergency preparedness, response and resilience
15 ... teams."
16 He says:
17 "A direct result of these changes was a reduction in
18 the amount of professional exposure that the public
19 health specialist generalist workforce had to health
20 protection duties and continuing professional
21 development outside of PHE."
22 Now, first of all, could you help both my Lady and
23 myself by explaining what a specialist generalist
24 workforce might be?
25 **A.** I will try very hard.

1 So the Faculty of Public Health and the
2 Royal Society of Public Health, but the Faculty sets the
3 standards for public health training. As people go
4 through their training programme, they could become
5 a health protection specialist, I mentioned a CCDC,
6 a consultant in communicable disease control, who is
7 very focused on health protection, or they could become
8 a specialist generalist, meaning that they were general
9 across all those three areas of public health.
10 But we would expect a generalist still to have basic
11 health protection training and exposure, so that if you
12 have something like a pandemic they also would turn to
13 support that.
14 So I think what he's suggesting is that if the teams
15 in health protection were getting smaller and perhaps
16 a little bit more fraught and overworked, they would
17 potentially have less time to support that training as
18 the generalists came through.
19 **Q.** Is that something that you recognise?
20 **A.** It works both ways, because actually if you have less
21 capacity in your health protection teams, it's great way
22 to learn, because you get given a whole load of things
23 because there's nobody else there to pick it up. But
24 I think his point is he would be wanting to ensure those
25 people were receiving on-the-job training, and there

1 might be less capacity to do that.
2 **Q.** All right, thank you.
3 I want to touch briefly upon the developments in the
4 infrastructure of public laboratories and in the
5 generation of microbiological data, because there will
6 be other witnesses who will be helping the Inquiry with
7 this, but we have received a report from the then CMO,
8 Sir Liam Donaldson, called *Getting Ahead of the Curve*,
9 which the Inquiry has read, and it was a report which
10 proposed the creation, I think, of the HPA.
11 Within that report, there is reference to structural
12 reforms that brought about the creation of the HPA
13 in 2003. Is it right that during the creation of HPA
14 that the public health laboratory service, PHLS, was
15 disbanded and merged into the HPA, and that control over
16 all the local PHLS laboratories was transferred into the
17 NHS?
18 **A.** I wasn't around at the time so I'm only able to give you
19 the information as I understand it, but I think what
20 happened is that there were 30 -- broadly the public
21 health laboratory service grew up after the war and had
22 quite a wide reach. At the 2002 reforms, when HPA was
23 formed, around 32 laboratories went into the NHS, and
24 the rest, if you like, the specialist laboratories and
25 reference -- public health reference laboratories, went

1 to Health Protection Agency, and those are the ones
2 which we retain in the UK Health Security Agency and,
3 previously, Public Health England.
4 Q. How did that work in practice?
5 A. Well, it meant that the local -- the NHS trusts, the
6 hospitals, had their own laboratories attached, and so
7 I presume what Liam Donaldson is referring to is there
8 would -- he would perceive a fracture, if you like,
9 between the NHS laboratories, now, and the specialist
10 laboratories, and sometimes you need an alerting system
11 to see where there are cases being diagnosed and then,
12 if you like, send them on to the reference laboratories
13 to check them out in detail.
14 I think in around 2010, again before I came into the
15 English system, the -- there was a change in data flows,
16 and therefore actually the reporting of data almost
17 automatically then caught up, I suspect, with the
18 concerns of 2002. So in general that work flows
19 through.
20 We have different issues now, which is around staff
21 retention and training and differential pay issues
22 across the two divides, but I think the data flow issue
23 is predominantly resolved.
24 Q. Right, thank you.
25 Does the microbiological testing of virus samples

1 require laboratory facilities and laboratory scientists
2 who are specially trained or is it something that all
3 scientists working within the service can deal with, and
4 can it be dealt with at any of the laboratory sites?
5 A. No. So I think for many of the viruses that we will be
6 talking about -- and they're very rare, you know, before
7 I draw everybody's anxiety levels up. The Public Health
8 England, at the time UKHSA now, deals with the very
9 highest level pathogens. So we talk about containment
10 level 4, the highest level laboratories, and those are
11 only situated with -- on two sites for what was then
12 Public Health England and another one, which was the
13 government's scientific laboratory at Porton Down, and
14 so none of the -- if we have a case of the
15 high-consequence infectious disease case or pathogen X,
16 whatever it might be, that we're uncertain about, they
17 will be managed in a way which goes almost always to
18 Porton Down or respiratory to Colindale labs, and they
19 will be dealt with in those high containment facilities
20 for safety.
21 Q. What about the infrastructure of those two laboratory
22 settings, in Porton Down and Colindale, and the
23 requirement obviously to keep that infrastructure
24 updated and safe?
25 A. Yeah, so these are major undertakings. They're part, if

1 you like, of the national -- well, they are part of the
2 national security infrastructure, and therefore it's
3 absolutely vital that the country retains them. In
4 fact, as we've discussed, I think, through the early
5 part of the Inquiry, we can see that the risks of these
6 new emerging diseases developing and potential for
7 needing to do more research and to use them for vaccine
8 evaluation as well is growing.
9 Meanwhile, they take an awful long time to build, so
10 it's very important that when decisions are being made
11 about health protection, those sorts of decisions in
12 funding and maintenance of laboratories absolutely
13 factors in the timeframe for safe refurbishment and
14 building.
15 Q. Looking back now, do you have any reflections on whether
16 all of the structural reforms had an impact on pandemic
17 preparedness in England leading up to January 2020?
18 A. It's very difficult to look back because the comments
19 you've made about fractured lines and the potential --
20 there definitely was uncertainty after 2013 when Public
21 Health England started. We know, in fact we've
22 submitted a number of papers, where different parts of
23 the system have tried to work, directors of public
24 health, with Public Health England proactively to
25 recognise different roles and responsibilities.

1 That said, we've also put forward in the evidence
2 a survey which suggests actually that people do
3 understand them. So my feeling is that the overall
4 issue is more to do with capacity rather than roles and
5 responsibilities.
6 Q. Thank you.
7 You also deal with the funding situation of PHE in
8 your witness statement and you tell us at paragraph 91
9 that:
10 "Over the lifetime of PHE, its funding from central
11 Government was reduced by over 40% in real terms
12 (ie taking into account inflation and unfunded pay
13 pressures). Thus, the organisation had to implement the
14 cost savings that this required so it met its duty to
15 operate within its budget. In addition, there were
16 budget reductions on the level of funding in PHE's
17 predecessor bodies for the functions that came into PHE
18 in 2013."
19 I'd like to display INQ000090350, which is
20 an absolutely of yearly funding for PHE received from
21 the DHSC that UKHSA has produced for the Inquiry.
22 We can see the year in the left-hand column, and the
23 funding in levels of millions on the right-hand column.
24 So we can see that the core grant in aid funding
25 that PHE received from the DHSC in 2019/20 --

1 thank you -- was 287.1 million.
2 If we move further up the chart and further back in
3 time, in 2013/14 the amount was 392.5 million.
4 Is that the 40% reduction that you were referring
5 to?
6 A. It is, but it's in real terms, and I think we've
7 explained in the submission, in the statement how that
8 is derived.
9 But yes, effectively what was happening, not only
10 was the grant in aid dropping, but the costs were going
11 up, so maintenance of these very expensive laboratories
12 which you have to retain. But also the organisation
13 therefore, in order to sustain itself, became very
14 dependent on its earnt income. It has absolutely
15 brilliant scientists and it can generate some income.
16 But by the end of this period my view would be that,
17 rather than having a system that was a critical system
18 for the UK, founded on a substantial grant that could
19 maintain it, it was trying to pedal fast to keep up,
20 generating income, and often using its scientists to do
21 that rather than perhaps strengthen the wider health
22 protection system.
23 Q. Just so we understand, although it appears that there is
24 a big rise in funding in the years 2012/13 to 2013/14,
25 that's because Public Health England was a much larger

1 organisation than PHA, wasn't it, and it had to take on
2 many more functions when it was created?
3 A. It was, and also there's a change in the middle, and
4 again I think explained in the statement, because it
5 took on child -- some of the child public health
6 programmes --
7 Q. Yes.
8 A. -- which actually -- you know, the overall system went
9 down but the -- there was an additional grant in aid for
10 that.
11 Q. Apart from the way in which you've described in your
12 answers just now, are there any other ways in which
13 those funding cuts which ran in parallel to workforce
14 issues and structural changes that we've just looked at
15 impacted on PHE's pandemic preparedness functions?
16 A. I mean, you know, I wouldn't like to make a particular
17 case for this in the sense that I recognise at that time
18 almost all public sector organisations were -- had
19 budget decreases, but of course the combined effect of
20 that meant that if the local authority also had
21 insufficient and the NHS had also dropped their numbers
22 of staff, what happened was, when you met round the
23 local resilience forum table, you may not see the person
24 you saw last week because they'd gone to another one.
25 There weren't as many people there to staff.

1 So I think the overall impact was quite
2 significant --
3 **(Alarm)**
4 Q. Just pause, please, Dame Jenny, sorry. I'm afraid this
5 is a recurring theme in the afternoon. And it's usually
6 when I'm on my feet.
7 **LADY HALLETT:** Don't get paranoid, Ms Blackwell.
8 **MS BLACKWELL:** I'm sorry, I won't.
9 Sorry, Dame Jenny, you were explaining about perhaps
10 not seeing the same face around the table?
11 A. Well, concurrent efficiencies in relevant partner
12 organisations is really important to meant a system-wide
13 health protection response.
14 Q. Thank you.
15 I'd like to turn now to discuss the interaction and
16 involvement between PHE and the national risk assessment
17 and how PHE works to create and provide the important
18 facts and figures and calculations.
19 So could we have on the screen, please,
20 INQ000206659, which is a document entitled "Risk
21 assessment template cross-government risk assessment of
22 2018 emerging infectious diseases".
23 Is this the document that PHE would have produced
24 and provided to DHSC in relation to the NRSA assessment
25 for the risk pertaining to emerging infectious diseases?

1 A. I'm unable personally to answer that directly. I would
2 imagine so.
3 Q. All right.
4 A. Yes.
5 Q. Because it's dated 2018, from your general knowledge of
6 the system, could we assume that this was in preparation
7 for the 2019 NSRA?
8 A. I'm making that assumption.
9 Q. All right. Who would have produced this document,
10 Dame Jenny?
11 A. This is difficult, and I think it would be better to
12 check. The general principle was that DHSC would feed
13 into the national risk assessment, but they absolutely
14 would consult with the specialists in Public Health
15 England to ensure that the right information was fed
16 back.
17 Q. So does that suggest that the first stage of collating
18 the information and performing the assessment happens
19 at DHSC, and that that information is then provided to
20 PHE for their comments and additions?
21 A. Yes, I think with most of these processes you have
22 a starting point and the first question is: is this
23 still correct?
24 Q. Right.
25 A. I mean, it's a practical issue, which, if you've got

1 something on a piece of paper, people will comment no.
2 If you put it open, they're less likely to. So I think
3 you start off with: this is the position as it was last
4 year or two years ago, does this still look right, are
5 there new risks or should this change?
6 Q. I'd like to look at the last two paragraphs on this
7 page, please, and just remind ourselves of the
8 reasonable worst-case scenario risk description, or
9 indeed to see how it is in this template document.
10 Over the past 30 years, more than 30 new or newly
11 recognised diseases have been identified. Most of these
12 have been zoonoses, ie diseases that are naturally
13 transmissible, directly or indirectly, from animals to
14 humans. The reasonable worst-case scenario ... is
15 an outbreak of a high-consequence infectious disease ...
16 which is airborne. An airborne disease is more likely
17 to spread rapidly from person to person, and can make
18 contact tracing more difficult compared to other
19 diseases which have a different route of transmission.
20 Other emerging infectious diseases which are spread
21 through different routes of transmission are explored in
22 the three variations below.
23 "Specifically, the current RWCS is based on
24 an outbreak of a respiratory infection in the
25 United Kingdom ... which is similar to the outbreak

1 of ... (MERS) seen in South Korea in the 2015. This has
2 been chosen due to the current risk of this disease and
3 the historical precedent of imported MERS cases leading
4 to outbreaks. However, it should be noted that due to
5 the nature of an emerging infectious disease there is
6 some uncertainty as to whether a different emerging
7 pathogen, including one which was airborne, would lead
8 to an outbreak similar to the scenario described."
9 We can see, moving back to paragraph 4, that the
10 "overall confidence assessment", the likelihood or
11 plausibility, is assessed as being low.
12 Was the reference to infection control procedures
13 a reference to IPC within the healthcare setting or
14 community IPC or both?
15 A. Sorry, where is the reference to IPC?
16 Q. If we look at, in fact, over the page at page 2, I think
17 it's clearer here. If we look at the first two
18 paragraphs here:
19 "The RWCS is predicated on a novel or emerging
20 infection (ie one that is either globally unknown or
21 unknown/very rare in the UK) arising in another country
22 and then arriving in the UK before it is identified. It
23 is possible that a novel infection could arise in the UK
24 first but this is less likely.
25 "Based upon the experience of recent international

1 outbreaks of MERS, the likely impact of such an outbreak
2 originating outside the UK would be cases occurring
3 amongst returning travellers and their families and
4 close contacts, with potential spread to health care
5 workers, and other patients within a hospital setting.
6 The resulting cluster of individuals with a similar
7 illness should lead to infection control within health
8 care settings and other public health measures being
9 instigated which can control the spread of the disease.
10 For MERS, sustained human-to-human transmission outside
11 of close contacts and healthcare workers has been
12 limited so far ... and therefore there is currently
13 a low risk of this disease presenting a wider threat to
14 the UK. However, sustained human-to-human transmission
15 in emerging airborne diseases is possible, which is why
16 infection control procedures are critical to the
17 mitigation of this risk."
18 A. Sorry, and could you repeat the actual question?
19 Q. Yes. So the reference in the middle of that paragraph,
20 if we can highlight it:
21 "The resulting cluster of individuals with a similar
22 illness should lead to infection control within health
23 care settings and other public health measures being
24 instigated which can control the spread of the disease."
25 So is the reference to infection control procedures

1 a reference to IPC within healthcare settings or within
2 community IPC or both, do you think?
3 A. So, I mean, as I say, I'm slightly -- we just need to
4 take this carefully because I'm not clear of the
5 absolute origin of the document, but I can see
6 a peer reviewed reference there, of 2017, so it's going
7 to be 2017 or later, which -- and the reference to
8 infection control will be, it says, within healthcare
9 settings. But we always have infection control measures
10 within healthcare settings. This will refer to,
11 potentially, bolstered healthcare settings controls, and
12 I think this work actually was taken forward in the HCID
13 pathway work which resulted in the commissioning of five
14 new airborne HCID transmission control centres, if you
15 like, which were not in the UK prior to this.
16 Q. Right. When were those created or where were they
17 created?
18 A. So the names are actually in the statement, but the HCID
19 work which started after Ebola, which is obviously
20 a contact transmission, but looked at the potential for
21 high-consequence airborne and touch transmission, and at
22 the time there were just two contact transmission
23 centres, which was the Royal Free and Newcastle, so,
24 working with DHSC and with NHSE, new airborne
25 transmission control centres, if you like, were created,

1 so this is a direct result of the HCID pathway. And in
2 fact in 2018, of course, we had a MERS case; appropriate
3 IPC in healthcare settings was put in place, and there
4 was no transmission.
5 **Q.** All right, thank you.
6 Is it right that, certainly looking at this
7 document, which appears to have been based on the MERS
8 outbreak, that SARS and MERS were considered to be
9 primarily transmitted via droplets rather than aerosols?
10 **A.** No, I mean, I think Professor David Heymann put it --
11 **Q.** Sliding --
12 **A.** -- I thought expressed it very well in his -- the
13 evidence prior to this was that mostly people were
14 infectious when they were symptomatic, and the aerosol
15 generating procedures, so these are procedures where you
16 are, if you like, it's not quite right, but actively
17 pushing air up from the bottom of the lungs, which is
18 different, for example, to having a virus sitting in
19 your nose and it just popping out if you sneeze or are
20 passing somebody.
21 So these were -- that is how the transmission had
22 occurred, and if we go to the Korea case, for example,
23 as soon as they had put in good infection control
24 measures in the healthcare setting, then they got on top
25 of the transmission.

1 **Q.** All right. And you've referred to the evidence that
2 Professor Heymann gave to the Inquiry. He described,
3 didn't he, that really the difference between droplets
4 and aerosols is best described by a sliding scale --
5 **A.** Yes.
6 **Q.** -- droplets being the heavier, larger particles and
7 aerosols being smaller, so the bottom of the scale.
8 **A.** But there is also a generational thing, it depends about
9 how forcefully they come out, which is why we have these
10 distinctions about singing or shouting.
11 **Q.** Yes.
12 If we can go to paragraph 15, please, at page 9 of
13 this document. Now, we can see that according to this
14 risk assessment, it states that the total number of
15 estimated fatalities -- there we are, at the top of the
16 page -- is between 40 and 70.
17 If we go to the last paragraph on page 10, please,
18 thank you, and highlight the bottom paragraph, we can
19 see that:
20 "The number of casualties is based on the MERS
21 outbreak in South Korea."
22 Which we have already established. And:
23 "Given this number of casualties, the number of
24 fatalities could range from 40 to 70. Approximately 40
25 people died in the MERS outbreak, but with a case

1 fatality rate of 34.9% it is possible that up to
2 70 people could have died. Both figures could be higher
3 or lower than this, depending on how communicable the
4 disease is, as well as how quickly the disease is
5 recognised and prevented from spreading further using
6 infection control measures."
7 Let's just look for a moment, please, also at
8 paragraph 16, which is on the previous page. We can see
9 that the number of physical casualties is assessed here
10 as being 200.
11 Do you know, Dame Jenny, why that figure was
12 assessed at that level, taking into account that the
13 number of cases in Korea was 186?
14 **A.** Well, I don't, and I think I would need to look at this.
15 I'm very happy to do that outside the court and provide
16 written feedback. It's quite difficult to just look at
17 the numbers and make that decision.
18 But clearly, you know, Korea is one setting.
19 I think all of these suggestions or scenarios around
20 reasonable worst-case scenarios are based on what we
21 know and the context at the time, and that's as good as
22 we have. So we know case fatality rate around 35%, and
23 the rest of it is a very sensible but, in many ways,
24 a slightly educated guess unless you've got other
25 parameters.

1 **Q.** Thank you. Can we take that down, please, and replace
2 it with INQ000185135, which is part of the 2019 National
3 Security Risk Assessment, which this information fed
4 into. Could we go straight to page 8, please.
5 Thank you.
6 Now, if we look at -- without highlighting, if we
7 look at the two main paragraphs under "Human welfare",
8 going further down to "Casualties", first of all, the
9 total number of casualties here, in the document itself,
10 is 2,000, and if we move up the page, the total number
11 of fatalities is 200.
12 Now, again, I appreciate, Dame Jenny, that you
13 weren't personally involved in creating this risk
14 assessment, nor indeed in providing the figures that
15 we've just looked at that appear on the template, but in
16 your experience of these matters are you able to assist
17 as to why, having been provided with the figures of
18 between 40 and 70 fatalities and 200 casualties, those
19 figures could have been expanded to 200 fatalities and
20 2,000 casualties, as we see in the actual document?
21 **A.** So as I've said before, I mean, I would need to look at
22 the whole document. On this sheet that you're showing
23 me it doesn't actually mention which disease we're
24 looking at, so case fatality rate for MERS was around
25 35% but I think for SARS in the early days it was

1 around 10%, so that would immediately answer your
2 question, but I don't have the rest of the information
3 to do that. I'm very happy to take it away and look in
4 more detail.
5 Q. I think that would be helpful to the Inquiry.
6 On that point, let's just look at page 9, please,
7 and the section entitled "Human welfare -- confidence
8 assessment". Can we highlight that paragraph, please,
9 because what it makes clear is that:
10 "For the number of casualties and fatalities, the
11 lower bound is based on the MERS outbreak in
12 South Korea. However, there's the potential for this to
13 be much higher. During the SARS outbreak in 2003, there
14 were approximately 350 reported deaths in China although
15 this was where the outbreak [was] originating. Both
16 figures could be higher or lower than this depending on
17 how communicable the disease is [which is a phrase that
18 we've also seen in the template], as well as how quickly
19 the disease is recognised and prevented from spreading
20 further using infection control measures. There is
21 considerable uncertainty regarding the impact of the
22 outbreak on British Nationals Overseas. This scenario
23 has not been modelled by the FCO or
24 Department of Health. The number of non-British
25 fatalities and casualties abroad will depend on the

1 country where the outbreak occurs and the response of
2 the responding health system. For MERS there have been
3 2,102 casualties; 733 deaths from 2012-2017 but for SARS
4 there were 8,096 casualties and 774 deaths from
5 November 2002-July 2003. The figures presented are
6 therefore based on the SARS outbreak in 2003."
7 A. Which aligns with what I've just suggested.
8 Q. Yes. So the figures are provided by PHE, and then
9 they're not simply taken at face value, they will be
10 worked on or adapted or perhaps even given a slightly
11 different scenario in the preparation of this final
12 document; is that right?
13 A. I don't think I would translate it that way.
14 Q. All right.
15 A. In the sense that the information -- I don't disagree
16 with anything which is on the screen in front of me now,
17 it's just we're talking about estimates.
18 Q. Yes.
19 A. We have no cases to go on. So it's extremely difficult.
20 All it's looking at is the totality of cases and other
21 outbreaks and the case fatality rates. And even that,
22 actually, could be over or underestimated depending on
23 how many people were tested at the time.
24 So, I mean -- if I may, my Lady, there is a general
25 point here about the way we're trying to fit viruses

1 backwards, I suspect, either into legal arguments or the
2 pockets of differentials in the risk assessment when
3 they don't fit neatly in each. It's not possible often,
4 in civil service terms, to actually say "unknown" in
5 a box because it needs a number in a box in order to
6 generate the next bit of the logic and the money that
7 goes with it, and I think it drives some of these
8 conversations into differentials which are not
9 realistic. We just don't know, this is as good as we
10 get.
11 Q. All right. There is a high level of uncertainty within
12 that paragraph, isn't there?
13 A. Yes.
14 Q. Lots of variables?
15 A. Yes.
16 Q. And I suppose to a certain extent, you know, the figures
17 are the best that can be achieved at the present time
18 that the document is created?
19 A. But I wouldn't like to suggest -- or at least I have no
20 evidence to suggest that somebody has taken some figures
21 in one place and then moved them around in the others.
22 What is stated here looks reasonable.
23 Q. Right.
24 A. It's just very uncertain.
25 Q. Thank you, we can take that down.

1 The provision of expert scientific advice and
2 contribution to expert advisory groups. We know that
3 PHE contributed to a number of the scientific committees
4 that advised central government and often provided
5 a secretariat for them.
6 As far as you're aware, to what extent were experts
7 provided by PHE able to challenge the views of experts
8 on those panels?
9 A. So usually if colleagues in PHE were attending any of
10 those groups they were there as individual experts. It
11 depends what group it was. And in fact for UKHSA we've
12 just done a review and we've identified 19 different
13 government -- I mean, just to make the spaghetti even
14 worse -- different advisory committees. And then there
15 are a whole load beyond that which are not government
16 ones, are technical advisory groups.
17 So if they're on a government -- there is
18 a government advisory committee, there are rules about
19 how you -- and I think you've had those as well. They
20 will be there offering their independent professional
21 advice and they will be receiving that from other
22 colleagues around the room.
23 If you looked now, for example, we run technical
24 advisory groups and UKHSA will chair them, and so they
25 would be there as a UKHSA representative. But actually

1 there are a number of places where people will get
2 external advice, including, for example, from the
3 advisory boards both of PHE and UKHSA.
4 **Q.** You will be aware, I think, Dame Jenny, that the Inquiry
5 has heard about the need to avoid groupthink,
6 particularly in these advisory groups. Do you have any
7 reflections on whether or not the PHE scientific experts
8 may have contributed to groupthink or suffered from that
9 as a principle?
10 **A.** I'm smiling because there are a number of words which
11 keep repeating through the Inquiry. I don't hold with
12 the groupthink agenda, I think people spoke very freely,
13 they may not all have thought the same thing, and at the
14 end of a meeting you have to come to a consensus
15 statement and position to support progressing whatever
16 the topic in charge is. But on the whole, scientists
17 are quite outspoken. And I think it was
18 Sir Patrick Vallance who said they actually quite like
19 to be challenged and have to change their mind. It's
20 quite exciting if you're a scientist. So I don't really
21 hold with that.
22 I do recognise that particularly during the
23 pandemic, and actually through lots of incidents, there
24 is a feeling of people being left out of the room.
25 Everybody wants to be in the room offering views, and

1 there has to be a practical limit to that. It should be
2 representative, it should be challenging, you should
3 have the right skills, but you can't have everybody or
4 the whole response stops.
5 **Q.** So perhaps the composition of the groups is important
6 to --
7 **A.** Yes.
8 **Q.** -- make sure that there is a range of experience and
9 viewpoints?
10 **A.** Absolutely.
11 **Q.** Yes.
12 Simulation exercises. We've received information
13 about several exercises through the course of our
14 preparation for the Inquiry. I want to concentrate,
15 please, Dame Jenny, with you on Exercise Alice.
16 Could we have up on screen, please, the report,
17 which is at INQ000090431. Thank you.
18 I think it's possible also to display at the same
19 time a freedom of information request which was made by
20 a member of the public in relation to actions
21 implemented as a result of this exercise, which is at
22 INQ000191910, if we could put that up on the right-hand
23 side of the screen, please. Thank you.
24 This, as the Inquiry has already heard, was
25 a tabletop exercise conducted on 16 February 2016 in

1 London to explore the challenges that a large-scale
2 outbreak of MERS CoV could present nationally to health
3 partners in England, and participating in the exercise
4 were representatives from NHS England, Public Health
5 England and the Department of Health, as it then was,
6 and also observers from the Cabinet Office, the devolved
7 administrations and GO-Science.
8 If we look at page 5 of the report, please, we can
9 see the objectives of the exercise at paragraph 2.2:
10 "1. To explore and confirm the health capabilities,
11 capacities, protocols and resources, including surge
12 arrangements.
13 "2. To explore and confirm national command,
14 control, communication and co-ordination arrangements.
15 "3. To explore the capability for contact tracing
16 and quarantining of possible MERS CoV cases.
17 "4. To explore and confirm co-ordination of public
18 messaging associated with a large number of MERS CoV
19 cases."
20 If we just remind ourselves of the scenario, it was
21 where a group of people from London and Birmingham had
22 travelled to the Middle East and ten days after they
23 returned three of them presented at three different
24 hospitals with flu like symptoms. After their histories
25 had been analysed MERS CoV was suspected and a process

1 of contact tracing was initiated, and after two days two
2 of the cases were lab confirmed and a further case, at
3 St Thomas' Hospital was strongly suspected. Prior to
4 arriving at the hospitals, two of the patients had been
5 part of a large gathering, and the scenario then
6 developed with 50 lab confirmed cases and 650 possible
7 contacts, and various elements of the NHS were under
8 pressure from the cases and the media had taken a keen
9 interest.
10 There was a general consensus on the need to
11 identify capacity and capability of assets within the
12 health system, and the level and use of PPE was central
13 and considered of crucial importance for frontline
14 staff. It was noted that the learning from Ebola on
15 infection control understanding, although improved, was
16 still not embedded with staff. And also considered
17 important were access to sufficient levels of
18 appropriate PPE and pandemic stockpiles to ensure
19 sufficient quantities of PPE were available.
20 If we can look at some of the lessons and actions
21 identified, and go to page 10, please, and look at
22 action 4. Action 4 was to develop a MERS CoV serology
23 assay procedure to include a plan for a process to
24 scale-up capacity.
25 Now, is that relating to an antibody test?

1 A. Well, it's a detection test, yes, a diagnostic test, and
2 that was completed by PHE, and in fact they'd been
3 working on them since 2011. It's why we had such good
4 early access during the Covid pandemic.
5 Q. Thank you.
6 In relation to this action 4, if we look to the
7 document on the right-hand side, please, which if we go
8 to page 2, fortuitously is set out in the same order,
9 and we highlight number 4, we can see that the answer to
10 this question was that the procedure was developed and
11 used during the management of the imported case in
12 August of 2018 -- that's the imported case of MERS,
13 isn't it? -- and that:
14 "Laboratory procedures for scaling up capacity have
15 been well rehearsed across a range of outbreaks."
16 Can you explain what range of outbreaks that
17 capacity would have been rehearsed in relation to?
18 A. So if you have a new infection, it would be PHE's role
19 to create the assay, the diagnostic test, and be able to
20 scale that, and initially you would usually go out to
21 Public Health England laboratories, then out to NHS
22 laboratories, depending on the risk associated with the
23 pathogen itself.
24 So, I mean, when -- once you have an assay for
25 something, it's -- I mean, I'm not an expert in serology

1 assays, that's why we have them. Once you have them,
2 there's a -- you've usually got your skill there,
3 although you do need to ensure that they are -- remain
4 quality assured.
5 So in terms of rehearsed across a range of
6 outbreaks, I'm trying to think what else would have
7 happened in that intervening period.
8 So I can't offhand think what happened between 2015
9 and August 2018 save to say that obviously this is
10 an example that it had been rolled out and was
11 available.
12 Q. Right. All right, thank you.
13 Can we go to action 5, please, which is on the
14 following page of the report, on the left-hand side.
15 Thank you.
16 Now, this is an action to:
17 "Produce a briefing paper on the South Korea
18 outbreak with details on the cases and response and [to]
19 consider the direct application to the UK including port
20 of entry screening."
21 In relation to this point, can we now go to the
22 freedom of information request and have a look at
23 whether or not this was an action that had been taken up
24 by the time that this response was provided.
25 The response is that:

1 "... port of entry screening has been found to be of
2 minimal use across a number of outbreaks and has been
3 widely studied. The details of individual cases have
4 not been released apart from the index case. The
5 protocols developed following Exercise Alice were tested
6 in the response to the importation of a case in 2018
7 which was successfully managed."
8 But in terms of whether or not the briefing paper
9 was ever prepared on the South Korea outbreak with the
10 intention of taking on board the manner in which
11 South Korea reacted to their outbreak of MERS and
12 attempting to learn for the United Kingdom, do you know,
13 Dame Jenny, whether or not that briefing paper was ever
14 prepared?
15 A. So I think what I'm reading here is -- and I wasn't at
16 Exercise Alice myself, but what I understand has
17 happened is that the lessons that were learned from it,
18 in terms of the importation of this case and the
19 learning from South Korea, was moved into what I would
20 call practical utilisation. So we may well come on to
21 the National Incident and Emergency Response Plan, the
22 NIERP, gets updated regularly, now on an annual basis,
23 proactively reviewed, and learning from this will get
24 fed into it. But I think importantly there will have
25 been discussion, and I think it was in our pack that we

1 sent in, around the clinical management of cases.
2 Q. Yes.
3 A. That actually went into the doctors' packs, for example,
4 for those people who were on call, it went out to the
5 NHS, so there was a clear pathway for managing cases.
6 So depending on whether you -- I think there are two
7 issues here: there's management of the case, and I think
8 we have submitted some evidence that PHE did that.
9 I think the port of entry screening evidence base, about
10 whether it works, is a separate issue, and I'm happy to
11 talk about that. Then, though, I think there are then
12 port health, which is a completely different issue, and
13 I'm very happy to talk about that as well.
14 Q. I was particularly interested in the management of
15 cases, but it's --
16 A. So there was -- I think we've submitted a document,
17 I think it was 2017, which went through the normal
18 review process in the EPRR delivery group that was
19 included in the pack. I think it was temporarily held
20 up, not from the doctors' packs but in order to make
21 sure that it aligned with the HCID pathway that was
22 under development. And that's now out on the website
23 for everybody to use.
24 Q. So once that was affirmed, then the guidance was given,
25 thank you.

1 Can we look at action 7, please, which is on the
2 following page of the report. Page 13, thank you.
3 To:
4 "Produce an options plan using extant evidence and
5 cost benefits for quarantine versus self-isolation for
6 a range of contact types including symptomatic,
7 asymptomatic and high risk groups."
8 Is it right that there was a lot of discussion
9 around the issue of restriction of movement of
10 symptomatic and asymptomatic patients and whether this
11 should be voluntary, that's self-isolation, or through
12 enforced isolation, which is quarantine?
13 **A.** Not just for this, but for Ebola as well.
14 **Q.** Right.
15 **A.** And I was personally involved with some -- many of the
16 Ebola discussions. So I would classify action
17 identified 7 as a wicked issue and one that we might
18 want to return to.
19 One of the problems with this is it's not something,
20 I think, that PHE can resolve independently, and I think
21 there is submitted with the statement a document
22 from 2019, after quite a long piece of work, about port
23 entry screening, and the two link together, because
24 obviously if somebody's coming in you need to grab them
25 when they come in if you're going to do this.

1 These are very, very difficult decisions for
2 individuals to make. The law needs to support them, and
3 there are costs involved. And the evidence base is
4 often in a completely different direction to political
5 will, and so they're very difficult issues to deal with.
6 So I think PHE, as far as I understand it, had done
7 quite a lot of work on port health. This was one of the
8 areas that they had identified that they needed support
9 from the lead department. It requires buy-in from the
10 Department for Transport, Border Force, almost
11 everybody, and I think it hasn't progressed beyond that.
12 **Q.** This issue in particular has a number of possible
13 options, doesn't it? I think in South Korea there was
14 the use of hotels, but then there is also the option of
15 using specific locations as sites for quarantine, and
16 also the legal rights of the restriction of movement of
17 people, and all of that is brought to bear, isn't it,
18 during this discussion? So it's not a simple matter by
19 any means?
20 **A.** It's not at all, although we -- you know, the country
21 has used a managed quarantine service during Covid, but
22 many of those difficult issues have surfaced through
23 that utilisation.
24 **Q.** Thank you.
25 If we just look, please, over to the other document

1 and see what response was given by PHE, it says:
2 "This background research has been used to develop
3 the current guidance. Any decisions about making this
4 enforceable were outside the remit of PHE."
5 Which is --
6 **A.** Which is more or less what I'm saying, and it does link
7 very closely with the port health discussion.
8 **Q.** Thank you.
9 Actions 8 and 9 are to:
10 "Develop a plan for the process of community
11 sampling in a MERS-CoV outbreak ..."
12 And also to:
13 "Develop a live tool or system to collect data from
14 MERS-CoV contacts ..."
15 If we look over to the FOI document, dealing with
16 8 first, we can see:
17 "Develop a plan for the process of community
18 sampling."
19 PHE confirm that "guidance has been produced and is
20 available at", the following place, and:
21 "Sample processing will take place in the routine
22 manner, adjusted for scale. As part of any incident
23 response, this scale will be determined and then
24 appropriately resourced in conjunction with other
25 responding agencies."

1 And that:
2 "This is also contained in the first few hundred
3 (FF100) Enhanced Case and Contact Protocol which is also
4 available at the above link."
5 Then we see the answer to number 9, to develop
6 a live tool or system, is that:
7 "... There are a range of systems that were employed
8 by PHE and continue to be employed by UKHSA for
9 gathering data from contacts across a range of outbreaks
10 and are chosen based on the scale of the outbreak. They
11 are causative organism agnostic to avoid duplication or
12 processes."
13 Can you explain to us, please, what causative
14 organism agnostic means?
15 **A.** I was going to say, both of those are quite Mr Humphrey.
16 So basically what it's saying is there are ways of
17 collecting data depending on the sides of the outbreak
18 and the type that it is, and you do need to fit it to
19 that. For example, in fact, if it was not this organism
20 but a food-borne one, for example, we might be working
21 and looking at local authority systems and environmental
22 health officers.
23 So I think there are two issues in both of those
24 examples. One is, my other wicked issue for the Inquiry
25 would actually be community sampling. So UKHSA has

1 actually put in a sort of mini rapid response team to
2 enable that in some cases, but it is not mass testing.
3 So I think this move from large-scale contact tracing or
4 large-scale community testing to mass testing is one
5 that is not resolved.
6 There are -- I think our data systems are much
7 better, but actually it requires infrastructure as well,
8 and we're still continuing to try and build the systems
9 that we had, which were excellent towards the latter
10 phases of the Covid pandemic, but still need both
11 infrastructure support, if you like, and operational
12 utilisation.
13 **Q.** Right, thank you.
14 We can put those documents off the screen now.
15 Do you agree, Dame Jenny, using what we've just
16 looked at as examples, that Exercise Alice presented us
17 with the opportunity of conducting important research
18 which should feed into emergency plans not only for
19 a future MERS CoV outbreak but also any other type of
20 emerging infectious disease?
21 **A.** Yeah, I think actually I looked at these with interest
22 because I worked directly on the airport screening for
23 Ebola, and a number of these discussions and problems
24 arose, and then we had this. But at the time that
25 Exercise Alice happened, we were developing proactively

1 the HCID pathway --
2 **Q.** Already?
3 **A.** Yes. So I think to some extent, whereas you might think
4 this would be a stop point to say, "Let's do something",
5 in fact a lot of the activity was already happening.
6 What we do now in UKHSA is if we have an outbreak we
7 immediately put in a research programme at the start
8 that says: what are the questions we're finding that we
9 don't know the answer to? So that we try and kick that
10 off immediately so it supports, you know, outbreak
11 management later.
12 **Q.** Yes. It's fair to say, though, that looking at
13 Exercise Alice and some of the actions or lessons
14 learned that were highlighted, and from the evidence
15 that you've given and what we've seen from the freedom
16 of information request, that some of the actions were
17 implemented by Public Health England even though that
18 was not the commissioning organisation for the exercise.
19 Why would that be? Would Public Health England have
20 taken on actions that were ordinarily outwith their own
21 work areas?
22 **A.** They will always try and do the right thing, and that's
23 often not recognised. So this is a great opportunity to
24 do so. And I tell staff to run towards things if it's
25 important for health protection. But those two issues

1 around port health -- and I think we can see that in the
2 work frame there -- were there from Ebola, and community
3 sampling is a long-standing issue, so those are two
4 issues which I think the organisation has felt unable to
5 resolve on its own, and it needs wider than DHSC.
6 That's also my point.
7 **Q.** Thank you.
8 There was an exercise that took place in 2016 called
9 Exercise Northern Light. I don't want to go to the
10 details with you, but just to say that one of the
11 matters identified during the course of the exercise was
12 that current arrangements with supporting surge centres
13 and partner organisations would benefit from future
14 development in preparation for multiple HCID cases; and
15 I just raise that because I'd like to move on to
16 Exercise Cygnus which took place in October of 2016.
17 Again I don't want to go to the documentation, but
18 simply to confirm that one of the lessons identified in
19 Operation Cygnus was that an effective response to
20 pandemic influenza -- because that was the subject
21 matter of this exercise -- requires the capability and
22 capacity to surge resources into key areas which in some
23 areas were lacking.
24 Then Exercise Broad Street in January of 2018, which
25 had as its subject matter an HCID outbreak, also touched

1 upon the need for surge capacity.
2 Do you accept, Dame Jenny, that by the time we
3 reached the outbreak of Covid-19 in January of 2020,
4 that there had been lessons identified, warnings given,
5 however you want to describe it, that come a pandemic,
6 whether it be influenza or another type of disease,
7 there needed to be within the health systems of the
8 United Kingdom public health and also general health the
9 capacity for a surge in terms of within hospitals,
10 within workforces, and within a capacity in order to try
11 and deal with a significant outbreak?
12 **A.** I do, but I think all of those three things are quite
13 different surge mechanisms, and I'm wildly trying to
14 remember -- it's a bit like variants for Covid -- which
15 one the Northern Lights exercise was, I think it was
16 Lassa fever and H7N9, which was to try and see if two
17 HCIDs, an airborne and a touch, could be handled at the
18 same time.
19 **Q.** Yes.
20 **A.** Which is -- as long as they're small case numbers, it's
21 a different type of surge. Whereas pan flu is obviously
22 a very large national one, and the Broad Street I think
23 was checking --
24 **Q.** Yes.
25 **A.** -- effectively the pathway that we were just putting in

1 on the HCID pathway. So -- and they're checking
2 different parts of the system. There's an NHS surge,
3 there's a whole population public health surge.
4 So I do broadly agree, but I think two of those
5 worked reasonably well. It's the Cygnus pan flu one
6 where the capacity obviously was stretched, and there
7 are mutual support arrangements. So each Public Health
8 England centre would support the other one, it would
9 divert calls or you could have whole regions working,
10 and the emergency response plan outlines that work and
11 allows resource to be flexed, and we can work across
12 with NHSE as well. But I think the pan flu one is the
13 one -- is more like the Covid that we've just
14 experienced, and says "Actually when really stressed the
15 resources are very, very low".
16 **Q.** Yes.
17 At paragraph 106 in your witness statement, you say
18 this, that:
19 "PHE had identified a gap in national strategy
20 across government focusing on infectious diseases since
21 the 2002 *Getting Ahead of the Curve* document, thus in
22 2018 it started work on an infectious diseases strategy
23 which was published in autumn 2019 through a joint
24 launch with the Chief Medical Officer."
25 You go on to say:

1 "This identified ten strategic priorities including
2 infectious disease surveillance, whole genome
3 sequencing, major emergency response, and health
4 inequalities."
5 For how long had that gap existed?
6 **A.** So I don't think it was a gap in action, it's a gap in
7 focus.
8 **Q.** Right.
9 **A.** So the initial Liam Donaldson document from 2002,
10 *Getting Ahead of the Curve*, was a CMO document setting
11 out a strategic direction and actually forecasting
12 almost the creation of the Health Protection Agency.
13 This one was actually very much more about -- it was
14 actually an internal strategy. It wasn't so much
15 a national one, but it had very wide consultation, and
16 it was designed to put some focus and also recognise
17 that there were new developing techniques. So the whole
18 genome sequencing activity is moving us into
19 a completely different realm of health protection with
20 new opportunities in how we manage outbreaks and get on
21 top of them more quickly.
22 So I wouldn't like it to be thought that the --
23 those streams of work were not ongoing and, in fact,
24 you know, we're just about to publish our own UKHSA
25 strategy for the next three years and the topics will be

1 pretty familiar because that's what we need to focus on.
2 So I would not read an absence into that, I would
3 just say it was far more of, after an internal
4 reorganisation, getting a focus on the topics that were
5 already being worked on.
6 **Q.** So is it possible to say whether that gap in infectious
7 disease strategy had any impact on the UK's preparedness
8 for a pandemic?
9 **A.** I don't -- I mean, apart from the general capacity
10 issues and the financial background, I don't think it
11 did, and in fact what you can see during that time is,
12 for example, the way that we started diagnosing and
13 treating TB -- which is done at the Birmingham PHE, now
14 UKHSA, laboratory using whole genome sequencing --
15 actually progressed very rapidly and moved from around
16 a month in detection to coming to a week, and knowing
17 whether you had a multidrug-resistant TB case. So these
18 were actually advances, not going backwards, so I don't
19 think I would accept that.
20 **Q.** Before we leave this subject, I just want to ask you: to
21 what extent did PHE seek learning from other countries
22 that dealt first-hand with outbreaks including SARS and
23 MERS?
24 **A.** So that happens at a number of levels. It works -- it
25 used to work, we continue to work with DHSC who have the

1 prime relationship with WHO, for example, but actually
2 the previous health protection and medical director
3 Sir Paul Cosford was on whatever the board level was for
4 European Centre for Disease ... Control and contributed
5 to that regularly. There are individual groups across,
6 we have experts supporting -- in fact in many ways
7 leading -- WHO laboratory -- reference laboratories.
8 So there's a lot of different individual
9 professional levels. And again, I know it's a recurrent
10 theme, but I think people are unfamiliar with the level
11 of interconnectivity on an international basis, both on
12 an individual level and organisational.
13 I mean, I might say as well that PHE was part of
14 IANPHI, which is the institute -- association of
15 national public health -- International Association of
16 National Public Health Institutes, yet another acronym,
17 and would regularly exchange information, and that
18 happened through Covid and continues to.
19 **Q.** Thank you.
20 I'd like to ask you now about the Public Health
21 England emergency planning documents, and two in
22 particular, the ConOps document and also the NIERP, did
23 you call it?
24 **A.** I call it the NIERP, it's the national planning
25 document.

1 **Q.** Yes, all right.
2 So the ConOps document, was this updated after 2013?
3 **A.** It's updated regularly and annually and it had a very
4 big update, I think it was after Ebola, it was around
5 2016/17.
6 **Q.** Right, okay, and this is the document that details PHE's
7 response to incidents. Yes. And is it intended to be
8 used alongside the NIERP and also deal with threat
9 specific plans?
10 **A.** So it's progressed. So it started life well before
11 I was involved within it but, as I say, it's almost come
12 together as a single plan, so an operating process in
13 the background framework, and is, yes, is agnostic to
14 the threat. But the people who might be involved in it
15 will be decided by the nature of the threat.
16 So, for example, it would manage a business
17 continuity issue. When all the steam valves go
18 supporting one of the laboratories, it's more likely to
19 be somebody on the corporate management side, a senior
20 leader; whereas if it was a high-consequence infectious
21 disease, the strategic response director would almost
22 certainly be a medical professional.
23 **Q.** All right, thank you.
24 I would like to look at the pandemic influenza
25 response plan 2014, please, and we can see this at

1 INQ000178938. In fact, these are the minutes of a board
2 meeting of the Pandemic Influenza Co-ordination Group of
3 July 2019, and we can see that if we move down the page,
4 please, and move to page 2 and look at the first
5 paragraph, we can see that there has been prepared
6 a paper on outline specific functions:
7 "... as this is a draft, the divisions listed in the
8 document are in no particular order. GD thanked those
9 who have already contributed; GD still waiting for a few
10 more sections of PHE to contribute."
11 Then this:
12 "Noted that the challenge is that some PHE
13 structures have changed significantly since the last PHE
14 pandemic flu plan was published so we have to reorganise
15 the document in that respect (eg NIS was formed since
16 the last plan was published)."
17 All right, just pausing there, please, do you know,
18 Dame Jenny, whether or not the pandemic influenza
19 response plan was updated post-2014 in order to reflect
20 the fact that there had been a change in PHE structures?
21 **A.** I think it wasn't, because the plan was -- and I think
22 you may have heard earlier -- that Department of Health
23 were due to upgrade their plan and therefore the idea is
24 that these cascade and follow and link with each other.
25 That said, the national infection service was formed of

1 recognised groupings within PHE, professional groupings.
2 So I think it wouldn't be that the plan would be
3 inoperable, and in actual fact the way that the NIERP --
4 if you'll excuse the acronyms -- works is that you have
5 that as the backbone of emergency responses and then
6 your plan runs alongside it. So the operational
7 response would still have happened, but you are right,
8 there wasn't a follow-up plan from this. We were --
9 I think PHE was waiting for the DHSC one to come
10 through.
11 **Q.** Right, so no update between 2014 and the outbreak of the
12 pandemic in January 2020?
13 **A.** Yes.
14 **MS BLACKWELL:** I'm being told that our brave stenographer
15 would like a break in about five minutes.
16 **LADY HALLETT:** How much longer have we got to go?
17 **MS BLACKWELL:** I've probably got about 15 minutes left, so
18 ...
19 **LADY HALLETT:** Right.
20 **MS BLACKWELL:** Then I think there's about five minutes of
21 questioning from another of the CPs, so --
22 **LADY HALLETT:** Let's break now.
23 **MS BLACKWELL:** -- it's convenient to do so. Thank you.
24 **LADY HALLETT:** Five minutes.
25 **(4.26 pm)**

1 **(A short break)**
2 **(4.31 pm)**
3 **MS BLACKWELL:** Thank you, my Lady.
4 So we'd established, Dame Jenny, that in relation to
5 the pandemic influenza response plan of 2014 it was not
6 subsequently updated between its implementation and the
7 pandemic hitting to update in terms of a change in
8 organisational structures.
9 Could we go to page 67 of the plan, please --
10 thank you -- the first paragraph, which states:
11 "During a pandemic NSC(THRC) will co-ordinate
12 central government activities, make key strategic
13 decisions such as the countermeasures required and
14 determine UK priorities."
15 Do you agree, Dame Jenny, that that appears to be
16 a misunderstanding of that body's role, that in fact the
17 NSC(THRC) was a body that enabled ministers to spot
18 major emerging diseases and understand the risks and
19 receive expert advice on response and mitigation?
20 **A.** I read it as a co-ordination role. I realise that's not
21 exactly -- it does say "co-ordinate", it's not exactly
22 what it says. How I read that and in fact what happens
23 in practice --
24 **Q.** Yes.
25 **A.** -- is that CCS will ensure that everybody is in the

1 right place and obviously all the ministerial decisions
2 finally get agreed at COBR --
3 **Q.** All right.
4 **A.** -- for something like this. So, you know, I cannot
5 foresee that we would have a pandemic without some COBR
6 decision-making.
7 **Q.** No, but this sentence, as I've just read it out, and the
8 description that it provides about the practical level
9 at which this group would be involved in a pandemic is
10 misleading, isn't it?
11 **A.** I think it could be phrased better, let's put it that
12 way.
13 **Q.** All right.
14 **A.** I mean, it pre-dates -- well, no, it must have been
15 started when I joined, around the time that I joined
16 PHE, and I wouldn't necessarily have personally been
17 responsible; and sometimes you do look back at documents
18 and you think that was not entirely well articulated.
19 So I think it could be better articulated.
20 I think people will have -- those people involved in
21 the response will have known where the wheels were
22 turning and in fact will have been invited, for
23 something like this, to contribute either directly to
24 COBR or through CMO.
25 **Q.** But the benefit of a document like this being

1 accurate -- not only in terms of its description of the
2 health bodies but also of the role of a CCS,
3 Cabinet Office body like this -- is that whoever reads
4 the document is clear about roles and responsibilities
5 and this, in the two aspects that we've just looked at,
6 could have been clearer and on one level could be
7 described as misleading?
8 **A.** I think I would agree with you. I mean, there are two
9 things I would say: one is I notice the date is 2014,
10 and I now have the same problem at UKHSA, every time
11 an organisation changes you're having to go back and
12 work through documents to try and make them work with
13 the ones before. And it's not just your own
14 organisation, it's the other pieces of the machinery
15 that have changed at the same time, and they're
16 sometimes changing as you're trying to update your
17 document. So I agree with you. I am less concerned in
18 practice that that sentence would have affected how
19 individuals responded. They would have worked to the
20 NIERP and the systems in place.
21 **Q.** Because, as you may or may not be aware, the NSC(THRC)
22 was retired in 2018 and became completely disbanded by
23 2019. So in fact, as we get towards the time that the
24 pandemic hit, that organisation was no longer in
25 existence.

1 **A.** I agree with you, I think it's unhelpful. We're
2 probably -- I should suspect PHE is not the only
3 organisation with outdated documents and it's why, for
4 things like the NIERP particularly -- which is the
5 backbone of response, and I think you can see that
6 through the evidence that's there -- it is proactively
7 updated after each incident.
8 **Q.** I want to move away from this document now -- we can
9 take that down, please, thank you -- and just ask you
10 about a plan, a UKHSA plan for MERS. Is there one in
11 force other than a draft interim response plan that was
12 created some time ago? Do you know whether there's
13 a final plan in force?
14 **A.** There is guidance and it would be handled along an HCID
15 pathway, so effectively the practical application is
16 there.
17 **Q.** How is it viewed in terms of the level of concern that
18 MERS poses?
19 **A.** So MERS is on the HCID list. So, I mean, in practice,
20 what that means is if we have ten cases of something
21 else, we say: is this a cluster? Does it look unusual?
22 If there's one case of MERS, somebody's on the phone to
23 me immediately and the CMO knows and the HCID pathway
24 goes in and the HCID network is activated. So -- and we
25 have seen that happen. We've had a Lassa fever case

1 recently, we've had MERS.
2 So I'm very confident -- I mean, you can't -- you
3 will never secure 100% confidence, but it has been
4 rehearsed, and the 2018 example of that is that that
5 case was managed well.
6 **Q.** All right, thank you.
7 In terms of planning for an HCID or Disease X
8 pandemic, Professor Oliver in her witness statement to
9 us has confirmed that Public Health England was not
10 involved in any programmes of work related to specific
11 planning for a pandemic caused by any pathogen other
12 than influenza -- and indeed that accords with other
13 evidence that the Inquiry has received -- or indeed any
14 pathogen agnostic planning.
15 **A.** Yes. Can I be invited to continue?
16 **Q.** Yes, please do.
17 **A.** So, yes, strictly to -- you said, that's my
18 understanding. But it does go back a little bit to
19 trying to fit what we have -- the way I see what we
20 have, from a clinical perspective -- and I think in many
21 ways probably reflecting what Sir Patrick and
22 Sir Chris Whitty said -- is that we have a respiratory
23 virus plan, currently, I think, because the national
24 strategic risk assessment says you have to use
25 an example, and that is geared to flu, and then we have

1 an HCID pathway which is smaller but has very high
2 protection. And I'm probably pre-empting some further
3 questions.
4 My view is that the flu plan is actually a pretty
5 good one. I turned round and thought I'd ask the
6 question the other way round: if I was going to choose
7 an example, because that's what the risk assessment says
8 I must do, what other example of a respiratory virus
9 with pandemic potential would I use? And there
10 wouldn't -- I would still use flu because that's the
11 history to date. But what it doesn't have is what
12 I would call a sensitivity analysis. It doesn't do the
13 bits that says: well, what if this flu virus had
14 a longer incubation period or this flu virus transmitted
15 asymptomatically for 50% of cases?
16 So the actual sort of structures of the pathways,
17 whether it's a new virus or not, feel okay to me, but
18 that's the bit that's missing at a national level and
19 that would have got us to a consideration of, you know,
20 what's -- what is -- had we planned for more
21 asymptomatic transmission or a containment phase, as the
22 Hine report suggested.
23 **Q.** Yes, but also doesn't it have an effect on decisions in
24 terms of pandemic stockpiles and clinical
25 countermeasures?

1 **A.** Yes.
2 **Q.** Because there was only a pandemic influenza plan, the
3 planning, the practical planning for pandemic stockpiles
4 and clinical countermeasures followed that plan and so
5 in terms of antivirals they were entirely suitable for
6 an influenza pandemic but, as it happened, not for the
7 pandemic that hit us?
8 **A.** To an extent, yes, but, I mean, if we did a sensitivity
9 analysis that said, "We're going to have a new virus
10 that's got 100% asymptomatic transmission, we'll only
11 know if we go into it", we'd all be walking around in
12 PPE every day of our lives. So there is a limit to what
13 that stockpile might ever do, and it's not
14 an unreasonable assumption to put it somewhere around
15 the boundaries that I think it was. But I do think
16 this, however you call it -- as I say, I call it
17 a sensitivity analysis -- we didn't think -- it should
18 have been flexed to potential characteristics of the
19 virus. The underlying plan is fine, but that isn't
20 of course -- this is the problem, that's not what the
21 NSRA, I think, allows PHE or the Department of Health to
22 do. It gets very specific on -- it wants to know how
23 many cases, and we have the same thing with Covid where
24 I will be asked, you know, what is your trigger point?
25 But if you have a virus that is behaving -- is a new

1 virus or you don't know how it's going to behave,
2 specifying a trigger point is not the right thing to do;
3 you need to leave your mind open to what it might do.
4 **Q.** What are PHE's responsibilities in terms of stockpiling
5 clinical countermeasures and PPE?
6 **A.** So -- what were they?
7 **Q.** Yes, of course.
8 **A.** Sorry, because I'm sort of jumping between organisations
9 and actually I wasn't responsible personally for PHE.
10 **Q.** No, of course. And, sorry, just to remind ourselves
11 that we are dealing with the period of time running up
12 to --
13 **A.** Exactly.
14 **Q.** -- the pandemic, so that's why I'd counted the question
15 in terms of --
16 **A.** Yes, exactly.
17 **Q.** -- PHE.
18 **A.** So PHE had a VCR team, it was a vaccine and
19 countermeasures response team --
20 **Q.** Yes.
21 **A.** -- which was not there to set the parameters of the
22 stockpile, it was there to do the procurement and manage
23 the processing of it and make sure it was stored
24 effectively and that it turned over effectively. And
25 it's quite a complex procurement and management system

1 which -- I realise you have a very, very long chapter on
2 that, but important because there is another part in
3 Department of Health which links with it, and the actual
4 parameters of the stockpile are set through the
5 Department of Health and with input from groups such as
6 NERVTAG.
7 **Q.** All right.
8 I have two topics left. One is the health of the
9 population prior to Covid-19 and the extent to which
10 pre-existing inequalities and vulnerabilities were
11 considered and accounted for in pandemic planning and
12 preparations.
13 Was it part of PHE's functions to assess the
14 nation's health from time to time and also to seek to
15 improve it?
16 **A.** Yes.
17 **Q.** Right, and what assessment would you give to the Inquiry
18 about the state of the nation's health in the months
19 running up to the Covid pandemic hitting?
20 **A.** I've read Sir Michael Marmot's report and I would agree
21 with the broad headline. I'll put some caveats. The
22 principle, which I think many people have established
23 and we know, is that infectious disease will follow
24 those areas of vulnerability, and that's -- and I don't
25 just mean clinical vulnerability, although that is

1 important separately. It will be the vulnerability,
2 combined vulnerability of socio-economic deprivation and
3 things like housing and, you know, whether people have
4 got good jobs. These are all protective measures for
5 good health outcomes.
6 So I broadly agree. I -- and he says himself --
7 I don't agree necessarily that the causative element,
8 the link between the timeframe for austerity and the
9 burden of disease in the population, it's very difficult
10 to draw that conclusion directly. It's possible, but
11 even he acknowledges that.
12 **Q.** Right, okay. So as a principle?
13 **A.** But as a principle, people who are in the more deprived
14 areas will suffer from -- they're more adversely
15 affected by infectious diseases but also by underlying
16 health conditions as well, which combined then creates
17 a major problem.
18 **Q.** Right. Although you question the timescale, do you
19 accept what Professors Marmot and Bambra said about the
20 decline in the ten years running up to the Covid
21 pandemic?
22 **A.** I think what I'm saying is the object of evidence of
23 decline you can measure, health and socio-economic
24 deprivation and burden of disease. The bit that's not
25 so easy to do is draw the direct link. They were making

1 a link directly between austerity and (inaudible) --
2 **Q.** Yes. No, no.
3 **A.** -- and some people will and others won't, and I'm just
4 saying it's difficult to draw that. But definitely the
5 shape of the curve, if you like --
6 **Q.** Yes.
7 **A.** -- is clear, it's evidential.
8 **Q.** Over the ten years leading up to the pandemic?
9 **A.** Yes.
10 **Q.** Thank you.
11 May we put up on the screen, please, the report from
12 the Institute of Government which is entitled "How fit
13 were public services for the coronavirus?" Thank you
14 very much. If we go immediately, please, to page 11,
15 I would just like to look with you, please, Dame Jenny,
16 at the chart at the top of the page.
17 This is a piece of work that has been prepared by
18 the institute and they have through various pieces of
19 evidence received, sought to draw conclusions in
20 relation to how prepared and resilient public services
21 were at the start of the crisis, providing red for
22 a level of organisational preparedness that was below
23 par or failed, amber for something that was acceptable,
24 and green for good.
25 We can see that on the left-hand side the categories

1 are split into "Preparedness" and "Resilience", and each
2 of those into "Quality of plans", "Ability to implement
3 plans", "Performance going into the crisis", "Staff",
4 "Buildings" and "Equipment".
5 Then along the horizontal axis and in the columns
6 coming down from the top, we see "The NHS": "Hospitals"
7 and "General practice"; "Local government": "Local
8 emergency support services", "Adult social care",
9 "Children's social care"; "Education": "Schools". And
10 then "The criminal justice system", on the right-hand
11 side, separated into "Police", "Criminal courts" and
12 "Prisons".
13 The resilience of hospitals wasn't good, but if we
14 look further to the middle of the graph we can see that,
15 both in relation to preparedness and resilience, adult
16 social care appears to have failed.
17 Are those concerns reflected in your experience of
18 these organisations running up to the time that the
19 pandemic hit?
20 **A.** I think I will have to refrain from comment, I'm
21 a scientist, this looks completely subjective and I have
22 absolutely no idea on how the ratings have been derived.
23 I mean, I can make a few comments, but just looking
24 at it, for example, hospitals, ability to implement
25 plans if you have no staff, or we've said that the EPRR

1 arrangements are low, feels a slightly strange
2 conclusion.
3 I think in adult social care as well. I mean, it is
4 one of the big problems for social care -- and I might
5 add I have personal family experience of this and used
6 to support commissioning in local authorities -- so
7 I think, notwithstanding what's on there, I would agree
8 that social care was a high-risk area and one of the
9 difficulties -- and this goes to buildings and equipment
10 and what have you -- is it is a largely privately
11 provided service, so the difficulties of ensuring that
12 there are plans that are fit or that people who are
13 running those services, their responsibility at the
14 start of the pandemic to understand infection control
15 and have PPE ready for their staff is really
16 challenging, and I think that has come out through the
17 pandemic.
18 What I do know is they are an extremely vulnerable
19 group of individuals and I think, you know, recognise --
20 and I personally always see this as a continuum for
21 medical care, you can't just exclude one side of it.
22 But I would -- I'm afraid would have to refrain from
23 comment on the rest, because it's not very evidential.
24 **Q.** Well, I had understood that you'd been provided with the
25 report provided by the Institute of Government prior to

1 today, and you would have understood that the findings
2 are based on extensive desk research, analysis of
3 government data, interviews with civil servants,
4 frontline staff, representative bodies and other
5 experts.
6 **A.** But it still has a subjective element to it. I mean,
7 things that I could comment on: for example, prisons
8 actually in the first wave of the pandemic had excellent
9 outcomes, and in fact PHE is a WHO collaborating centre
10 for prison health, and you can see a marked contrast
11 between the outcomes there in the first wave and the US.
12 But, you know, I still think by the time you put those
13 together somebody has to knit them. So I agree with you
14 in the overarching. The red column in the middle
15 absolutely stands out and I would agree with it.
16 **Q.** Thank you.
17 Finally I want to give you the opportunity,
18 Dame Jenny, to provide us with your experience and
19 knowledge in terms of what we have been through, your
20 evidence today, but also any aspects that we haven't
21 touched upon and allow you to assist the Chair in terms
22 of any recommendations that she may want to consider in
23 terms of lessons learned.
24 I know that in particular you were impressed with
25 evidence that has been given to the Inquiry about the

1 possibility of recommending the appointment of
2 a resilience minister.
3 **A.** Yes, thank you. It wasn't an idea that I thought
4 I would warm to when somebody first suggested it, but
5 actually when I look back through my experience and when
6 you look at what I'm calling the wicked issues, one of
7 the difficulties is that these -- for example,
8 infrastructure for maintaining very high containment
9 level laboratories, or social care agenda -- cannot be
10 tackled even by a very willing -- and I might add
11 Department of Health have worked very hard with us --
12 individual department. It needs somebody, and you see
13 it happening in incident response, which is why
14 Sir Oliver Letwin's contribution was very interesting.
15 I don't say that with a political slant at all. It was
16 very evident that he understood what happened and how
17 you needed to make things work.
18 So I tend to agree. I would add a note of caution,
19 which is: just like the rest of the system, churn in the
20 system is a major problem, we lose understanding, we
21 lose connections, and I've had four different ministers
22 in the Department of Health, and you can start to see
23 the difference of people who understand the problems and
24 then clearly it turns to other things, which we --
25 you know, is inevitable.

1 So I think that minister almost needs to stay with
2 it for the whole of the Parliamentary session, almost,
3 for it to maintain the infrastructure for the country.
4 The second point I would make is to do with the
5 science. Again, Sir Patrick Vallance said this, but
6 I think we are -- and I think David Heymann said it,
7 we're missing what the opportunities are. This all
8 sounds very depressing and where everything may or may
9 not have gone wrong, but for UKHSA, one of the positive
10 things about having a science -- more science-focused
11 organisation is to work upstream. So in contrast to
12 perhaps where we have been, it's allowing me to put in
13 more systematic horizon scanning and surveillance, we're
14 already starting to work with industry and we've taken
15 in -- so somebody I think mentioned: where has the
16 vaccine taskforce gone? The answer is: I've got it and
17 I'm working with it upfront, because we have the
18 opportunity with new vaccine products, new diagnostic
19 tests, to actually do one was things which was missing
20 here, which was put equal focus on prevention for the
21 next pandemic. And we have new tools.
22 **MS BLACKWELL:** Thank you.
23 My Lady, that completes my questions. I know that
24 provisional permission has been given to
25 Ms Claire Mitchell King's Counsel on behalf of the

1 Scottish Covid Bereaved to ask a question, I think one
2 or two questions on the topic of Dame Jenny Harries'
3 role as DCMO for England, and may she do that now?
4 **LADY HALLETT:** Of course.
5 Ms Mitchell.
6 **Questions from MS MITCHELL KC**
7 **MS MITCHELL:** I'm obliged.
8 Dame Jenny, we have heard that you were Deputy Chief
9 Medical Officer for England 2019 to 2021, and in your
10 evidence today you've spoken about connections between
11 governments and organisations and also the
12 interconnectivity and the benefits of interconnectivity.
13 I'd like to ask you, please, about the connections
14 between individuals in the roles of the four nations,
15 and particularly your role when you were Deputy Chief
16 Medical Officer.
17 During your time as Deputy Chief Medical Officer,
18 did you have meetings or discussions with the other
19 Deputy Chief Medical Officers in their roles in the
20 four nations?
21 **A.** Yes.
22 **Q.** Can you tell me, was any of the work that was done in
23 those discussions and meetings related to pandemic
24 planning or pandemic preparedness?
25 **A.** So during the Covid pandemic, most of it is obviously --

1 I mean, we're moving on to the next phase, almost, so
2 I'm just looking for a signal as to how I should answer
3 this.
4 **LADY HALLETT:** No, we're asking about -- I think Ms Mitchell
5 is asking about what was the work done in collaboration
6 with the devolved administrations in relation to
7 planning and preparedness, not response.
8 **A.** In that case, I might decline slightly, because -- just
9 to explain, my -- although it may not appear that to the
10 nation, my Deputy -- there are usually two Deputy Chief
11 Medical Officers supporting the English CMO. One of
12 them did the health protection role, which was
13 Professor Jonathan Van-Tam, and the other one is the
14 health improvement role. So actually when I joined the
15 department it was to support work on tobacco control,
16 obesity, physical exercise and that sort of agenda. So
17 I would not have expected to be involved in the planning
18 for pandemics. It would be more with the health
19 protection DCMO.
20 **MS MITCHELL:** I see, but one of your colleagues would be the
21 person that we posed that question to then?
22 **A.** Yes.
23 **MS MITCHELL:** I'm obliged.
24 **LADY HALLETT:** Thank you very much, Ms Mitchell.
25 Thank you very much, Dame Jenny, I think that

1 concludes the questions -- thank you very much to our
2 stenographer for keeping going -- I'm very grateful to
3 you for all your help and for your interesting thoughts.
4 **THE WITNESS:** Thank you.
5 **(The witness withdrew)**
6 **LADY HALLETT:** Thank you, and 10 o'clock tomorrow morning,
7 please.
8 **MS BLACKWELL:** Thank you, my Lady.
9 **(5.00 pm)**
10 **(The hearing adjourned until 10 am**
11 **on Tuesday, 27 June 2023)**
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