

IN THE MATTER OF THE INQUIRIES ACT 2005
AND IN THE MATTER OF THE INQUIRY RULES 2006

UK COVID-19 INQUIRY

FIRST WITNESS STATEMENT OF MATT HANCOCK

I, Matt Hancock, Member of Parliament for West Suffolk, House of Commons, London SW1A 0AA, will say as follows:

1. There isn't a day that goes by that I do not think about all those who lost their lives to this awful disease or the loved ones they have left behind. My office in Parliament overlooks the National Memorial Covid Wall, I have visited the wall and been able to read about many of the families affected. I express my deepest sympathies to all those affected.
2. I express my heartfelt thanks to all those who rose to the enormous challenge of dealing with this unprecedented pandemic, in the NHS, social care, public health, civil service and much wider. The UK COVID-19 Public Inquiry ("the Inquiry") is a vital opportunity to learn from what happened, and to prepare better for the future. Although this Inquiry won't heal all the pain, I want to answer all questions to the best of my ability.
3. As the Secretary of State for Health and Social Care ("the Health Secretary") my motivation was to improve the health services in this country and to save lives. All of the evidence from the time, whether previously published or made available to the Inquiry, shows a team of people working incredibly hard, with limited information, in extremely difficult circumstances, to do their best to lead the country through an unprecedented crisis. Huge decisions had to be made very fast. A large amount of work by a very large number of people was done with diligence, due care and tireless effort against the background that any pandemic is by its nature a response to a novel disease. Throughout, I was guided by the best available science at the time.

4. I hope that the Inquiry, through careful, objective consideration of what happened, and also what did not happen, will ensure the right lessons can be learned so that we are better prepared for next time.
5. This first Statement is confined to analysis of preparation. In short, we discovered over the first three months of 2020 that the nation's preparations for a pandemic of this nature were not good enough. In many areas there are lessons to be learned to prepare for the next pandemic, both where things went wrong, and where the UK response was exemplary.
6. On coming into post as Health Secretary I was advised that the UK was a world leader in preparations for a pandemic (MH/1 - INQ000184101; MH/2 - INQ000184105). Whilst this may have been the heartfelt belief, it did not turn out to be the case when faced with what became known as COVID-19. Once we understood the threat from the disease, the lack of concrete preparedness plans became clear. It is of course impossible to prepare precisely for a novel disease, because by its nature it is new. There were areas where preparations were strong, for example with respect to draft emergency legislation, and where the nation's existing capacity was able to be turned to serve the pandemic response very quickly, for example our scientific capabilities, but there were other areas that had been overlooked, for example in relation to the ability to scale up testing.

INTRODUCTION

7. I make this statement in response to a request from the Inquiry dated 8 February 2023 made under Rule 9 of The Inquiry Rules 2006 ("the Request") asking for a witness statement in connection with Module 1 of the Inquiry.
8. I understand that while the Inquiry's Request identifies the period 11 June 2009 to 21 January 2020 as being the timeframe for Module 1, it specifically wishes to draw upon my experience as Paymaster General and Minister for the Cabinet Office between 11 May 2015 and 14 July 2016 and my time as Health Secretary between 9 July 2018 and 26 June 2021. I have therefore focused on my time in those two posts, within the period identified by the Inquiry as relevant to Module 1.
9. This statement is to the best of my knowledge and belief accurate and complete at the time of signing. The Department of Health and Social Care ("the Department") continues to prepare for its involvement in the Inquiry and should any additional material be

discovered I will of course ensure this additional material is provided to the Inquiry and I would be happy to make a supplementary statement if required.

10. With hindsight, there is much more that could have been done in respect of preparedness. Indeed, answering the question of what more can be done – for next time – is the central task of the Inquiry. While it is impossible to prepare perfectly for a pandemic, because by its nature a pandemic involves a novel disease, it is imperative that the UK is as well prepared as possible in future. I fear we have not yet learned the lessons of Covid, and have even begun to dismantle some of the defences that we built up in the pandemic.

PAYMASTER GENERAL AND MINISTER FOR THE CABINET OFFICE

11. I served as Paymaster General and Minister for the Cabinet Office from May 2015 to July 2016. In that role I had oversight of the National Security Risk Assessment (“NSRA”), which is the confidential assessment of risk to the UK, and the National Risk Register (“NRR”), which is its published summary. While I had a role in oversight of the NSRA and the NRR, the then Chancellor of the Duchy of Lancaster, Oliver Letwin, was the lead Minister for resilience within the Cabinet Office, as set out in a submission from the Civil Contingencies Secretariat dated 11 June 2015 (MH/3 - INQ000184144).
12. A new NRR had been published in March 2015, two months before I took on that role, and I had played no part in its authorship. The very first risk set out in the 2015 NRR is ‘Pandemic Influenza’ which it states was “...*the most significant civil emergency risk*” (MH/4 - INQ000184146). The document then sets out that a future pandemic may not follow the same risk as previous novel influenza, and also sets out the risk of ‘Emerging infectious diseases’ – i.e. non-flu pandemics – and states “*SARS and pandemic influenza contingency plans would provide the basis for dealing with any future outbreak of an emerging infectious disease.*”
13. As the Minister responsible for the NRR, I was therefore of course aware of a pandemic as a Category One risk to the UK. The NRR is clearly written with an influenza pandemic in mind as the top risk, but does acknowledge that other pandemics are possible. My role was to be vigilant to all risks on the NRR, and the underlying NSRA, and as such I was aware of, but not responsible for, preparations for pandemic response, alongside the many other risks as set out in the NRR.

14. To the extent that the Cabinet Office responded to the House of Commons Science and Technology Committee investigation into 'UK lessons from Ebola' during my time as Paymaster General and Minister for the Cabinet Office, for example see the draft response to the Committee's report dated 29 February 2016 (MH/5 - INQ000184143), Oliver Letwin would have led on this work as the lead Minister for resilience. For example, Jane Ellison, then Parliamentary Under Secretary of State for Public Health, wrote to Oliver Letwin in March 2016 (MH/6 - INQ000184145) seeking permission to publish to the Government's response.

SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE

15. I served as Health Secretary from July 2018 to June 2021 under two Prime Ministers, Theresa May and Boris Johnson. When I was initially appointed, as with previous Ministerial roles, I was given a series of 'day one' briefings by officials within the Department to alert me as to its ongoing work.

WAYS OF WORKING

16. My daily work was heavily diarised, and run by my Private Office. Before the pandemic, I would hold regular – usually weekly – meetings on the areas of responsibility I wanted to drive hardest. For example, in late 2019 I would have regular weekly meetings on:

- a. The NHS – with Simon Stevens on the managements of the NHS;
- b. Technology – improving health technology and use of data;
- c. People – improving the way the NHS recruits and rewards staff;
- d. Prevention – driving the agenda to prevent disease, not just react to it;
- e. Media – to consider communications, including public health communications;
- f. Ministers – to stay in regular contact with Ministerial colleagues; and
- g. Cabinet – chaired by the Prime Minister in No10.

17. I would also hold regular meetings on ad hoc topics, such as delivering on manifesto commitments, securing Departmental finances, hosting visiting dignitaries, making statements in Parliament and other speeches to drive forward progress, responding to questions in Parliament, undertaking media appearances, attending cross-Government meetings such as Cabinet Committees or COBR, delivering a myriad of specific projects, like access to Orkambi (a drug to help those with cystic fibrosis), or making visits across the UK and occasionally overseas to represent the Government and listen and learn.

18. In addition to meetings, many decisions were made through paperwork. The primary method of decision making throughout my period as Health Secretary – including in the pandemic – was the formal Departmental submission: a detailed note from the Civil Service, considering an issue from all angles, that would usually put forward options for decision. Cross-Government matters were largely dealt with through formal letters setting out a Department's position, to seek a cross-Government agreed position. Normally I would receive around twenty submissions or letters per day, typically in my evening red box (my 'box'). On top of each submission, Private Office would attach a one-page note which included:

- a. the date of submission;
- b. the deadline for response;
- c. a summary of issue and decisions needed, and any interaction with other relevant work;
- d. the view of the Junior Minister responsible for that area; and
- e. any views from Special Advisers.

19. I split my box into five files:

- a. Constituency matters relating to my role as MP for West Suffolk;
- b. urgent matters (I always completed this file overnight);
- c. routine submissions for decision (I usually completed this overnight);
- d. reading materials not for decision; and
- e. diary questions and invitations.

20. My box would typically take an hour to ninety minutes each day. In addition to this, I would talk to colleagues in person and on the phone, and use email and messages in a fairly limited way. Sometimes I would write on a submission itself and then photograph the submission with my notes and send to my private office when this was the most efficient way of sending back my views.

21. All major decisions were made and documented in the formal way through submissions within the Department and letters between Departments. This is the entirely standard way Government operates, and given the sheer scale of the number and size of decisions, in normal times it works well.

22. Discussions on WhatsApp are best thought of as like an informal discussion, like the conversation that happens around a formal meeting, rather than the meeting itself. Any significant decision was taken in a formal way, based on a submission, even if it had been preceded by a discussion or in principle decision on WhatsApp beforehand. Looking only at WhatsApp messages alone gives a highly partial and skewed account of what happened. Actual decision making was much more formal, whether on paper or in formal meetings.

ADVICE ON PREPAREDNESS

23. When I joined the Department, initial 'day one' high level briefings were provided to my Private Office on 11 July 2018 and included a briefing from the Permanent Secretary for the Department, Sir Chris Wormald, and summaries of workstreams from the Director General in the Department. Sir Chris' briefing identified that the Department was responsible for a number of the highest ranked risks on the National Risk Register, including an 'influenza pandemic' whilst the note from Clara Swinson (Director General of Global and Public Health) identified that (emphasis in the original):

*"10. **Pandemic flu** is the government's highest risk (on the Cabinet Office's national risk register). In any given year we estimate the likelihood of a pandemic to be 3%, based on 3 pandemics in the 20th century, and the impact of a 'reasonable worst case scenario' to be 750k deaths. We have contingency plans and a work programme to keep this up to date and supplement it. We can brief you further on the current threat and our work in response."*

24. Following the first-day briefings I requested further reading over the summer recess. I was sent a submission on 30 July 2018 from Clara Swinson that appended, amongst other things, a paper on 'Emergency Preparedness, Resilience and Response' (MH/2 - INQ000184105).

25. In respect of 'Emergency Preparedness' the paper provided an overview of the Civil Contingencies Act 2004 and, as relevant to Module 1, then explained that (emphasis in underline):

"10. [The Department] is responsible for three of the risks in the NRA [National Risk Assessment (sic)]:

- Pandemic Influenza*
- Emerging Infections Disease*
- A cyber related risk*

11. *There are specific programmes of work underway in [the Department] to plan for all of these risks including pandemic flu. Pandemic Influenza is considered as one of the most significant risks in the NRA due to the likelihood of a pandemic occurring and the impact it would have. **The UK is acknowledged as being amongst the global leaders in preparing for a pandemic.***
12. *Following a national-level exercise in 2016 and a subsequent National Security Council (Threats, Hazards, Resilience and Contingencies) meeting in February 2017, a cross-Government Pandemic Flu Readiness Board (PFRB) was established to develop and manage the UK's preparedness for a flu pandemic (of any strain). The first year of the programme include the following work streams:*
 - *Prioritising the pressure on hospitals*
 - *Response of the adult social care and community health care system*
 - *Coping with excess deaths (an additional 800,000 bodies)*
 - *Communicating legal, moral and ethical considerations*
 - *Keeping different sectors working with reduced staff numbers.”*

(Emphasis added)

26. I reviewed the 'Emergency Preparedness' note (and the other materials) over the summer recess and asked for further briefing on the suite of documents to my Private Office, which in turn provided them to the relevant officials on 22 August 2018. In respect of the preparedness briefing and the paragraphs quoted above, I felt like I needed more information about this topic and I asked for more detail from the 'National Risk Assessment'.

27. The lack of detail in the note notwithstanding, I was reassured by what I was told about the 'UK being amongst the global leaders in preparing for a pandemic'

28. By this time, the NRR had been updated to its 2017 edition (MH/7 – INQ000107099)¹ which was largely unchanged from the 2015 version with respect to pandemics. It identified the risk from 'human diseases' at pages 34-36 but again largely focussed on an influenza pandemic. The 2017 NRR recognised that:

“Emerging infection diseases could also cause large numbers of people to fall ill. These are diseases which have recently been recognised or where cases have increased over the last 20 years in a specific place or among a specific population (e.g. the Zika virus). The likelihood of an emerging infectious disease spreading within the UK is assessed to be lower than that of a flu pandemic.

...

Over the past 25 years more than 30 new (or newly recognised) emerging infectious diseases have been identified around the world, such as Ebola, Zika and Middle East

¹ The NRR was updated again in 2020, after the emergence of Covid-19

Respiratory Syndrome. The latter emerged recently in 2012 and poses a global health threat.”

29. As set out above, the NRR focussed on a flu pandemic. Beyond reflecting what is said in the NRR I am unable to assist the Inquiry in identifying precisely why so much focus was placed on a flu pandemic or why other countries' experience of SARS and MERS – both caused by coronaviruses – were not adequately reflected in the UK's preparedness plans. Neither do I know why the World Health Organisation (“WHO”) regarded the UK as one of the best prepared, if not the best prepared, countries in the world, but I regarded them as an authoritative source.
30. Furthermore, the NRR explicitly assumed that in the event of a pandemic large numbers of people would fall ill. It did not mention action that might be taken to prevent this from happening.
31. This mistake reflects the fundamental error at the heart of the 2011 UK Influenza Pandemic Preparedness Strategy: instead of a strategy for preventing a pandemic having a disastrous effect, it is a strategy for dealing with the disastrous effect of a pandemic.
32. When the disease threat first emerged I was repeatedly reassured by Public Health England (“PHE”) that “the risk to the UK population is assessed as very low”, and essentially that all was in hand and I was not to worry. I did worry and I chased for action. Even at the end of January 2020, PHE stated that the UK was “well prepared” and “diagnosing, handling and dealing with the case of finding and then the treatment and the specialist centres is all set up.” While true, this was wholly inadequate. Looking back now it seems to me that the health system was convinced it was well prepared, but as we discovered it was not.
33. When considering the Department's response in early 2020 it is important to remember that the UK monitors and responds to the threat of novel diseases, including High Consequence Infectious Diseases (“HCID”), on a regular, ‘business as usual’ basis. During my time as the Health Secretary prior to 2020 I was regularly informed of risks to the UK population from HCIDs, such as Ebola, Lassa fever, novel flu strains or Monkeypox (MH/8 - INQ000184142). To take one example, on 12 December 2019 my Private Office emailed me (MH/9 - INQ000184139; MH/10 - INQ000184141) an update note on Avian flu at a Suffolk poultry farm, providing another example of me being kept aware of risks to public health from communicable disease.

34. Updates provided to me as Health Secretary in respect of communicable diseases could take the form of email updates, notes from PHE or submissions from Departmental civil servants, such as one that was sent to me by my Private Office regarding Ebola in Tanzania and a strain of H3N2 influenza in China on a 'For information only' basis on 13 September 2019 (MH/11 - INQ000184124; MH/12 - INQ000184125; MH/13 - INQ000184126; MH/14 - INQ000184127). Updates on the risks from communicable diseases are matters that I would have expected to be routinely provided by Private Office in my red box. In some cases, departmental officials or Private Office might have been made aware of a case, but chosen not to notify me. For example, Emma Reed, Director for Emergency Preparedness and Health Protection, emailed Jenny Harries of PHE, copying Private Office and my Special Adviser Jamie Njoku-Goodwin. The email refers to it being 'great news' that a patient with MERS had been discharged from hospital. I do not recall seeing this email and it is likely that it was not escalated to me because the case was resolved (MH/15 - INQ000184111).
35. Prioritisation of what goes to the Secretary of State is vital for the running of any Department, but particularly important for the Department of Health and Social Care, due to its size, and was even more vital during the pandemic when my time was exceptionally tight. I think this system generally worked well.
36. I would also routinely be advised on a 'business as usual' basis of the threat from flu. During the summer this included monitoring the southern hemisphere flu season, particularly in Australia, in order to understand what the impacts on the UK might be each winter. This included being provided with a 'Weekly National Influenza Report' prepared by PHE (MH/16 - INQ000184137; MH/17 - INQ000184138). This report also refers to the risk from Middle East respiratory syndrome coronavirus (MERS) and therefore the update was not strictly confined to flu, but the purposes of the note was to consider the risk to the NHS, so flu was the main focus.
37. It is perhaps also worthy of noting that I was provided with the Week 50 report, and the update on Avian flu at the Suffolk Poultry Farm, by email by my Private Office on 12 December 2019; this was the date of the 2019 General Election. Whilst this was during the purdah period, these emails are demonstrative of me continuing in my role as Health Secretary to ensure continued governance and the protection of public health, which is in line with the Cabinet Office 'General Election Guidance 2019' that made clear that the

essential business of Government must be allowed to continue (MH/17A - INQ000185141).

38. I say all this to explain the context of the normal operation of vigilance for threats to health from communicable diseases when the disease that came to be known as Covid-19 first came to light at the start of 2020. There were regular, low risk, threats to health that were brought to my attention on a fairly regular basis, on which we kept a watching brief and took action where appropriate.

39. I consider that this vigilance worked well. On 2 January 2020 Professor Jonathan van Tam read the regular WHO ProMED digest report into potential novel infectious diseases, commented "I think one we should watch", and recommended PHE actively track it. I first read about the disease on 1 January 2020, and when I asked for a briefing, officials were aware of the potential threat, in the same way they were aware of many other potential threats for example from Monkeypox.

AREAS OF STRENGTH IN PREPAREDNESS

40. Some other areas of preparedness were extremely good and very important.

41. The Project Cygnus exercise had highlighted that stronger legislation would be vital for responding to a pandemic. Legislation was drafted, which we found could be easily adapted to requirements for the COVID-19 response. However, the legislation was not perfect and I consider that a new 'Public Health Act' is required to be prepared for future pandemics for two reasons: firstly, to update the Public Health Act 1984 ("the 1984 Act") to account for the lessons from the pandemic including, but not limited to, the need to:

- a. Improve the operation of the devolution settlement in a pandemic that does not recognise administrative boundaries
- b. Swiftly require isolation for those infected
- c. Provide financial support akin to furlough to those affected

42. Secondly, an updated Public Health Act is needed because in an emergency, Parliament should be able to vote on necessary measures with proper scrutiny, rather than having to put in place emergency legislation. Parliamentary support for interventionist measures is vital, and would be much better structured as specific votes, on a pre-agreed procedure, that is more appropriate for an emergency than primary legislation. Thankfully business

managers and Opposition Parties were helpful and supportive during the COVID-19 pandemic, but this cannot always be relied upon, and Parliamentary procedure became more and more contentious as the pandemic wore on.

43. Preparation for *early* contact tracing was successful. PHE maintained a small standing capacity which could effectively contact trace the very early known cases. However, this was insufficient: the problem was that this capacity could not be effectively scaled, and instead a new large scale contact tracing system had to be invented from scratch.
44. The diagnostic science was impressive. PHE developed a test for COVID-19 within three days of the publication of the genomic sequence by the Chinese Government. They were one of the first labs in the world to do so. Sadly, again, the failure was the inability to build a large capacity, which we had to effectively build from scratch.
45. The protocols for dealing with early cases were well designed. The standing protocols for handling a “High Consequence Infectious Disease” were helpful for the first few weeks, requiring full “hazmat” PPE and strict isolation units for patients. However, once the disease became so widespread that the standing protocols were no longer practical, no replacement protocol existed, and had instead to be written and agreed at the time.
46. Preparedness on vaccines was impressive. During 2019 I pushed the Department to advance work on a Vaccine Strategy for the UK, and made the case for the £200m necessary funding to deliver it. I thought the attitude to tackling antivax sentiment was complacent, and took steps to put in place a more robust approach. I also requested to the Department for Digital, Culture, Media and Sport to add antivax into the Online Harms White Paper. The immediate purpose was to reverse the UK’s loss of measles-free status, which I thought was appalling, but I took action to drive forward vaccine preparedness across the board.
47. On vaccine science, thanks to work at several Universities, including the work funded by the Fleming Fund led by Sarah Gilbert and Catherine Green at Oxford University, and Robin Shattock’s work at Imperial, teams of scientists were able quickly to begin work on potential vaccines. Despite the spectacular success of the vaccine programme, there are still improvements that need to be made on the development of vaccines for a future pandemic. Critically, the time to make a new vaccine available to the population as a whole must be radically reduced. This work has not progressed enough. Challenge study protocols must be ready, and MHRA protocols for approval of a safe and effective vaccine

must be on standby. During my time as Health Secretary I recognised the importance of vaccines, leading the work on a 'Vaccine Strategy' and pushing for its publication to be moved forwards by around six months (MH/18 - INQ000184130; MH/19 - INQ000184131; MH/20 - INQ000184132; MH/21 - INQ000184132; MH/22 - INQ000184134) (noting that the whole area had been 'prone to complacency' (MH/23 - INQ000184122)) and combating the direct impact of disinformation from 'anti-vaxxers'; this is something I felt and feel very strongly about (MH/24 - INQ000184121), so much so that I recall having to overrule the Department's policy team, which I felt was complacent as to the risks from social media in respect of anti-vaxxers (MH/23 - INQ000184122).

48. The stockpiling of antivirals for an influenza pandemic was also given careful consideration with a submission for the business case being sent to me for approval in September 2018 (MH/25 - INQ000184107; MH/26 - INQ000184108; MH/27 - INQ000184109; MH/28 - INQ000184110).

49. As well as specific preparedness for a pandemic, the UK's existing capacity in several areas could be turned to address the new disease, and meant we were better prepared. For example the UK's genomic capacity was not developed with a pandemic in mind, but was instrumental in the leading role the UK played in response to the pandemic. At one point more than half of the sequences in the WHO's genomic repository were from the UK – thanks not to specific pandemic preparedness but genomic capacity that was turned to face the disease.

50. Likewise the strength of the NHS as a universal free-at-the-point-of-use service was incredibly helpful. Again, this was not designed with a pandemic in mind, but the fact that we could direct resources meant we were better prepared than other countries. We took action to ensure that the NHS was never overwhelmed, including through the expansion of NHS services like the Nightingale hospitals, and the recruitment of more staff. While the NHS had not specifically prepared for this, its existing excellent capability and leadership meant it was able to step up.

51. Thanks to the work done in 2019 to prepare for a "no deal" Brexit, which had included consideration of the impact on pandemic preparedness, including on the devolved administrations (MH/29 - INQ000184116; MH/30 - INQ000184117; MH/31 - INQ000184118; MH/32 - INQ000184119; MH/33 - INQ000184120), the Department's knowledge of medicine and medical devices supply chains, including vaccines, was greater than at any time in modern history. This proved vital as the team who led this work

could seamlessly transition to supply of key drugs and materials needed for the pandemic. The fact, for example, that we did not at any stage run out of all anaesthetic drugs was a success, in part, down to the work of the Department's supply team.

FLAWED DOCTRINE

52. Alongside the areas of strength in preparedness, there were significant areas of weakness.

Below, I will set out the areas of operational weakness in pandemic response as I found them in early 2020. However, much bigger than these operational weaknesses, the absolutely central failure was essentially an intellectual mistake in the prevailing attitude: a failure of what the military would call *doctrine*.

53. The UK's pandemic doctrine, as set out in the 2011 UK Influenza Pandemic Preparedness Strategy, was to contain the very early cases, but once capacity to contain a relatively small number of cases was overwhelmed, to turn that capacity off, to give up on controlling the pandemic, and prepare to handle the consequences. So, rather than being ready to act to expand pandemic-fighting capacity at pace, and being ready to act to stop the spread of the disease, preparation was focussed on coping with the overwhelming consequences of the disease, for example how to deal with hundreds of thousands of excess bodies – based on an estimate of 820,000 - rather than stopping those people from dying.

54. Crucially, the prevailing doctrine contained the implicit assumption that a lockdown, as had been witnessed in Asia to manage SARS, would not be possible in the UK. Many unprecedented actions were not contemplated and there was a complete lack of imagination about what the public would put up with in order to keep them safe.

55. Prevailing doctrine in countries affected by SARS was to act early to control the spread of the disease. By contrast in the UK the 2011 Influenza Pandemic Preparedness Strategy states as a matter of fact at the start (para 1.3) that *“When an influenza pandemic occurs, large swathes of the population may become infected by the new virus over a relatively short period of time.”* The strategy sets out the overall objectives, including to:

“Minimise the potential health impact of a future influenza pandemic by:

- *Supporting international efforts to detect its emergence, and early assessment of the virus by sharing scientific information.*
- *Promoting individual responsibility and action to reduce the spread of infection through good hygiene practices and uptake of seasonal influenza vaccination in high-risk groups.*

- *Ensuring the health and social care systems are ready to provide treatment and support for the large numbers likely to suffer from influenza or its complications whilst maintaining other essential care.”*

56. Clearly, the approach in the 2011 strategy was woefully inadequate. I have no idea why the 2011 strategy did not consider the approach taken by countries affected by SARS, and learn those lessons for the UK. I also do not know why the WHO considered the UK one of the best prepared countries in the world, when our strategic approach did not consider it possible to take the social distancing measures necessary to stop the spread of a killer disease.

57. Looking back, I think that before the Covid-19 pandemic it was assumed that a liberal democracy like ours could not effectively implement measures as intrusive as those which were needed to contain a highly transmissible virus. However, this is a fundamental misunderstanding of the principles of liberal democracy: liberty requires not just freedom, but protection from harm. This 'harm principle', i.e., that an individual's freedom should be tempered by protection of others from harm, is central to liberal democracy. So, just as in the face of military invasion, a liberal democracy will reasonable take steps to defend itself; in the face of a deadly pandemic, when harm can be done by one person to another even without knowing it, very significant state intrusion on the freedom of individuals can be, and in my view is, morally justified for the protection of others. We have learned that, if the price of inaction is set to be too high, lockdown is not only feasible, but right. This doctrine has consequences, far beyond a justification of lockdown.

58. The harm principle gives strong justification for social distancing measures, including lockdowns, to stop people inadvertently harming others. It requires a standing capacity, ready to defend people from a pandemic, akin to a standing defensive army in the military analogy. This capacity must include for example rapidly expandable testing, vaccine, therapeutic and contact tracing capacity.

59. The doctrine for example also implies that in a pandemic the balance between the sharing of data and the right to privacy tips towards sharing that data to protect lives: such policies are justifiable because a liberal society protects the vulnerable from harm.

60. To be clear, this pandemic doctrine does *not* justify any further state intervention in normal times. Its only justification can be the fact that in the extreme circumstances of a serious pandemic we can inadvertently harm each other by spreading the disease, so extraordinary state action can be justified to save lives.

61. The flawed doctrine led to the wrong policy. The 'Contain, Delay, Mitigate, Research' policy published on 3 March 2020 was a mistake. During February to March 2020 the data increasingly demonstrated that the worst-case scenario modelling prediction of over 500,000 deaths was coming true. It became clear that we should not merely 'Mitigate' the growing disease, but had to stop it. With a disease of the morbidity and transmissibility of COVID-19 it became clear that the only way to generate immunity in the population was through a vaccine. Therefore, by mid-March it became clear that the only feasible doctrine was to use social distancing measures to protect people.
62. Making the judgement of whether lockdown measures were justifiable was extremely difficult. Data was sparse. Testing capacity was extremely limited. Modelling is by its nature uncertain. My point is not that lockdown is good – it is not - or should always be used, but that lockdown must be an option as a policy response, and as soon as it is judged to be needed, it should be introduced.
63. There are those who say the lockdown was wrong and we should rule it out for the future. This is wrong. Suppose a pandemic with a higher transmissibility than Covid-19, and a mortality of 50%, with a higher mortality in children. Then of course lockdown would be justifiable. The right doctrine should give a framework for making the decision on whether lockdown is justified or not.
64. Of course, this does not mean lockdown is always needed, and nor does such a strategy prescribe what form lockdown should take, nor how much of it should be compulsory and how much voluntary. All of that must be calibrated based on the nature of the virus and the impact of each measure on the R number (the average number of people affected by each infected person). We have learned a huge amount about that calibration, but the judgements are not easy.
65. Crucially, once it is judged that a lockdown *is* needed, it should be brought in as soon as feasible. After all, if the R number is above 1, and a lockdown will be needed at some point, then action should be taken urgently to bring R below 1. As we saw in autumn 2020, the choice is not between lockdown and no lockdown, it is between early lockdown with low mortality, and later lockdown, probably for longer, with high mortality.
66. I propose, in the face of a potential pandemic, we should develop a doctrine along the following lines:

- a. Assess as early as possible the impact of the population gaining immunity to a new disease without social distancing,
- b. If the likely impact in terms of morbidity and mortality is less bad than the cost of social distancing measures needed to keep R below 1, then the 'Contain, Delay, Mitigate, Research' framework is appropriate.
- c. If, however, the impact of a disease in terms of morbidity and mortality is greater than the cost of social distancing measures, then we should act to keep the R number below 1 as soon as possible to keep people safe until a vaccine is developed.
- d. In practice, *if* (and only if) a lockdown is needed, it should be sooner, stronger, and wider than anticipated. That is the way to save most lives and keep lockdown in place for the shortest period possible. As we discovered in autumn 2020, without a vaccine there is no trade-off between the two.
- e. Develop a vaccine and other countermeasures urgently to ensure damaging social distancing provisions are in place for as short a time as possible.

67. In practice this means we must be ready to implement social distancing measures, including lockdowns, if the impact of the disease, unchecked, is set to be greater than the negative impact of such measures. Just as a lockdown will not always be the right response, ruling out lockdowns in all circumstances is completely irresponsible.

WEAKNESS IN PREPAREDNESS

68. The UK's flawed doctrine had consequences that led to weakness in our readiness for a pandemic, because of the wrong attitude and because of operational weaknesses.

69. In respect of both **testing and contact tracing** there was no capacity for expansion to industrial scale: we had to build both.

70. The UK entered the pandemic with a very small private sector diagnostics industry, and a public sector diagnostic capacity that was either embedded in the NHS and not scalable, or embedded in research labs and so not scalable. This meant we were not well placed.

71. The early problem was not just that we did not have a big diagnostic capacity ready to scale. Much worse, PHE refused to engage the private sector with the goal of building a huge testing capacity, and shut down their contact tracing capacity. While I eventually took

control of both testing and contact tracing within the Department, the preparedness work was entirely focussed on handling a very small number of initial cases – which was done superbly – and not on preventing the spread once community transmission became entrenched.

72. The contact tracing system was designed to deal with very small numbers of cases of diseases such as Legionnaires, and simply was not geared towards mass contract tracing. PHE decided that contact tracing should be turned off when community transmission had become so widespread that small scale contact tracing was effectively useless. Instead we should have had the ability to scale that capacity rapidly, rather than having to build that capacity from scratch.

73. On testing, PHE refused to engage private sector testing capacity, despite it being obvious that a massive expansion of testing was necessary, and that the existing capacity was not scalable.

74. In terms of Government facilities, I visited the PHE laboratory in Colindale, North London. The science was impressive but the testing facilities consisted of two scientists in a laboratory side room hand-pipetting samples. Whilst PHE did superbly well in developing a test very early that could detect the COVID-19 virus, it was simply not set up to conduct mass testing. What was required to introduce a large-scale testing operation was the use of industrial production lines. After I removed responsibility for testing PHE and brought it into the Department, we began radically to expand the availability of tests.

75. My insistence on a massive testing expansion, most publicly with the 100,000 tests a day target, was done both to drive the operational expansion, and also to change attitudes from one of highly targeted testing to mass testing. Eventually we built one of the biggest testing operations in the world, but the consequences of a lack of testing capacity early on are well documented.

76. For the future, a rapidly scalable testing and tracing capacity should be maintained, ready for urgent expansion. I am concerned that at present our current capacity is being dismantled and we will find it much harder to scale again in the future as a result.

77. A further failure of preparedness was around the assumptions of the nature of the virus. The global scientific consensus – shared by UK scientists – was that a coronavirus does not **transmit without symptoms**. This remained the official UK scientific advice until after

the CDC updated its position on 3 April 2020. This assumption proved to be wrong. In future we should not make assumptions like this. After all, a pandemic occurs because of a novel disease. The consequence of this wrong assumption were widespread and significant.

78. I challenged the assumption of asymptomatic transmission, given the anecdotal evidence to the contrary. However, the scientific advice did not change. I was told reports of asymptomatic transmission were “translation errors” or “unproven”. My error was not to require the system to take a risk-averse worst case scenario assumption, irrespective of the global scientific consensus.
79. In future we should assume the reasonable worst case scenario, which is asymptomatic transmission, until such time as the contrary can be demonstrated.
80. The flawed doctrine also led to flawed **assumptions about behaviour** which might be expected from the UK population. In respect of questions such as, ‘would the public comply with restrictions on gatherings?’, ‘would the public accept the closure of schools and travel and the need for wear face masks?’, we simply did not know with any confidence what the response would be. We were advised that if measures were brought in too early the public may tire of them, and so the consequences would be worse. One important lesson is that if the purpose of measures is well communicated, and the right support is given, the public are very willing to do what is necessary to keep each other safe. It was impossible to know this before, but we do now.

OPERATIONAL AREAS FOR IMPROVEMENT

81. There are other areas where operational preparation should be improved for the future.
82. According to experts, the development, purchasing and rollout of the **vaccine** was one of the largest and most impressive civilian projects in the UK’s history. Nevertheless, we could have been even better prepared and should be better prepared for next time. We should further optimise the regulatory process, build a UK manufacturing capacity, and maintain a system to distribute the vaccine.
83. Future preparedness must include delivering on the 100-days project, so a vaccine can be ready for deployment in 100 days. Further improvement can be made to the already very impressive regulatory clearance process, that approves a vaccine as safe and

effective. Yet more parts of the clinical trials should be conducted in parallel. Challenge studies, with pre-agreed protocols, should be made ready for immediate deployment to accelerate trials. Capacity for onshore manufacturing and fill and finish should be maintained, and manufacturing begun as soon as a vaccine candidate is ready. The cost of a standing capacity for urgent vaccine development and deployment is cheap compared to the cost of a lockdown needed to keep people safe. Bringing vaccine manufacturing onshore is something that I had tried to achieve in my role as Health Secretary prior to the pandemic. Then in October 2019 when making the Department's submission to the Treasury for the 2019 Budget I set out that:

*“On national security grounds, we also have an opportunity to strengthen our pandemic influenza preparedness through incentivising companies to bring on-shore new vaccine technologies. **£200m capital investment over four years from 2021/22** would put us as world leaders in vaccine development. It would allow vaccines – not just the flu – to start being produced in weeks instead of months. At the very least, an HMT signal now that it will consider proposals in this space would facilitate further discussions with industry.” (MH/34 - INQ000184128; MH/35 - INQ000184129)*

84. When the 2019 Budget was delayed I prepared a letter to the Prime Minister seeking to request the £200m needed to bring vaccine manufacture onshore (MH/36 - INQ000184135; MH37 - INQ000184136). The priorities represented in the submission to the Treasury and the letter to the Prime Minister are reflective of those policies that I considered, as Health Secretary, particularly worthy of pursuing out of a host presented by policy officials. I was protective of the Department's budget as Health Secretary; in August 2019 when preparing for the Spending Round 2019 (MH/38 - INQ000184123), as any significant cut to Departmental budgets would inevitably have hit public health budgets.
85. Across the health system, access to high quality **management information** was poor. Much has been done during the pandemic and afterwards to improve the quality of information available to policymakers; this work must continue – and is important for the operation of the NHS in non-pandemic times too. The improved use of data, and the availability of many of the tech platforms we built at pace, must be maintained to ensure we are better prepared in future.
86. Residents of **care homes** were amongst the most vulnerable to COVID-19, and are among the most frail and vulnerable to any disease. Despite the prominence of social care in the 2011 pandemic preparedness strategy, there were no effective policy levers in the Department to require pandemic preparedness in social care. The Department had asked

all local authorities to prepare a pandemic preparedness plan, but in effect the Department had no powers to deliver on this request. I am told that only two such plans existed, and where they existed they were poor.

87. Because care homes are accountable to local authorities and local taxpayers, the Department began the pandemic with no effective policy controls or levers on social care. Like in so many other areas, the Department had very little data on social care, and so very little visibility. No-one even knew how many care homes were in operation across the country – each council had a separate list. Even the Care Quality Commission (“CQC”) did not know. Across Government, MHCLG (now DLUHC), through its responsibilities for local government finance, had some effective policy levers when extra money was allocated to support social care, which were incredibly important in improving the data reporting from care homes over time. Although England’s performance in terms of protecting residents in social care was comparable to other similar countries, and better than some, including Scotland’s, throughout the pandemic, we increasingly learned about how to protect care homes and these lessons need to be retained for the future.

88. There was no preparedness at all for **restrictions at the border**. Before the pandemic, and in the early months of our response, the global public health consensus manifested in the global public health regulations, and the advice to me, was that restrictions at the border was an inappropriate policy. This proved not to be the case. The result of this error was that there was no preparedness at all for the fact that health measures at the border may be needed to protect the population. While early measures in some countries were completely ineffective, for example temperature testing in Italy and the USA, clearly border measures came to play a major role in slowing the spread of the virus. The UK’s early action at the borders amounted to leaflets and tannoy announcements. Even once stricter measures were introduced, administrative disagreements, a failure of Border Force to take responsibility for health measures, a lack of clear leadership and ongoing tensions between the Government authorities and private airport operators led to significant challenges.

89. Border measures were further undermined by an error in the 1984 Act. The UK border is clearly a UK Government responsibility. However, because health measures are devolved in the 1984 Act, health measures at the border are devolved too. It is likely this mistake was unforeseen by those framing the 1984 Act, because the decision makers at the time would have been the relevant Secretary of State in the UK Government. Now that there are Devolved Governments, this did not work, and created huge confusion and

complications. Legislation clearly needs to change to make health measures at the border unambiguously a UK Government responsibility.

90. More broadly, the preparedness for **co-ordination across the UK** was mixed. The engagement of the four Chief Medical Officers (“CMOs”) gave a bedrock of consistent scientific advice, because they rightly chose to reach a consensus on the evidence, and give the same advice to the four governing authorities across the UK. Initially there was no health ministers’ forum – I had to create one – and at the start of the pandemic arrangements for policy co-ordination was weak. Pandemics do not recognise administrative boundaries. While I support the devolution of health services, this should not automatically mean the devolution of health security policy. The virus does not respect administrative boundaries, and as an archipelago the UK should use its geography to its advantage to control the spread of a future pandemic. A full review of the appropriate level of administration of each element of pandemic preparedness is crucial, with legislative backing for an objective new settlement.

91. In respect of **PPE**, while the UK had a large stockpile that had been laid down in the late 2000s, the warehouse in which it was stored in the north-west was not designed for rapid access, and the distribution system was designed for delivering to 250 hospitals, but suddenly needed to deliver to over 50,000 sites including GP practices and care homes. In future, all sites should maintain basic supplies, and we need an emergency system so PPE can be distributed around the country in an emergency from storage facilities spread across the regions.

92. **Procurement processes** for normal times did not work in the pandemic. Emergency procurement processes existed, and could be made to work with the extraordinary urgency that was needed. However, with hindsight many people involved in procurement – including me – were quite wrongly accused of wrongdoing for work to buy lifesaving equipment rapidly, at scale, when global demand rose in an unprecedented way. I was not involved in any individual procurement decisions, except on vaccines, but of course, had responsibility for ensuring the procurement rules allowed the rapid purchasing that was required to save lives. Updated processes are needed to ensure that, when emergency procedures are used, those using or overseeing them are protected from such false accusations.

93. In respect of the Government’s preparedness for seeking and considering **scientific advice** from outside the consensus, this worked well. I saw no issue with the Government

obtaining such advice and indeed the Scientific Advisory Group for Emergencies (“SAGE”) contains a wide variety of members. Views on SAGE were debated and the overall view, including the breadth of considerations, reported to Minister through the minutes and in verbal briefings from the CMO and Chief Scientific Adviser (“CSA”).

94. My view is that Ministers should be ‘guided by the science’ rather than ‘following the science’ because this enables Ministers to take into account of all considerations including, for example, advice on the operational capacity to deliver a scientific recommendation. In most cases we did follow the science, but in some cases, for good reasons, we did not. For example, when the Government was repatriating evacuees from China at the end of January 2020, PHE advised that they should be given a leaflet and asked to go home to isolate. I took the view that the evacuees should be required to be placed into quarantine, which led to the returnees being placed in Arrowe Park Hospital.
95. Turning to the **international context**, co-ordination was very poor. Most countries turned to consider their domestic situation first. Had China closed all borders in early 2020, there is a chance the pandemic could have been contained there. But international health regulations contained an embedded assumption that shutting borders would not be effective in combatting a pandemic. Policy co-ordination mainly followed bilateral and G7 discussions. There was some co-ordination of scientific work by the WHO, but their policy advice, for example on declaring a public health emergency of international concern, was slow and behind the curve.
96. I support a new global health treaty to address the need for transparency of reporting, for scientific co-ordination, the appropriate time for border restrictions, co-ordination over vaccine preparedness and other matters. Such a treaty should not allow the WHO to determine a domestic response, but to maximise its chances of being adopted should focus on when most important areas on international co-ordination. Reform of the WHO is also needed to ensure it can act faster and with fewer political constraints. I believe that such a treaty is important based on my experience of a Memorandum of Understanding on patient safety agreed with the Chinese during my time as Health Secretary; (MH/39 - INQ000184112; MH/40 - INQ000184115) whilst this called at paragraph 3.5 for the *“encouragement and facilitation of communication and collaboration between appropriate public organisations and companies from both countries,”* once the pandemic hit, the Chinese drew down the shutters.

97. Many improvements to support scientific co-ordination, strengthen transparency, and improve the international community's ability to collect, share and analyse emerging health data were made during the pandemic. These can and should continue to improve, for example, with improvements to the international coordination and standardisation of clinical trials. The UK Health Security Agency ("UKHSA") has and must continue to play a vital role in leading this global scientific work.
98. **Modelling** was useful for indicating possible future scenarios. By their nature no model will always make precise forecasts but, properly understood, modelling is a useful way of organising discussion around unknowable potential future scenarios. Communication of modelling is difficult, especially when policy is changed in response to the model. So for example, some criticise the modelling of the reasonable worst case scenario, because the modelled outcome did not happen. But the reason it did not happen is that we took action to stop it happening. The data were starting to follow the reasonable worst case scenario in an extremely worrying way, and other measures, like the doubling time in the number of cases, corroborated the model. Much can be learned about the presentation of modelling, for example from the Bank of England's fan chart models that do not imply undue accuracy in any forecast.
99. In the UK's **institutional architecture**, we were poorly prepared, and improvements have begun to be made. It was a mistake to create PHE as a body responsible both for tackling non-communicable public health, like obesity, as well as communicable diseases and preparing for pandemics. Policy over the two areas is completely different. It was inevitable that the organisation spent more senior attention on tackling the issues in front of it, rather than worrying about the next pandemic.
100. Looking to the future, I consider that the UK, through the work being undertaken by the UK Health Security Agency ("UKHSA"), is now better placed to monitor for future pandemics, to be vigilant to zoonotic links in communicable diseases, for example, and to maintain and develop the best possible preparedness. UKHSA must also address biosecurity concerns, and work to the risk of a novel virus escaping from any laboratory, whether in the UK or around the world. To be best prepared, we must ensure UKHSA is properly funded to maintain both the standing capacity ready to expand fast, as I have set out, as well as the highest standards of day to day work, such as ensuring our own Category 4 labs are up to date and safe, and to play our part in insisting on the highest standards in every country equipped with top level biosecurity capabilities.

101. I hope that through the process of the Inquiry we refine and find further areas for lessons to be learned so that next time a pandemic strikes we truly are as well prepared as any country in the world.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Personal Data

Signed.....

12/05/23

Dated.....