

Tuesday, 27 June 2023

1  
2 (10.00 am)  
3 **LADY HALLETT:** Morning, Mr Keith.  
4 **MR KEITH:** Good morning, my Lady. Matt Hancock MP, please.  
5 **MR MATT HANCOCK (affirmed)**  
6 **Questions from LEAD COUNSEL TO THE INQUIRY**  
7 **MR KEITH:** Could you give the Inquiry, please, your full  
8 name.  
9 **A.** Yes, my full name is Matthew John David Hancock.  
10 **Q.** Mr Hancock, thank you for attending today. Whilst you  
11 give evidence, could you please speak up so that we may  
12 all hear you clearly, and also so that the stenographer  
13 can hear you for the purposes of the transcript.  
14 If I ask a question that is not clear, please don't  
15 hesitate to ask me to repeat it. There will be a break  
16 in the course of the morning's evidence session.  
17 You have kindly provided a witness statement dated  
18 20 April of this year; is that right?  
19 **A.** That's right, yes.  
20 **Q.** Could we have, please, on the screen INQ000181825, and  
21 page 14, please. Page 24, I think, is the last page.  
22 It's signed, I think, on 12 May, therefore, and it was  
23 accompanied by the usual statement of truth.  
24 Mr Hancock, you were Paymaster General and Minister  
25 for the Cabinet Office between 11 May 2015 and

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1 with the discharge of your functions as the Minister for  
2 the Cabinet Office and as Secretary of State in the  
3 Department of Health and Social Care pre-pandemic.  
4 **A.** Yes.  
5 **Q.** We are concerned today only with the issues of emergency  
6 planning and preparedness, and so may I make clear that  
7 I will not be asking you questions about the detail of  
8 non-pharmaceutical interventions, lockdowns, the  
9 government's response, or the test and trace or  
10 procurement or PPE issues which arose after the pandemic  
11 struck.  
12 **LADY HALLETT:** They will come in later modules, just so  
13 people understand.  
14 **MR KEITH:** They will all be in later modules, particularly  
15 Module 2 in the autumn, for which Mr Hancock has  
16 provided a draft statement.  
17 EPRR pandemic planning. The functions of the  
18 Secretary of State, Mr Hancock, in relation to pandemic  
19 planning, are wide-ranging and complex, are they not?  
20 There is quite a lot to be concerned with in this field.  
21 **A.** Yes, and that is in addition to the very broad  
22 responsibilities overall as Secretary of State.  
23 **Q.** You are responsible or were responsible in broad terms  
24 for health and social care, and that includes,  
25 therefore, health protection, health improvement, the

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1 July 2016.  
2 **A.** Yes.  
3 **Q.** During that time, were you, therefore, responsible  
4 ministerially for an important part of this pandemic  
5 preparedness structure, namely the National Security  
6 Risk Assessment process?  
7 **A.** Yes, I was formerly the junior minister responsible for  
8 that, both for the secret part and for the National Risk  
9 Register. I reported to Oliver Letwin, and he in  
10 practice led on those areas, but nevertheless I had  
11 junior oversight of them.  
12 **Q.** Is that because the senior minister in that regard is  
13 the Chancellor of the Duchy of Lancaster, which he was,  
14 and you were the junior ministerial colleague as  
15 Minister for the Cabinet Office?  
16 **A.** I was effectively the number two in the Cabinet Office,  
17 yes.  
18 **Q.** Then did you become Secretary of State at the  
19 Department of Health and Social Care between  
20 9 July 2018, when you took over from Jeremy Hunt MP, and  
21 26 June 2021, when you resigned?  
22 **A.** Yes.  
23 **Q.** My Lady, for the purposes of -- for those who may be  
24 listening to Mr Hancock's evidence, I'm going to make  
25 clear that your appearance today is obviously concerned

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1 healthcare systems, the social care systems, although  
2 that's largely in the hands of local authorities, and  
3 most importantly perhaps the NHS, so it's a very wide  
4 brief indeed.  
5 **A.** I wouldn't say most importantly the NHS, I would say  
6 that there are many, many areas of importance, and  
7 actually one of the challenges of the job is to try to  
8 put your attention to the most important areas, because  
9 it is so broad.  
10 **Q.** Is a vital function of the Secretary of State to deal  
11 with health emergencies?  
12 **A.** Absolutely, and going into the job, I had some  
13 experience at a more junior level of dealing with crises  
14 and emergencies, and so I took my responsibilities as  
15 the -- as the principal responder to a pandemic very  
16 seriously.  
17 **Q.** Does dealing with health emergencies include dealing  
18 with infectious diseases?  
19 **A.** Yes, of course.  
20 **Q.** And being ready to deal with them? Being ready to deal  
21 with the risk of infectious diseases?  
22 **A.** Absolutely.  
23 **Q.** So when concerned in the field of emergency  
24 preparedness, resilience, civil contingencies, where  
25 there is a health emergency it is the

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1 Department of Health and Social Care that is the lead  
2 government department, in effect it is the department in  
3 the driving seat?

4 **A.** Yes, and as Secretary of State I felt keenly the  
5 responsibility as essentially the lead responder in the  
6 first instance to those sorts of health emergencies, and  
7 it was a -- it was a part of my day-to-day work, because  
8 these emergencies happen from time to time.

9 **Q.** Were, when you were Secretary of State, risks  
10 prioritised in any way? Was there a grading system to  
11 prioritise those most important and serious risks from  
12 those that were less so?

13 **A.** Yes, of course, that's absolutely vital, and one of the  
14 challenges in a system as big as the health system is  
15 making sure the decisions are taken at the right level,  
16 because if you escalated everything to the  
17 Secretary of State, whoever they are, they would be  
18 completely overwhelmed. Yet it's vital to escalate the  
19 things that need to be seen by the Secretary of State to  
20 the -- to their desk.

21 **Q.** Was influenza pandemic prioritised as a Tier 1 risk?

22 **A.** Yes, it was. On -- I recall that on my first day I was  
23 given a briefing document, about as big as this one, and  
24 one of the elements of it was making clear my  
25 responsibility as a -- as the Tier 1 national responder

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1 If you could scroll down, please, to row 11. There  
2 are two names on the left, in the column second from the  
3 left, Mr Hancock, Emma Reed and Clara Swinson, both of  
4 whom have been witnesses before this Inquiry:

5 "[The] Description -- (Major national infectious  
6 disease outbreak and pandemic flu) ..."

7 The risk identified, for self-evident reasons, is  
8 that:

9 "... the department fails to respond and mobilise  
10 adequately to a major national infectious disease  
11 hazard, such as pandemic flu or other novel infection."

12 The approach taken, the response on the part of the  
13 department, is in the next column, to:

14 "Manage the risk and likely domestic impact of  
15 a major pandemic flu or emerging infectious disease  
16 outbreak."

17 So the risk was identified in terms not just of the  
18 pandemic being an influenza pandemic, but obviously the  
19 risk of an infectious disease outbreak, an emerging  
20 infectious disease outbreak.

21 **A.** Yes.

22 **Q.** Does its presence in that chart, in that schedule,  
23 Mr Hancock, indicate the seriousness with which the  
24 department took the risk of a major infectious disease  
25 outbreak or pandemic flu?

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1 for pandemic flu and for other infectious diseases.

2 I was already aware of this element of the role from my  
3 time at the Cabinet Office, but nevertheless it was  
4 properly and formally brought to my attention, and on  
5 day one I asked for more information on preparedness,  
6 because I -- having been involved in previous crises,  
7 for instance, at the Bank of England in, before I went  
8 into politics, I knew that when things go wrong, things  
9 move quickly and you need to be as well prepared as you  
10 can.

11 **Q.** At the highest level of the department, was there  
12 a board known as the departmental board which looked at  
13 the highest level of major risks confronting the  
14 department?

15 **A.** Yes, and the role of the departmental board was to  
16 ensure that the department was structuring itself  
17 properly to deal with the different challenges that it  
18 faced.

19 **Q.** May we have, please, INQ000023142, which is a copy of  
20 your department's then high level risk register for  
21 quarter 3, 2019 to 2020.

22 If you can go to the top of the page, we will see  
23 there the years, "201920 [quarter] 3 [high level risk  
24 register]", and if you go to the far left-hand side of  
25 the page, there will be a number of row numbers.

6

1 **A.** Yes, and the red rating demonstrates that the  
2 significance of the impact of this, should it strike,  
3 could be very serious, and the day-to-day life of  
4 a Health Secretary involves being aware of and, from  
5 time to time, being involved in managing the response to  
6 potential infectious disease risks, which happen from  
7 time to time. And I set out in my statement that over  
8 the autumn of 2019 there was a potential flu outbreak,  
9 there was a -- what's now known as Mpox outbreak, then  
10 known as monkeypox, and over this period we were also  
11 dealing with the Ebola epidemic in West and  
12 Central Africa, and the particular responsibility of the  
13 health department was to ensure that we were prepared,  
14 should Ebola come to the UK.

15 So this was a -- this was not a theoretical  
16 exercise, it was part of the day-to-day job of being  
17 Health Secretary.

18 **Q.** It is apparent from the document that, in relation to  
19 each risk identified on the left of the schedule,  
20 a number of what's known as mitigations are put in place  
21 in order to manage the risk. In other words, the  
22 department sets out, in columns K, L, M and N in respect  
23 of each risk, what the department is doing to manage the  
24 risk, to mitigate it, to ensure either that the risk  
25 does not eventuate, it does not come to pass, or to

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1 manage the consequences of whatever it is that the risk  
2 amounts to, what it brings about and how the  
3 consequences can be managed.

4 Do you happen to know why, in this risk register,  
5 there is no mitigation set out in respect of that row 11  
6 risk?

7 **A.** No, I don't know why those boxes are empty, but I do  
8 know that there was significant activity under way, both  
9 in the department and in Public Health England, to make  
10 sure that we were prepared, as prepared as then thought  
11 possible -- and I'll come on to that, because it's  
12 absolutely central, that question -- and frankly it was  
13 a -- it was a regular occurrence to deal with these  
14 sorts of novel infectious diseases and threats, so it  
15 was something that happened all the time.

16 **Q.** Do you recall, Mr Hancock, any particular departmental  
17 board, which presumably you attended, at which the  
18 row 11 risk of a major national infectious disease and  
19 pandemic flu was actively debated?

20 **A.** No.

21 **Q.** Do you have any recollection of the debate surrounding  
22 this particular risk at departmental boards? I mean,  
23 obviously a great deal -- many points go across the  
24 Secretary of State's desk, but do you have any personal  
25 recollection of --

9

1 have been the normal place to have had such discussion.

2 **Q.** Well, Mr Hancock, that cannot be right, can it, because  
3 this is a schedule of the high-level risks which were  
4 put before the departmental board, and therefore it must  
5 follow that these are risks and mitigations which are  
6 debated by the departmental board, that is what this  
7 chart shows?

8 **A.** The purpose of the board was to ensure that the  
9 department was doing what needed to happen, rather than  
10 to debate the substance of it.

11 **Q.** All right.

12 You have referred to the fact that the  
13 Department of Health and Social Care was the lead  
14 government department when it comes to dealing with  
15 planning and preparedness for a health emergency, and  
16 also in relation to the necessary response.

17 As the Secretary of State, what did you understand  
18 that responsibility to consist of? What did lead  
19 government department in the civil contingencies field  
20 mean to you?

21 **A.** Oh, it means that if that risk begins to materialise, it  
22 is the department's responsibility to act appropriately.  
23 It is also, before that stage, the department's  
24 responsibility to have adequate surveillance to that  
25 sort of risk, and therefore, as Secretary of State, it

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1 **A.** I don't at the departmental board, but I also wouldn't  
2 have expected it to be debated at the departmental  
3 board, because the departmental board was focused on  
4 ensuring that there was appropriate resource in place  
5 for any of the different risks that the department  
6 faced, and ensuring that the department was set up to  
7 respond, not to do the responding itself -- it's  
8 an important distinction in terms of how the board  
9 operated and what its job was -- and I was aware from  
10 the day one brief onwards of the work that was -- that  
11 was under way. So there's no substantive reason these  
12 boxes should be empty, and I think it would be wrong to  
13 read from this, which I don't recall myself, this  
14 implying that there wasn't work ongoing, because as you  
15 can see from the other paperwork there was.

16 **Q.** My question was, in fact, to ask you whether you  
17 recollected what was being done, in terms of: was there  
18 a debate about, as you say, the processes that needed to  
19 put into place, was there a debate about what needed to  
20 be set up to mitigate this risk at a departmental board  
21 level?

22 **A.** There was at a departmental level.

23 **Q.** Departmental --

24 **A.** There was not, from my recollection, at the board, but  
25 I don't think the board would have been the -- would

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1 was my responsibility to ensure, as much as possible,  
2 given all the other pressures, that there was adequate  
3 oversight.

4 **Q.** Did that oversight comprise matters such as ensuring  
5 that the department played its proper part in the risk  
6 assessment process?

7 **A.** Yes.

8 **Q.** Owning, to use a terrible phrase, the risks for which  
9 the department was responsible, dealing with capability,  
10 how to respond to risks eventuating, contingency and  
11 emergency planning in response to again those risks, and  
12 building up the department's own resilience, how it  
13 would cope with the impact of one or more of these  
14 risks?

15 **A.** Yes, and bringing all of that to the attention of the  
16 rest of government should action be needed elsewhere in  
17 government in addition.

18 **Q.** Indeed.

19 So focusing firstly, please, on one of those areas,  
20 the risk assessment area, when you joined the department  
21 as Secretary of State, you wouldn't, I think, have been  
22 engaged in the NSRA process, the risk assessment  
23 process, because one wasn't produced after you took  
24 office until 2019 --

25 **A.** Correct.

12

1 Q. -- when the NSRA and NRA process was brought together,  
2 but do you recall the detail of that process? Do you  
3 recall specific debate about the contents of that 2019  
4 Cabinet Office-produced risk assessment?

5 A. No, I was not involved in those debates. There was  
6 an NSRA and NRR published in 2015, just before I joined  
7 the Cabinet Office, so when I joined the Cabinet Office  
8 with responsibility for that area, a significant piece  
9 of work had just been concluded, which had been led by  
10 Oliver Letwin. I of course was aware of and read those  
11 documents at the time, but then was not aware of the  
12 next iteration of that work going on, and as you say,  
13 there wasn't a publication in that area for a number of  
14 years.

15 And in any case, the language in those documents, as  
16 they were revisited over the years, was essentially the  
17 same, which is that the category 1 top risk was of  
18 a pandemic, influenza pandemic, pandemic influenza, and  
19 then there was a -- also consideration of other  
20 infectious diseases and external threats.

21 I know there's been significant discussion so far at  
22 the Inquiry on the -- of the focus on influenza  
23 pandemic. I was told that the reason that was  
24 the category 1 risk is because it's the most likely  
25 pandemic, but of course we were aware of other

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1 Page 10.

2 There is the section on global and public health.  
3 If you could scroll down the page, please, to  
4 paragraph 5:

5 "The main work areas in the group are ..."

6 Then the first bullet point:

7 "Emergency Preparedness and Health Protection,  
8 (Director -- Emma Reed): This directorate prepares for  
9 and responds to emergencies, including COBRA, and works  
10 on the government's Prevent strategy. It practices for  
11 terrorist or other threats, such as pandemic flu or  
12 Ebola. It ensures the delivery of a national  
13 immunisation and screening programmes. It also runs  
14 a global health security programme, supporting middle  
15 and low income countries ..."

16 There was no reference there in that first day  
17 briefing pack to the level of risk that pandemic flu  
18 posed, so there is no reference to Tier 1, the risk that  
19 you've identified in relation to pandemic flu.

20 Were you provided, either on that day or later, with  
21 more detail concerning the risk that pandemic flu posed?  
22 Did you in fact ask to be better briefed in relation to  
23 what the risks to the department were in relation to  
24 pandemic threat?

25 A. Yes. I remember this document, I remember reading it,

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1 infectious diseases, not least because we were actively  
2 involved in responding to Ebola and, to a lesser extent,  
3 Mpox and the -- and PHE had a day-to-day responsibility  
4 for other infectious diseases that tend to happen in  
5 much smaller numbers, like Legionnaires' disease.

6 So I was aware of it both from the work in the  
7 formal production of those risk assessments and in the  
8 day-to-day work of the department.

9 Q. When you joined the department, you were, as you say,  
10 provided with, I think it's called a day one high level  
11 briefing?

12 A. Yeah.

13 Q. May we please have INQ000183334 on the screen.

14 This pack, first day pack, included a briefing from  
15 the permanent secretary, Sir Chris Wormald, and a number  
16 of other senior officials in your department and  
17 a number of documents.

18 Could we please have page 1.

19 At E -- if you could highlight that, please -- was  
20 one of the areas on which you were briefed, "Global and  
21 Public Health", and that briefing was delivered by  
22 Clara Swinson, then a deputy --

23 A. That's a director general.

24 Q. -- director general of one of the directorates in the  
25 department.

14

1 and on the first evening as Health Secretary I wrote on  
2 this particular paragraph to say "More details please".  
3 As you can imagine, I was going through this document  
4 working out which areas I needed to focus on, because  
5 you have to choose what to focus on, and this was  
6 an area that I knew I needed to be across.

7 Q. So you called for more information, and a written  
8 response was provided by, I think, Emma Reed.

9 INQ000184105, please.

10 "Introduction to Emergency preparedness, resilience  
11 and response (EPRR)."

12 On that first page, we can see in paragraph 1  
13 a reference to the fact that:

14 "... DHSC in conjunction with NHS England and Public  
15 Health England must provide a co-ordinated response to  
16 the challenge of risks set out in the National Risk  
17 Assessment ... such as natural hazards ..."

18 Of course natural hazards includes, does it not,  
19 Mr Hancock, the risk of pandemic flu?

20 A. Yes.

21 Q. You can see there references to the department  
22 co-ordinating a health response to the incidents in  
23 Salisbury and Amesbury.

24 If you could go further down the page, please,  
25 "Emergency Preparedness", above paragraph 6:

16

1 "This Civil Contingencies Act 2004 outlines the  
2 national response to civil emergencies, establishing  
3 roles and responsibilities for those involved in  
4 emergency preparation and response at the local level."

5 There is then a reference to the division in the  
6 Act, the bifurcation between Category 1 and Category 2  
7 responders, and you, as the Secretary of State, were  
8 a Category 1 responder, were you not?

9 **A.** Yes.

10 **Q.** Then paragraph 7, please.

11 Category 1 responders are required to carry out  
12 exercises and training of staff in emergency planning.  
13 The DHSC participates in a cross-government programme of  
14 exercises and ministers will be invited to participate  
15 in Tier 1 exercises and to participate in COBR style  
16 meetings.

17 You subsequently became aware of the fact that there  
18 had, in 2016, in October of that year, been an exercise,  
19 Exercise Cygnus --

20 **A.** Yes.

21 **Q.** -- which was an exercise designed to test the  
22 United Kingdom's systems to deal with pandemic  
23 influenza?

24 **A.** Yes.

25 **Q.** Mr Hancock, there's obviously ample material to show

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1 **A.** Yes, I wanted to know about the department's preparation  
2 and its planning processes, and I asked for a -- so  
3 I asked for further information based on -- on this, and  
4 I recall receiving a note in -- I think it was in  
5 August 2018, and continued to ask questions. For  
6 instance, one of the areas that I pushed hard on was the  
7 lack of UK domestic vaccine manufacturing, given the  
8 importance of a vaccine to responding to any pandemic,  
9 and that was an area that I worked on intensively up to  
10 the -- up until the pandemic struck, and obviously then  
11 thereafter.

12 So this was a programme of work for me which was --  
13 on which I iterated with the -- with the team. I kept  
14 asking more questions, and had meetings on it, and the  
15 area that I focused on was on the vaccine manufacturing  
16 point and others.

17 Alongside this I was also assured that the UK was  
18 one of the best placed countries in the world for  
19 responding to a pandemic, and indeed, in some areas,  
20 categorised by the World Health Organisation as the best  
21 placed in the world. So just to give context to  
22 these -- you know, this interaction between me, as the  
23 new Secretary of State, and my officials, at the same  
24 time -- you haven't brought it up, but in one of the  
25 documents I got very early on it stated clearly that we

19

1 that you became aware of Exercise Cygnus --

2 **A.** Yeah.

3 **Q.** -- and it was an important part of your departmental  
4 functions.

5 Looking back, are you surprised that in this more  
6 detailed briefing there was no reference to the fact  
7 that, just a year before, Exercise Cygnus had reported  
8 and in general terms had found that the plans and  
9 capabilities for the United Kingdom were not sufficient  
10 to deal with the likely demands of a severe pandemic?

11 **A.** That's a good question. I don't know why that's not  
12 written here. I did -- I was aware, became aware of  
13 Exercise Cygnus and the work that was being done to put  
14 its recommendations into action. I mean, there's  
15 a bigger challenge with Exercise Cygnus which perhaps  
16 we'll come on to.

17 **Q.** Of course.

18 In your witness statement you say that you asked for  
19 further --

20 **A.** Yes.

21 **Q.** -- briefings to be prepared, having read this document.

22 **A.** Yes.

23 **Q.** Can you now recall what areas concerned you and what  
24 areas you asked to be addressed by way of further  
25 briefing materials?

18

1 are well prepared, and that wasn't the civil servants'  
2 own assessment, that was the World Health Organisation  
3 assessment of the UK. I know that Mr Hunt referred to  
4 that last week, but -- you know, when you become the  
5 Secretary of State, you think about the challenges in  
6 front of you. In my case, I had a background in  
7 technology and the NHS desperately needed better  
8 technology, the NHS needed more people, and we needed to  
9 be better at prevention of ill health across the board.  
10 Of course, prevention of a pandemic is part of that, but  
11 there's also a huge focus on, for instance, obesity.

12 I took those as my three priorities. I continued  
13 the work on protection from these threats, but it's  
14 important to focus, and you can understand that when  
15 you're assured by the leading global authority that the  
16 UK's the best prepared in the world, that is quite  
17 a significant reassurance. That turned out to be wrong.

18 **Q.** Coming back to the internal briefing --

19 **A.** Yes.

20 **Q.** -- putting to one side what international authorities  
21 said about the United Kingdom's position, you've told us  
22 that there was therefore a debate with your civil  
23 servants about vaccines; that was one of the issues that  
24 you asked about?

25 **A.** Yes.

20

1 Q. When you were told, however, by your civil servants that  
2 the United Kingdom was well prepared --

3 A. Yes.

4 Q. -- what did they say, when you asked them, as you  
5 presumably did, "Well, in what way" --

6 A. Yes.

7 Q. -- "are we prepared?"

8 A. Yes.

9 Q. What did they say about the various other parts of the  
10 preparedness structure, stockpiles --

11 A. Yes.

12 Q. -- diagnostic testing, plans for quarantining or  
13 shielding or to deal with the impact of a pandemic, or  
14 the supply of antivirals, all of which are other aspects  
15 of the system of preparedness?

16 A. I'm --

17 Q. What were you told?

18 A. I was told that we had plans in these areas. So, for  
19 instance, on stockpiles, I was told that we had a very  
20 significant stockpile of PPE, and we did. The problem  
21 was that it was extremely hard to get it out fast enough  
22 when the crisis hit.

23 I was told that we were good at developing tests,  
24 and indeed we were. We developed a test in the first  
25 few days after the genetic code of Covid-19 was

21

1 disaster from happening in the first place? How do you  
2 suppress the virus?

3 I need to put on the record, if I may, my Lady, that  
4 my written statement -- I've got an update on my written  
5 statement, having continued to look through the  
6 documents. In --

7 Q. Mr Hancock, we'll return, if we may, to correcting one  
8 or two parts of your witness statement --

9 A. Okay.

10 Q. -- a little later. I'm aware that there are one or two  
11 areas that you want to say something more about in light  
12 of documentation which you have been provided with more  
13 recently.

14 A. Yeah.

15 Q. Can I bring you back, though, please, to the debate with  
16 your civil servants about the state of preparedness?

17 A. Yeah.

18 Q. Did you observe to your civil servants or ask, "Well,  
19 there is a significant stockpile, but it's only for  
20 flu"?

21 A. Well, in the case of PPE, the distinction between a flu  
22 pandemic and a coronavirus pandemic is really second  
23 order. A respiratory disease pandemic requires very  
24 similar or, in many, many cases, the same PPE,  
25 irrespective of the virology. What matters is the

23

1 published. The problem was there was no plan in place  
2 to scale testing that had any -- that we could execute.

3 On antivirals, we had a stockpile of antivirals for  
4 a flu, but not for a coronavirus.

5 On vaccines, I was concerned that we weren't in  
6 a strong enough position, because we were reliant on  
7 manufacturing vaccines overseas, and I thought that in  
8 a pandemic scenario, force majeure would mean that it  
9 would be hard to get hold of vaccine doses if they were  
10 physically manufactured overseas, no matter what our  
11 contracts said. So I insisted that we pushed on  
12 domestic manufacture and sought the funding to deliver  
13 on that. A plan was already in early development to  
14 make that happen.

15 So in each of these cases there was a plan, but the  
16 absolutely central problem with the planning in the UK  
17 was that the doctrine was wrong, and if I -- maybe  
18 I should set this out now. I've written it in my  
19 written statement.

20 The attitude, the doctrine of the UK was to plan for  
21 the consequences of a disaster: can we buy enough body  
22 bags? Where are we going to bury the dead? And that  
23 was completely wrong. Of course it's important to have  
24 that in case you fail to stop a pandemic, but central to  
25 pandemic planning needs to be: how do you stop the

22

1 characteristic of the virus.

2 Q. Indeed. Did you ask whether or not the stockpile about  
3 which you received assurances would be adequate for  
4 a non-influenza pandemic?

5 A. I don't recall whether I did or not, but I also know  
6 that if I'd asked the question, I would have been --  
7 I hopefully would have been told it's adequate for other  
8 respiratory diseases as well, because indeed it was,  
9 because we used it.

10 Q. Did you ask whether or not the antivirals --

11 A. Yes.

12 Q. -- in the main a brand antiviral called Tamiflu --

13 A. Yes.

14 Q. -- which was supplied in -- was available in large  
15 quantities, whether that was suitable for  
16 a non-influenza pandemic?

17 A. I don't know whether I asked or I was briefed, but I was  
18 certainly aware that that was only useful against a flu,  
19 not a coronavirus.

20 Q. Did you ask or were you made aware that the testing, the  
21 diagnostic testing which was in place was on a very  
22 small order, and of course was testing designed to deal  
23 with a limited high-consequence infectious disease,  
24 primarily one involving an outbreak in health settings?

25 A. Yes, I knew that the testing system was small, and the

24

1 reason that I explained the flawed doctrine at this  
2 point is that by not preparing to stop a pandemic, and  
3 worse by explicitly stating in the planning that it  
4 would not be possible to stop a pandemic, therefore  
5 a huge amount of other things that need to happen when  
6 you're trying to stop a pandemic didn't happen, and we  
7 had to build them from scratch when the pandemic struck.

8 For instance, large-scale testing did not exist, and  
9 a large-scale contact tracing did not exist, because it  
10 was assumed that as soon as there was community  
11 transmission, it wouldn't be possible to stop the spread  
12 and, therefore, what's the point in contact tracing?

13 That was completely wrong, and in my view is the  
14 absolutely central lesson, is: of course the difference  
15 between a flu and a coronavirus is important, but it is  
16 a -- but it is not nearly as important as getting the  
17 doctrine right so in future we're ready to suppress  
18 a pandemic, unless the costs of lockdown are greater  
19 than the costs that the pandemic would bring.

- 20 **Q.** Perhaps we'll return to the issue of the -- or the  
21 doctrinal arguments about lockdowns a little later.  
22 **A.** If I may, the reason to bring it up is because it had  
23 consequences in all the areas you've set out:  
24 stockpiles, testing, antivirals, contact tracing and  
25 much more widely.

25

1 the reasons that I feel so strongly about the importance  
2 of this Inquiry, and why I'm so emotionally committed to  
3 making sure that it's a success, with full transparency  
4 and total brutal honesty in answering your questions to  
5 get to the bottom of this, is because these -- because  
6 of these -- this huge error in the doctrine that the  
7 UK -- and, by the way the whole western world -- had in  
8 how to tackle a pandemic. And that, that flawed  
9 doctrine, underpinned many of the problems that made it  
10 extremely difficult to respond.

11 If I may say so, I am profoundly sorry for the  
12 impact that had. I'm profoundly sorry for each death  
13 that has occurred. And I also understand why for some  
14 it will be hard to take that apology from me.  
15 I understand that. I get it. But it is honest and  
16 heartfelt. And I'm not very good at talking about my  
17 emotions and how I feel, but that is honest and true,  
18 and all I can do is ensure that this Inquiry gets to the  
19 bottom of it and that for the future we learn the right  
20 lessons so that we stop a pandemic in its tracks much,  
21 much earlier, and that we have the systems in place  
22 ready to do that. Because I'm worried that they're  
23 being dismantled as we speak.

- 24 **Q.** Well, we'll come to that in a moment, Mr Hancock.

25 So with those words in mind, why in July 2018, when

27

- 1 **Q.** Those were, now, the acknowledged consequences of the  
2 doctrinal failure, Mr Hancock.

3 **A.** Yes.

- 4 **Q.** But why, if you asked the questions which you say now  
5 you did, about the fact that antivirals and the  
6 stockpiles of antivirals were only suitable for  
7 influenza, that the testing was limited and suitable for  
8 high-consequence infectious disease in a healthcare  
9 setting, that the PPE was designed for flu, although it  
10 had application to HCIDs as well, and that there was no  
11 debate about the potential countermeasures, mandatory  
12 quarantining, shielding, the impact on education or the  
13 economy, if these were questions which were posed when  
14 you took office in July 2018, why was the situation  
15 allowed to develop in which none of these matters were  
16 met, addressed, by the time you had to deal with the  
17 consequences of the pandemic in February 2020, when, as  
18 you've rightly said, you had to build, in all these  
19 areas, the entire system from scratch?

- 20 **A.** Because I was assured that the UK planning was among the  
21 best and, in some instances, the best in the world, and  
22 of course, with hindsight, I wish I'd spent that short  
23 period of time as Health Secretary before the pandemic  
24 struck also changing the entire attitude to how we  
25 respond to a pandemic. And perhaps -- you know, one of

26

1 you were made aware of the lacuna in the system of  
2 preparedness, the absence of stockpiled PPE for  
3 non-influenza pandemic, the lack of antiviral, the lack  
4 of mass diagnostic testing, the lack of contact trace  
5 systems, why did you not pursue those issues in the  
6 following 18 months before the pandemic struck?

- 7 **A.** The only answer I can give is because I was assured that  
8 we had the best system in place in the world, and  
9 because this system was working towards an approach to  
10 pandemic response that was wrong. That's why it was  
11 built that way. And that flaw, that failure, went back  
12 years and years and was embedded in the entire system  
13 response. So --

- 14 **Q.** Mr Hancock, forgive me. That doctrinal error, to which  
15 we'll come in a moment, in the 2011 strategy explains  
16 why the position was as it was in July 2018.

17 **A.** Yes.

- 18 **Q.** My question to you, though, is: why, having been alerted  
19 to these serious issues, was more not done over the  
20 following 18 months? Regardless of why you were in that  
21 position, regardless of why the department was in that  
22 position, regardless of the doctrinal foundation, why  
23 were those practical considerations not followed  
24 through?

- 25 **A.** Well, there was no recommendation to resolve those

28

1 problems that I was aware of. There were  
2 recommendations to put into place the learnings from  
3 project Cygnus, some but not all of which were taken  
4 forward. I was assured that there was a programme of  
5 work to put those in place, but there were no  
6 recommendations to build a testing system that I was  
7 aware of, there were no recommendations to change the  
8 stockpile, although on that point the stockpile was  
9 effectively transferable from one respiratory disease to  
10 another. These recommendations were not there because  
11 the system was geared towards how to clear up after  
12 a disaster, not prevent it.

13 **Q.** You were the Secretary of State.

14 **A.** Yes.

15 **Q.** It doesn't need a formal submission from civil servants  
16 for something to be done if, in the course of this  
17 debate, you asked your civil servants, "Where are the  
18 antivirals for a non-influenza pandemic?"

19 **A.** Yes.

20 **Q.** "Where is the stockpile for a non-influenza pandemic?  
21 Where are the plans for mass testing?"

22 They wouldn't have said "Secretary of State, we  
23 can't do anything about that, let's wait to see what the  
24 submission we draw up recommends".

25 **A.** That's right.

29

1 **Q.** There was only ever one strategy document, wasn't there?  
2 That was it.

3 **A.** That was the strategy document that I was aware of. Of  
4 course there was a whole load of underpinning documents  
5 and further work, but that was the strategy document,  
6 yes.

7 **Q.** That single strategy document identified no strategy for  
8 a non-influenza pandemic other than the hope that the  
9 plan for an influenza pandemic could be modified to deal  
10 with a high-consequence infectious disease that was not  
11 influenza?

12 **A.** That's right. I would also say that any pandemic, by  
13 its nature, is a novel disease.

14 **Q.** Indeed.

15 **A.** So you cannot have a plan precisely for the disease that  
16 comes. And the things that matter are: how long is the  
17 incubation period? How transmissible is it? How does  
18 it transmit? And, crucially, who does it affect more  
19 than others, what are the inequalities, the consequences  
20 of this disease? Those are the factors that matter.

21 It would be far better to have a respiratory disease  
22 plan and a blood-borne pandemic disease plan and  
23 a vector, ie touch-borne -- or touch-borne disease plan,  
24 that was non-specific about the virology of the  
25 pathogen, because what matters is how the thing's

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1 **Q.** You could have ordered it to be addressed and you could  
2 have pursued and harried them until something was done?

3 **A.** Of course, had I known the pandemic was about to strike,  
4 then I would have done that, but this was  
5 an unprecedented pandemic and the -- nobody was to know.  
6 So all I can explain is that when you are -- when you  
7 become the Secretary of State -- when you are the  
8 Secretary of State, new in post, there are a significant  
9 number of recommendations of what needs to be changed.  
10 For example, Dame Sally Davies came into my office and  
11 said, "We have to try to prevent more -- prevent ill  
12 health and tackle obesity, that is the number one  
13 problem facing the country". This was not regarded as  
14 a number one problem that needed to be fixed, because we  
15 were regarded by external organisations, that had been  
16 and investigated our preparedness, we were regarded as  
17 one of the best in the world. That's the only answer  
18 I can give you. I know I've repeated it, but that's  
19 because it's true.

20 **Q.** The 2011 strategy to which you refer was --

21 **A.** Yes.

22 **Q.** -- the 2011 influenza strategy document dealing, as it  
23 says on its face, with the strategy for an influenza  
24 pandemic.

25 **A.** Yes.

30

1 transmitted and how it affects people, as much as the  
2 underlying virology as well.

3 **Q.** So, in effect, the plan failed to provide for a range of  
4 scenarios, it focused too much upon an influenza  
5 pandemic, of course that's what it was called, and  
6 although there was a reference in it, Mr Hancock, to the  
7 inherent unpredictability of respiratory viruses, there  
8 was no detail, was there, of how, given those inherent  
9 unreliable characteristics of a respiratory virus, we  
10 could be hit by a non-influenza pandemic which had  
11 different characteristics to influenza but could be no  
12 less catastrophic?

13 **A.** So --

14 **Q.** That was the flaw, wasn't it?

15 **A.** That was not the main flaw, that was a flaw.

16 That was of course a problem. However, we also knew  
17 there could be another infectious disease and, as I've  
18 mentioned, we were dealing with a number of them, and  
19 I was cognisant of that. For instance, when we did the  
20 work on vaccine production, the plan that was put  
21 together was a pandemic disease plan, vaccine plan, not  
22 an influenza pandemic vaccine plan. So we were  
23 cognisant of that.

24 But I return to my central point, which is that to  
25 say that the main problem with that plan was that it was

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1 a flu plan and there was -- and we ended up with  
 2 a coronavirus pandemic is of course a flaw, but it is  
 3 not the central flaw. If we'd had a flu pandemic, we  
 4 would have had a massive problem because of the  
 5 doctrinal failure of how to respond to it as well. That  
 6 was a much bigger error. It was an error across the  
 7 western world, but it was a much bigger error, and it is  
 8 absolutely central. I know that I keep stressing this  
 9 point, but it is central to what we must learn as  
 10 a country, that we've got to be able to hit a pandemic  
 11 hard, that we've got to be able to take action, lockdown  
 12 action if necessary, that is wider, earlier, more  
 13 stringent than feels comfortable at the time. And the  
 14 failure to plan for that was a much bigger flaw in the  
 15 strategy than the fact that it was targeted at the wrong  
 16 disease.

17 **Q.** They were both major flaws in the strategy, were they  
 18 not, Mr Hancock?

19 **A.** They were both --

20 **Q.** It was not just one flaw. You have identified now two  
 21 major flaws in that strategy.

22 **A.** Yes, the point I'm trying to make is that the doctrinal  
 23 flaw was the biggest by a long way, because if we'd had  
 24 a flu pandemic, we still would have had the problem of  
 25 no plan in place for lockdown, no prep for how to do

33

1 **Q.** The 2011 strategy was never updated, was it?

2 **A.** Not that I -- no, it wasn't, no.

3 **Q.** Indeed, the workstream which was due to be carried out  
 4 by the Pandemic Flu Readiness Board to update that  
 5 strategy was itself paused, was it not?

6 **A.** As I understand it, yes.

7 **Q.** There has been ample evidence to show that the work was  
 8 not done to update this document, this strategy, because  
 9 of the diversion of resources to the necessary  
 10 preparations for a no-deal EU exit; is that your  
 11 understanding?

12 **A.** That is correct, yes.

13 **Q.** All right.

14 Were you told, when you were Secretary of State,  
 15 that the strategy was regarded as inadequate and not up  
 16 to date?

17 **A.** No. Not that I'm aware, not that I recall. On the  
 18 contrary, we were told that we were one of the best  
 19 places in terms of preparation.

20 **Q.** Are you surprised now that you were not informed that  
 21 the strategy was deemed to be, and I quote a document  
 22 from your own department, "out of date, unfit for  
 23 purpose"?

24 **A.** I was not aware of that, no.

25 **Q.** By July of 2019, an arm's length body, I suppose one

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1 one, no work on how best to lock down with the least  
 2 damage.

3 I know -- I understand deeply the consequences of  
 4 lockdown and the negative consequences for many, many  
 5 people, many of which persist to this day. The problem  
 6 that we faced was that the consequences of not locking  
 7 down was much worse, and we need to be able to be --  
 8 I think John Edmunds is excellent in his evidence  
 9 saying -- and Gus O'Donnell -- saying we need to have  
 10 a way to calibrate as early as possible: what would the  
 11 damage be of this if we don't, what would the damage be  
 12 of this if we do --

13 **Q.** I'm afraid I'm going to pause you there.

14 The issue of lockdown is, as you know very well  
 15 indeed, something for Module 2, and we are concerned now  
 16 with your understanding pre-pandemic and what was being  
 17 done pre-pandemic.

18 May I ask you, please, to focus on this strategy  
 19 document which sets out at that time what the thinking  
 20 was.

21 **A.** I understand that, but if I just may say --

22 **Q.** Mr Hancock, will you allow me, please. In this forum --

23 **A.** It is vital for planning, that's the point.

24 **Q.** -- I ask the questions.

25 **A.** Of course.

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1 would call it, or a stakeholder, Public Health England,  
 2 was stating in its own minutes that there had been no  
 3 word from the DHSC on the DHSC's pandemic strategy, so  
 4 they were concerned that they'd heard nothing from your  
 5 department in relation to the updating of this strategy,  
 6 because it was obviously a matter of very real concern.

7 **A.** I don't recall that ever being raised with me, and it  
 8 highlights the problem of not having a body that was  
 9 focused only on preparing to defend us against  
 10 a pandemic, since the Health Protection Agency was  
 11 abolished in 2012, and that was one of the reasons  
 12 behind the organisational change I brought in later.

13 **Q.** All right.

14 The Pandemic Influenza Preparedness board was  
 15 another important part of the department's work, was it  
 16 not?

17 **A.** Yes.

18 **Q.** What was its main function, as you saw it?

19 **A.** Well, it was an official-level board whose job  
 20 effectively was to put into place the conclusions of  
 21 Cygnus and to make sure that we were as well prepared as  
 22 possible.

23 **Q.** When you became Secretary of State, presumably you were  
 24 informed of the outcome of Exercise Cygnus and of the  
 25 fact that the then Prime Minister, Theresa May, had

36

1 ordered the setting up of the Pandemic Flu Readiness  
2 Board --  
3 **A.** Yes.  
4 **Q.** -- to put those recommendations into place?  
5 **A.** Yes. I found that reassuring. I'd been reassured that  
6 essentially everything was in hand because there was  
7 a structure, a resourced structure to make it happen.  
8 **Q.** As it happens, Mr Hancock, many of the workstreams which  
9 the Pandemic Flu Readiness Board planned to carry out  
10 were, for reasons we've discussed, paused or ceased  
11 altogether. So when you were Secretary of State, to  
12 what extent were you informed that the recommendations  
13 from Exercise Cygnus, about which you had been told,  
14 were not in fact being implemented?  
15 **A.** I don't know the answer to that question. I take full  
16 responsibility for the fact that, in the face of Brexit  
17 and the threats that a disorganised Brexit could do, we  
18 took -- the resources were moved across the department  
19 to focus on that threat, including away from pandemic  
20 preparedness planning. This was proposed to me by the  
21 permanent secretary and the CMO, and I signed it off.  
22 I regarded the Secretary of State's job not to run the  
23 department in terms of resource allocation, but to set  
24 the direction, but I take -- but I signed off that  
25 decision. The thing that -- the thing is that you face

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1 well prepared for that as possible.  
2 The second way of answering the same question is  
3 that it isn't really about the numbers of  
4 recommendations from Cygnus, it's about what those  
5 recommendations were, and the problem with Cygnus is it  
6 did not spot the central problem in pandemic planning.  
7 So I'm -- having looked through those recommendations  
8 that were not put in place, I'm not sure they would have  
9 helped much when the chickens, as you say, came home to  
10 roost. Because Cygnus did not recommend that we should  
11 be prepared to stop the spread of a pandemic. It made  
12 all sorts of recommendations for how to deal with the  
13 worst-case scenario happening.  
14 Therefore, I am not at all convinced that we would  
15 have been much better placed to face this pandemic had  
16 all of those recommendations been put into place,  
17 because -- because there was a much bigger error.  
18 **Q.** All right. But those exercises take place for good  
19 reason, do they not?  
20 **A.** Yes, but they still -- but it still didn't spot the main  
21 problem.  
22 **Q.** Are they important matters, Mr Hancock?  
23 **A.** Of course.  
24 **Q.** And were recommendations made, a number of them, as  
25 a result of that exercise?

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1 a lot of risks and threats.  
2 **Q.** But, Mr Hancock, why didn't you say to your civil  
3 servants -- this was a major exercise into the  
4 United Kingdom's pandemic influenza preparedness, it was  
5 one of the largest command post exercises ever held, it  
6 made a number of important recommendations, 22 in fact  
7 in all --  
8 **A.** Yeah.  
9 **Q.** -- across the whole board of the United Kingdom's plans  
10 and capabilities. And by June 2020 -- after the  
11 pandemic had struck, of course -- the DHSC acknowledged  
12 that of the 22 recommendations, eight had been fully  
13 addressed, six had been partially addressed, and work to  
14 address eight more was still ongoing.  
15 How could that have been missed? How could those  
16 recommendations not have been put into place between  
17 July 2018, when you took that post, and 2020, when the  
18 chickens came home to roost?  
19 **A.** Well, the answer to that question -- there's two ways of  
20 answering that question. The first is that as  
21 a secretary of state you have a limited set of  
22 resources, and you have to make sure that those  
23 resources are targeted at the threats that you face, and  
24 one of those risks was a disorganised Brexit and it was  
25 incumbent on the department to make sure that we were as

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1 **A.** Yes.  
2 **Q.** And did your department fail to implement all those  
3 recommendations?  
4 **A.** I'm not denying any of that. I'm explaining, firstly,  
5 the different pressures that you have on resources, and  
6 Brexit was real and a pressure, and I'm also explaining  
7 the consequences of those decisions, and I'm --  
8 I'm trying to articulate that there was a much bigger  
9 problem that we must -- and the central lesson that  
10 I think we need to learn.  
11 **Q.** Well, we'll come to that in a moment.  
12 The report into Exercise Cygnus was not published,  
13 was it, in July 2017, when it reported?  
14 **A.** No.  
15 **Q.** Could we have, please, INQ000057514, and page 2.  
16 **A.** Yeah.  
17 **Q.** You were asked in May of 2020 -- of course after the  
18 pandemic had struck -- whether or not you agreed that  
19 the report into Exercise Cygnus from July 2017 should be  
20 published.  
21 **A.** Yes.  
22 **Q.** We can see, the top left-hand corner of the page,  
23 number 2, "SoS", Secretary of State?  
24 **A.** Yes.  
25 **Q.** If you could scroll back out, please, the issue is --

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1 the issue identified in the submission was that  
2 "a number of public, parliamentary and legal requests  
3 for release of the report of Exercise Cygnus" had been  
4 received. It was "a pandemic influenza preparedness  
5 exercise carried out in 2016".

6 "To date, we have declined to release this report  
7 based on a balanced assessment of the public interest."

8 You were invited in fact to agree that the time had  
9 come for the publication of that report?

10 **A.** Yes.

11 **Q.** Do you know why, in general terms, the report -- or why  
12 the decision was taken in July 2017 not to publish the  
13 report, and why this only came to you for a decision in  
14 May 2020?

15 **A.** I've no idea about the 2017 decision. I know why it  
16 came to me for a decision in 2020, and that's because  
17 people were understandably asking to see it, and  
18 I supported publication.

19 **Q.** Could we have a look, please, at page 4, paragraphs 8  
20 and 10. Thank you.

21 Paragraph 8:

22 "Some projects had to be re-scheduled in 2018 and  
23 2019 due to competing priorities in civil  
24 contingencies."

25 Is that a partly concealed reference to the fact

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1 **A.** I'm explaining that the competing priorities in civil  
2 contingencies of course included that, but there are  
3 also other competing priorities.

4 The context I'm trying to set, explain, for all of  
5 this is that in health you have a certain amount of  
6 resources and you have a very broad set of risks, and  
7 whilst it's vital that this Inquiry uses hindsight to  
8 learn the lessons, we didn't have that at the time, and  
9 we didn't know that a pandemic was about to strike.

10 **Q.** Could we have, please, the bottom of page 5:

11 "Communications and public confidence. While this  
12 would not be a consideration for [freedom of  
13 information] purposes [this is in the context,  
14 of course, of deciding whether the report should be  
15 published] it is if you are considering going beyond  
16 your legal duties. Advice on communications is below:  
17 "- Mitigation ..."

18 That is to say, mitigation of damage done in the  
19 public sphere by virtue of the communications.

20 "You should note that while work is ongoing, there  
21 are no major gaps in our implementation of the lessons  
22 from Cygnus."

23 That wasn't quite right, was it?

24 **A.** I think that the officials writing this document have  
25 used the word "major" to explain that the central

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1 that workstreams had to be stopped to deal with the  
2 necessary preparations for a no-deal EU exit?

3 **A.** Yes. There will also have been -- there were other  
4 civil contingencies. For instance, there was a crisis  
5 of human body parts being left in hospital car parks  
6 that the civil contingencies team had to deal with.  
7 There were various other civil contingencies in that  
8 period. So it is not purely a euphemism for Brexit, it  
9 is an accurate description of the pressures on the civil  
10 contingent -- on the team.

11 **Q.** Mr Hancock, this is a document which is solely concerned  
12 with the publication of the report in Exercise Cygnus,  
13 which was itself only concerned with emergency  
14 preparedness for pandemic influenza?

15 **A.** Yes.

16 **Q.** The reference to "some projects" in paragraph 8 --

17 **A.** Yes.

18 **Q.** -- is only a reference, isn't it, to the projects which  
19 came from Exercise Cygnus?

20 **A.** That's correct, yes.

21 **Q.** The only reason that those projects were rescheduled by  
22 virtue of decisions of the Pandemic Influenza  
23 Preparedness Programme board, the Pandemic Flu Readiness  
24 Board and your own department, was because of the  
25 diversion of resources to deal with a no-deal EU exit?

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1 recommendations from Cygnus were implemented. For  
2 instance, Cygnus recommended that we have a draft legal  
3 Bill ready to go, and that proved to be incredibly  
4 important in the early response to the pandemic. And  
5 I made the point earlier that the Inquiry would be wrong  
6 to conclude that because not every lesson from Cygnus  
7 had been implemented -- that had every lesson been  
8 implemented, the response would have been that much  
9 better, because Cygnus was flawed in its central  
10 assumption about how best to respond to a pandemic.

11 **Q.** So you've referred, Mr Hancock, then to one particular  
12 workstream, which was the drawing up of a draft pandemic  
13 Bill --

14 **A.** Yes.

15 **Q.** -- to justify your answer that "there [were] no major  
16 gaps in our implementation of the lessons from Cygnus".  
17 What other workstreams were completed, as far as you're  
18 aware, in addition to the drafting of a Bill?

19 **A.** Were completed? Well, I don't have that paperwork to  
20 hand, but I'd be very happy to supply it.

21 **Q.** Page 7, please, paragraph 15:

22 "On 7 May, the Guardian newspaper published the full  
23 report on its website with personal information  
24 redacted. This was alongside an article highlighting  
25 there was no evidence recommendations from the report

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1 around social care preparedness had been acted on."

2 That was right, wasn't it?

3 **A.** Yes.

4 **Q.** One of the areas, the important workstreams which had  
5 not been concluded or even in part developed was to do  
6 with the capacity of the adult social care sector to be  
7 able to deal with --

8 **A.** That's not quite right.

9 **Q.** -- the demands of a pandemic?

10 **A.** As part of the work ongoing when I was  
11 Secretary of State, preparedness in social care was one  
12 of those workstreams, yes.

13 **Q.** Work was done, wasn't it, in order to try to see whether  
14 or not the department could make itself better informed  
15 as to the sheer number of people in the adult --

16 **A.** Yes.

17 **Q.** -- social care sector? Work was done on producing some  
18 policy papers that would be of use to local authorities,  
19 who of course are primarily responsible for the adult  
20 social care sector, but no work was done, was it, in  
21 relation to preparing the individual care homes for the  
22 necessary surge in numbers attendant upon a pandemic?

23 **A.** Work was done in the first two areas you mention. This  
24 report, the article, was inaccurate. However, the  
25 responsibility for ensuring preparedness in social care

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1 better data, but that was one of the workstreams.

2 And, you know, it's -- it was very important, and  
3 that work continued.

4 **Q.** Some work was done by the department to make itself  
5 better informed, in particular in relation to the  
6 numbers of persons in care homes and the working  
7 arrangements in the adult social care sector, but the  
8 vital work directly concerned with the preparation of  
9 those care homes, which was part of the workstream meant  
10 to be done by the Pandemic Flu Readiness Board, was not  
11 done, was it?

12 **A.** That's not --

13 **Q.** Those two plans were all that there was on the local  
14 authority side, and the surge planning in relation to  
15 the adult social care sector fell far behind that done  
16 for the NHS, did it not?

17 **A.** That work nevertheless was done, and being done, and it  
18 is a -- in fact, this discussion is an example of the  
19 challenge of why it's so hard for policy in social care  
20 when the accountability falls, understandably, to the  
21 Secretary of State, but in this case pandemic  
22 preparedness was a legal responsibility at the local  
23 level, and whilst we at the health department could  
24 require that, the money for social care from central  
25 government goes through a different department, and so

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1 formally fell to local authorities, and there was work  
2 required of local authorities to put in place pandemic  
3 preparedness plans. When the pandemic struck, and I was  
4 told that local authorities were required to have  
5 pandemic preparedness plans, I asked to see them, and my  
6 minister for social care, Helen Whately, found that  
7 there were only two, which she saw, and reported, to me,  
8 them to be wholly inadequate.

9 One of the central challenges in social care is that  
10 whilst I had the title Secretary of State for Health and  
11 Social Care, the primary responsibility, legal  
12 responsibility, contractual responsibility for  
13 social care falls to local councils. In a national  
14 crisis, this is a very significant problem, because, as  
15 I put it in my witness statement, we -- I had the title,  
16 I was accountable, but I didn't have the levers to act.  
17 And we didn't even have the data, and this is the work  
18 that was ongoing before the pandemic, which is why this  
19 statement here from The Guardian, reported from  
20 The Guardian is inaccurate, there was work ongoing to  
21 try to find out even the basics of the provision of  
22 social care.

23 For instance, how many care homes are operating  
24 right now in the UK? That was a fact that we did not  
25 know at that time. And I'm glad to say now there's far

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1 the requirement to produce those plans fell to the local  
2 authorities and they were in very large part not  
3 concluded before the pandemic struck. And that is --  
4 that is a major problem with how social care's run in  
5 this country.

6 **Q.** The obligation to get ready did not rest solely on the  
7 local authority, did it?

8 **A.** The obligation for the policy rested with me. The  
9 obligation for delivery in social care rests with local  
10 authorities. They're the ones who contract individual  
11 care homes.

12 **Q.** The Department of Health and Social Care understood that  
13 an important line of work, a workstream, to be carried  
14 out by the Pandemic Flu Readiness Board and the Pandemic  
15 Influenza Preparedness Programme board, was ensuring  
16 that the adult social care sector was ready in terms of  
17 plans, what would they do in the event of a pandemic,  
18 and surge capacity, how would they physically cope --

19 **A.** Yeah.

20 **Q.** -- with the impact of a catastrophic pandemic?

21 **A.** Yeah --

22 **Q.** Those were the obligations on the Department of Health  
23 and Social Care and they were not completed, were they?

24 **A.** They were to be delivered through local authorities,  
25 which proved extremely difficult, and that is

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1 a structural problem with how social care has been  
 2 organised in this country since 1948.  
 3 **Q.** That may be so, Mr Hancock, but it was a responsibility  
 4 that the Department of Health and Social Care was aware  
 5 of, otherwise it wouldn't have directed that these  
 6 workstreams be drawn up at all?  
 7 **A.** Absolutely.  
 8 **Q.** Right.  
 9 **A.** Absolutely.  
 10 **Q.** The NSC(THRC), the National Security Council Ministerial  
 11 sub-committee on Threats, Hazards, Resilience and  
 12 Contingencies was the committee to which you referred  
 13 earlier, the committee chaired by the then  
 14 Prime Minister, who had ordered the setting up of the  
 15 Pandemic Flu Readiness Board?  
 16 **A.** Yes.  
 17 **Q.** The terms of reference for that board required the  
 18 Secretary of State for Health to report progress to the  
 19 National Security Council THRC committee on the work of  
 20 the Pandemic Flu Readiness Board.  
 21 Could we have, please, INQ000022743.  
 22 **LADY HALLETT:** I think if we're going to a slightly  
 23 different topic, Mr Keith --  
 24 **MR KEITH:** Yes, my Lady.  
 25 **LADY HALLETT:** -- I think, probably, if that's convenient

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1 Mr Hancock, the Pandemic Flu Readiness Board was  
 2 co-chaired, of course, by your then department, DHSC,  
 3 and the Cabinet Office. But it was the only board which  
 4 provided "oversight for a programme which will deliver  
 5 the plans and capabilities to manage the wider  
 6 consequences of pandemic influenza".  
 7 Then on page 2, please, paragraphs 5 and 6, "Roles  
 8 and Responsibilities of Members":  
 9 "5. The membership of the Board is intended to  
 10 reflect the breadth of the Government's responsibility  
 11 for the potential consequences of an influenza pandemic  
 12 on the nation. Members of the Board will represent the  
 13 interests of their department ..."  
 14 Then at 6:  
 15 "The Board will report progress to NSC(THRC) [that's  
 16 the ministerial committee which set up the board] via  
 17 the Secretary of State for Health and Minister for the  
 18 Cabinet Office, who will receive regular progress  
 19 updates in parallel."  
 20 It is obvious that the Department of Health and the  
 21 Cabinet Office regarded it as essential that the work  
 22 being done by this sole cross-government body, the only  
 23 body dealing with cross-government pandemic influenza  
 24 preparedness, provide regular updates to the ministerial  
 25 committee which set it up.

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1 for you?  
 2 **MR KEITH:** Yes, indeed.  
 3 **LADY HALLETT:** We take regular breaks because we have  
 4 a brave stenographer who copes with us all, but ...  
 5 Very well, I shall return at 25 past -- half past.  
 6 **(11.12 am)**  
 7 **(A short break)**  
 8 **(11.30 am)**  
 9 **LADY HALLETT:** Mr Keith.  
 10 **MR KEITH:** Mr Hancock, I was about to put to you the terms  
 11 of reference for the Pandemic Flu Readiness Board.  
 12 They are at INQ000022743, page 1, please.  
 13 The first paragraph on page 1 provides the  
 14 background to the setting up of the board, and refers  
 15 back to that meeting about which you gave evidence  
 16 earlier, the NSC(THRC) meeting in February 2017.  
 17 The board and the discussion reaffirmed the  
 18 government's commitment to ensuring the UK was prepared  
 19 to manage the health effects of severe pandemic  
 20 influenza as defined by the reasonable worst-case  
 21 scenario, and the wider consequences.  
 22 "Since the demise of the Pandemic Flu Implementation  
 23 Group, there has been no dedicated group with  
 24 responsibility for preparations for the cross-government  
 25 impacts of pandemic influenza."

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1 There were two NSC(THRC), that's the overarching  
 2 committee, two such committee meetings attended by  
 3 officials.  
 4 How many of those overarching meetings, NSC(THRC)  
 5 meetings, did you go to in order to inform them of those  
 6 regular progress updates?  
 7 **A.** Personally?  
 8 **Q.** Personally.  
 9 **A.** None that I can remember. I attended the National  
 10 Security Council from time to time when the agenda  
 11 included areas that I was responsible for. I was not  
 12 a standing attendee. But I don't recall ever being  
 13 asked to attend to report on this.  
 14 **Q.** Did you know of the existence of the NSC(THRC), the  
 15 ministerial -- overarching ministerial committee to  
 16 which you were expected to report?  
 17 **A.** Yes, I attended it. That's essentially the National  
 18 Security Council.  
 19 **Q.** No, the NSC(THRC), the threats, hazards, resilience and  
 20 contingencies committee.  
 21 **A.** Yes, that's a subcommittee. That one is a subcommittee  
 22 of the National Security Council.  
 23 **Q.** How many of those subcommittee meetings did you attend?  
 24 **A.** I can't recall.  
 25 **Q.** Did you attend any?

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- 1 **A.** I may well have attended none, but I can't recall.  
 2 **Q.** Have you seen any piece of paper that suggests you did  
 3 attend?  
 4 **A.** No.  
 5 **Q.** Why not?  
 6 **A.** I've no idea. Because the Department for Health was not  
 7 responsible for the agenda of that, that committee or  
 8 indeed the wider National Security Council. The  
 9 attendance of ministers in the Department of Health was  
 10 determined by whether they were invited.  
 11 **Q.** Mr Hancock, your own department's committee, the board,  
 12 which it co-chaired with the Cabinet Office, knew full  
 13 well that you were expected to report to the NSC(THRC)  
 14 with updates on the board's work. Can you think of any  
 15 reason why you didn't attend those meetings, why you  
 16 weren't told about the meetings, why you weren't  
 17 informed of the expectation that you attend those  
 18 meetings?  
 19 **A.** The only explanation I can give is that the team faced  
 20 a significant number of different threats and  
 21 challenges, and they chose, during the relatively short  
 22 period I was Secretary of State before the pandemic  
 23 struck, to focus on other issues that they felt to be  
 24 appropriate.  
 25 I mean, my experience in government, both as

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- 1 continue normal preparedness activities and ensuring  
 2 that Part 2 of the CCA is refined if required ... In  
 3 discussion members raised the following points:  
 4 "As part of the normal preparedness activities --  
 5 would continuity of crisis management continue? The  
 6 Cabinet Office advised that it would be maintained ...  
 7 but ... some elements will be prioritised.  
 8 "... some departments still wished to provide  
 9 feedback ..."  
 10 Then there was a debate about:  
 11 "Would hostile state activity exercises ...  
 12 continue?"  
 13 "The Chair summarised that officials should continue  
 14 to brief ministers on what level of business as usual  
 15 activities/departmental responsibilities could continue  
 16 following a move to the operational mode of EU Exit  
 17 planning."  
 18 So in the autumn and the winter of 2018, over a year  
 19 before the pandemic struck, at this officials' meeting  
 20 of the National Security Council THRC committee, there  
 21 was debate about the fact that the EU exit planning was  
 22 starting to have an impact or would be likely to start  
 23 to have an impact on preparedness planning, because of  
 24 the prioritisation of work.

25 There is a clear reference there to ministers being

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- 1 Secretary of State for Health and Social Care and  
 2 before, was that the officials who handle and are  
 3 responsible for the National Security Council and its  
 4 subcommittees are exceptionally diligent, extremely hard  
 5 working, and have the highest integrity, and that goes  
 6 for all of the officials I worked for in the  
 7 department -- I worked with in the Department for Health  
 8 and Social Care. All I can say is they would have known  
 9 and it would have been incumbent on them to consider all  
 10 threats and make decisions as to the agenda according to  
 11 what's necessary.  
 12 **Q.** May we have, please, INQ000180188. This is a document  
 13 relating to the officials' subcommittee of the  
 14 NSC(THRC), in fact the NSC(THRC)(O) meeting, O for  
 15 officials.  
 16 **A.** Yes.  
 17 **Q.** It's dated 19 December 2018, so after you took office in  
 18 July 2018.  
 19 If we could go to page 3, paragraph 2:  
 20 "EU Exit Planning":  
 21 "The Cabinet Office updated members on Civil  
 22 Contingencies Secretariat ... prioritisation work in the  
 23 lead up to EU Exit. They planned to move into the  
 24 operational mode of EU Exit planning in early January.  
 25 CCS stressed that capacity will be maintained to

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- 1 briefed as to what levels of business as usual  
 2 activities would continue, notwithstanding the necessary  
 3 prioritisation of work towards a no-deal EU exit.  
 4 When were you briefed in the autumn and winter of  
 5 2018 as to what was coming?  
 6 **A.** Well, I was, of course, aware that Brexit was  
 7 a significant part of the national debate and that in  
 8 the department we needed to be prepared for it.  
 9 And the -- so that briefing was ongoing. And as we  
 10 discussed earlier, there was a moment at which we had to  
 11 move resources on to prepare for that, in the summer,  
 12 I think, of 2019. And we did that -- within the  
 13 department, the plans to do that were drawn up by the  
 14 team, and I signed them off.  
 15 But I return to my broader point, which is the  
 16 professionalism and diligence with which the  
 17 civil service team looked at all of the different  
 18 challenges and threats that were faced was exemplary.  
 19 **Q.** Could we have INQ000057430, please.  
 20 This is a memo from within your department to  
 21 Professor Sir Chris Whitty, the current CMO, of course,  
 22 who you know very well, and I think he was a former  
 23 departmental Chief Scientific Adviser --  
 24 **A.** Correct.  
 25 **Q.** -- in the department.

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1 It's dated 27 March 2019, and it concerns the  
 2 reallocation of work. Paragraph 1, to Sir Chris Whitty:  
 3 "You are aware that, following re-organisation and  
 4 re-prioritisation of DHSC work due to EU Exit no deal  
 5 planning, pan flu preparedness and high consequence  
 6 infectious disease ... policy has moved to your  
 7 portfolio of responsibilities on a temporary basis."  
 8 Then at paragraph 3:  
 9 "ExCo ..."  
 10 What is ExCo?  
 11 **A.** That's the executive committee of the Department for  
 12 Health and Social Care chaired by the  
 13 permanent secretary. That's the committee that  
 14 effectively runs the department on an executive basis.  
 15 **Q.** But subject to the supervisory role of the departmental  
 16 board to which you referred earlier, perhaps?  
 17 **A.** Yes, and of course working to ministerial priorities and  
 18 decisions.  
 19 **Q.** "ExCo agreed that the Department would need to do less  
 20 work in some areas in order to free up resource for  
 21 EU Exit preparations. As a result, Emma Reed and  
 22 Clara Swinson agreed a range of work related to pan flu  
 23 and HCID that would be scaled back or paused before this  
 24 policy area transferred across to you. Annex A  
 25 summarises the work areas that are continuing and those

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1 were many other areas of work that had to be stopped in  
 2 order to prepare for Brexit as well. I mean, this  
 3 wasn't the only area, there were a whole series of them.  
 4 **Q.** So you were aware and you agreed that a range of work  
 5 relating to pan flu and HCID would have to be scaled  
 6 back or paused?  
 7 **A.** Yes, and I wasn't enthusiastic about it but I signed it  
 8 off, and the reason that I signed off the overall  
 9 reshaping of the department is because we had a very  
 10 real and material threat, should a disorganised Brexit  
 11 happen, that we needed to be prepared for. And it comes  
 12 back to the point about context, that there are many,  
 13 many bad things you have to prepare for when you're  
 14 the -- in the health department.  
 15 **Q.** Moving forward eight months to the eve of the pandemic,  
 16 in November 2019, INQ000023089, the minutes for the  
 17 Pandemic Flu Readiness Board:  
 18 "The Pandemic Flu Readiness Board ... has not met  
 19 since November 2018 due to reprioritisation in 2019 to  
 20 plan for a potential no-deal EU Exit."  
 21 So the sole cross-government body set up by  
 22 direction of the Prime Minister did not meet at all, did  
 23 it, between November 2018 and 27 November 2019?  
 24 **A.** That's what this paper says.  
 25 **Q.** Were you aware, Mr Hancock, that for a whole year the

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1 which are on hold."  
 2 So this paragraph makes plain that at the highest  
 3 level in your department, subject only to the  
 4 supervisory review of the board and yourself, not just  
 5 that there was a prioritisation across government in  
 6 favour of EU exit work, but that a range of work related  
 7 to pan flu and HCID would be scaled back or paused.  
 8 That was a policy decision of great significance,  
 9 was it not?  
 10 **A.** It was a policy decision. I would query whether it had  
 11 great significance.  
 12 As you can see from the numbers on this page, the  
 13 numbers of people working in this area, the numbers of  
 14 movement, is small, and my second observation is that  
 15 this work was following a wrong -- the wrong approach,  
 16 and I'm not sure it would have been any use in the  
 17 pandemic. That's my judgment from having been the man  
 18 in the -- you know, the person in the hot seat when the  
 19 pandemic struck.  
 20 **Q.** Do you recall that debate before ExCo?  
 21 **A.** Yes, I recall the debate, because I discussed it with  
 22 the permanent secretary, because whilst he was  
 23 responsible for the running of the department, he  
 24 of course would then check with me that I was content  
 25 with the proposals that he'd put together, and there

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1 board did not even meet?  
 2 **A.** I do not recall being aware of that, no. But also --  
 3 but I do know that work under the board's guidance  
 4 continued, because I was engaged in some of the work, as  
 5 we've discussed, especially but not only on vaccine  
 6 manufacturing.  
 7 **Q.** Page 5, paragraphs 7 and 8.  
 8 "... PFRB had committed to meet every 6-8 weeks  
 9 until the key outputs of the work programme were  
 10 delivered. It is proposed that in 2020 [it] meets every  
 11 3 months. This will ensure that progress can be  
 12 communicated to key planning partners through updated  
 13 documentation where appropriate."  
 14 So it was understood, wasn't it, that although it  
 15 had committed to meet every six to eight weeks, the  
 16 failure to meet for a whole year fell very far short of  
 17 what it had apparently committed itself to doing?  
 18 **A.** That's what I understand too from reading these papers,  
 19 yeah.  
 20 **Q.** It says:  
 21 "NHS(THRC) [it should be NSC(THRC)] -- Under the  
 22 PFRB's current governance arrangements, the Board  
 23 reports on progress to NSC(THRC)."  
 24 The board which you -- the subcommittee which you  
 25 cannot recall attending.

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1 "Due to EU Exit pressures, NSC(THRC) were not  
2 updated at the end of Year 2, March 2019."  
3 So it didn't not just not meet, it wasn't even  
4 updated at the end of Year 2, March 2019, the second  
5 full year of its operations, was it?  
6 **A.** Evidently, from reading these papers. I wasn't aware of  
7 these papers at the time.  
8 **Q.** Then of course after the pandemic struck --  
9 INQ000023114 -- on 15 January 2020:  
10 "Pandemic Influenza Preparedness Programme Work  
11 Stream Updates (Last Updated: 15 January 2020)"  
12 The healthcare workstream:  
13 "Progress has slowed ..."  
14 For a number of reasons.  
15 "2 -- Community Care.  
16 "Progress on the community healthcare side has  
17 slowed ..."  
18 For a number of reasons.  
19 Then over the page, please, or further down the  
20 page, "Excess deaths", that was one of the workstreams  
21 on which work was completed, wasn't it?  
22 **(Pause)**  
23 You referred earlier in your evidence to the fact  
24 that you were aware that was a workstream on which work  
25 was done?

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1 impacts."  
2 Is that a reference to the drafting of the Bill to  
3 which you made reference earlier?  
4 **A.** The ... it -- it appears so. That's what --  
5 "4 Nations Bill" was used as the shorthand --  
6 **Q.** Yes, there is a reference to clauses and supporting  
7 documentation. So that appears to --  
8 **A.** That appears so. On the previous one, on number 4,  
9 of course, the work that was intended to be prepared for  
10 a no-deal Brexit was itself important, incredibly  
11 important, when it came to the pandemic. So this paper  
12 doesn't quite capture -- capture it. It captures the  
13 planning, and later --  
14 **Q.** Is that a reference to the fact that work was done on  
15 securing and safeguarding medicinal supply chains --  
16 **A.** Yes.  
17 **Q.** -- to deal with a no-deal EU exit?  
18 **A.** Yes.  
19 **Q.** But that issue of supply chains, Mr Hancock, was just  
20 one, wasn't it, of a very much larger number of areas in  
21 which work was required across the health sector and the  
22 adult social care sector? Not unimportant, but it was  
23 just one of the areas, wasn't it, where work was  
24 required?  
25 **A.** I wouldn't put it like that. If I may, the way I'd say

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1 **A.** Work was done, I'm not sure that it was completed,  
2 because we had to do further work on it when the  
3 pandemic struck. That's why I was pausing, to try to  
4 recollect and express that correctly.  
5 **Q.** Over the page, "Sector Resilience":  
6 "There has been no further work on this work stream  
7 as the statements of preparedness are finalised ... it  
8 was agreed that the sharing of the business checklist  
9 should be paused as a result of the need to communicate  
10 other risks, including EU Exit."  
11 What is sector resilience, Mr Hancock?  
12 **A.** Well, sector resilience is ensuring that there is  
13 resilience especially of supply chains.  
14 **Q.** Where?  
15 **A.** Well, in --  
16 **Q.** Which sectors?  
17 **A.** In this case pharmaceutical in particular, but also  
18 non-pharmaceutical goods required for the health and  
19 social care sector.  
20 **Q.** Health and social care sectors?  
21 **A.** Within the department, that would have been the purview.  
22 **Q.** Yes.  
23 "Cross Cutting Enablers."  
24 "All England clauses and supporting documentation  
25 complete including explanatory note and assessment of

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1 it is that the work done for a no-deal Brexit on supply  
2 chains for medicines was the difference between running  
3 out of medicines in the peak of the pandemic and not  
4 running out. We came extremely close, within hours, of  
5 running out of medicines for intensive care during the  
6 pandemic, it wasn't widely reported at the time, and  
7 I think the only reason that we didn't run out is  
8 because of the work that Steve Oldfield and his team  
9 did, which they did during 2019 in preparation for  
10 a no-deal Brexit, but became extremely useful in saving  
11 lives during the pandemic.  
12 At the point at which the pandemic struck, because  
13 of the no-deal Brexit work, we knew more about the  
14 pharmaceutical supply chain in the UK than at any time  
15 in history, and we had relationships with the  
16 pharmaceutical suppliers, and the data to know exactly  
17 who had what available and where, and the extent of that  
18 information was the difference between running out and  
19 not running out of drugs in intensive care in the  
20 pandemic.  
21 Now, that, of course, wasn't the intention of the  
22 work, but it was the consequence of the work. So when  
23 it comes to the question of the overall impact of  
24 Brexit, absolutely the paperwork is very clear that some  
25 of the preparation work was stopped and a small number

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1 of people were moved off that work. On the other hand,  
2 we were better prepared in terms of supply chains. Who  
3 knows the overall impact and which of those balances in  
4 the scales is greater. I'm afraid it's impossible to  
5 know.

6 **Q.** Mr Hancock, whilst that may well be right, that there  
7 was valuable work done in an important area of  
8 preparation, namely medicinal supply chains, this chart,  
9 and in particular row 4, "Sector Resilience", makes  
10 plain that across the swathe of the healthcare and adult  
11 social care sectors, important other areas of work, of  
12 which there were many more than the single issue of  
13 medicinal supply chains, were paused or interrupted.  
14 That is the point, isn't it?

15 **A.** That is one point. I agree.

16 **Q.** Thank you.

17 **A.** And a further -- but the further point is of  
18 significance: which is the most significant? And it's  
19 impossible to know whether one was more significant than  
20 the other.

21 **Q.** Than the others.

22 **A.** Whether the reduction in the number of people that -- as  
23 demonstrated by the paperwork, on pandemic preparedness,  
24 whether the impact, the negative impact of that is  
25 outweighed or is not outweighed by the positive impact

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1 that sort of risk register was not to learn the lessons  
2 from MERS and SARS, as has been discussed, and, as I've  
3 made clear in my submission, not to have the right plan  
4 to deal with a pandemic.

5 **Q.** Would you agree that in 2016, the risk register for that  
6 central DHSC-led board showed a risk that supplies of  
7 face masks, respirators and gloves could be below the  
8 optimum requirement in the event of a pandemic, and that  
9 the health and social care systems would be unable to  
10 cope with an extreme surge in demand for services in the  
11 event of a pandemic?

12 **A.** I wasn't aware of that, no.

13 **Q.** That in 2017, the following year, countermeasures were  
14 still a risk issue, the supply of face masks,  
15 respirators and gloves could be below the optimum  
16 requirement, and an extreme surge in the NHS and  
17 social care system was still an identified risk? That's  
18 2017.

19 **A.** Yes. If I may say so, my recollection was being  
20 reassured that we had a huge stockpile of PPE. Of  
21 course it's possible to write that it may be below the  
22 optimum, because the optimum may be an absolutely  
23 enormous quantity, which is exactly what we needed. So  
24 it's -- can be perfectly true to say it's below the  
25 optimum and at the same time reassure that it's huge.

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1 of the supply chain planning. As I've said, the number  
2 of activities is not as important as their consequence.  
3 And because Operation Cygnus, which was guiding this  
4 work, itself was flawed in conception, I'm not convinced  
5 that there would have been that much help, even if all  
6 of these things were done.

7 Of course it would have been better if they had, but  
8 I simply have no idea how helpful they would have been.

9 **Q.** Were you told, as Secretary of State, that the PFRB had  
10 not met for a year and that, as this document shows, by  
11 January of 2020 in a number of important areas work had  
12 paused?

13 **A.** I was aware that some work had paused. I don't recall  
14 being aware that the board hadn't met.

15 **Q.** There was another board, the Pandemic Influenza  
16 Preparedness board, again to which you've referred  
17 earlier. Do you recall that it was in the nature of  
18 that board's work to prepare annually a risk register  
19 setting out in the field of influenza preparedness what  
20 the greatest risks were?

21 Do you recall that?

22 **A.** I don't -- I don't recall that, but I'm not surprised.

23 **Q.** All right.

24 **A.** But from one year to another, I doubt it would have  
25 changed much. You know, again, the central failing of

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1 **Q.** The health and social care system may be unable to cope  
2 with an extreme surge in demand. That was an identified  
3 risk in the PIPP risk register in 2017, and by 2018,  
4 24 September, the following risks were still being  
5 identified: issues with face masks, respirators, gloves  
6 below the optimum requirement; plans for the surge that  
7 would be required in the health and social care systems  
8 were not fully tested; there was a risk in relation to  
9 the health and social care systems being unable to cope  
10 in the event of a pandemic and that risk remains.

11 So for two and a half years those risks, having been  
12 identified by the PIPP board, were not mitigated by  
13 virtue of being addressed. They remained, did they not?

14 **A.** They certainly did, and we had to deal with them when  
15 they materialised.

16 **Q.** Indeed. But that is a board and a programme which was  
17 led by your department, so the next question,  
18 Mr Hancock, is: how can that have been allowed to  
19 happen? With the inevitable consequence, Mr Hancock,  
20 that you yourself of course had to deal with the  
21 consequences of those risks not being mitigated when  
22 you --

23 **A.** Yes.

24 **Q.** -- faced the pandemic in January 2020.

25 **A.** Absolutely. The inability to get the PPE out fast

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1 enough was a very significant problem. One  
 2 recommendation I have for the future is that every  
 3 health and social care setting should be required to  
 4 have its own stockpile of PPE, and that should be paid  
 5 for by the government. Because in the early days  
 6 getting it out fast enough, when there was a sudden  
 7 increase in demand, just as explained there, that was  
 8 incredibly difficult.

9 So, yes, I totally accept that.

10 **Q.** And a PIPP paper, a Pandemic Influenza Preparedness  
 11 Programme board paper dated October 2019, on the eve of  
 12 the pandemic -- may we have INQ000023070, page 1,  
 13 paragraph 1:  
 14 "This paper:  
 15 "- [reminded] the ... Board of the pan flu programme  
 16 re-prioritisation that took place at the end  
 17 of 2018 ..."  
 18 And:  
 19 "- sets out the progress made on those areas of work  
 20 that continued and new priorities that arose ..."  
 21 At paragraph 3, there is a reference to an annex.  
 22 Perhaps we could have a look at that annex, please.  
 23 It's at the end. If you could go back up, please, to  
 24 the start of the annex, thank you.

25 **(Pause)**  
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1 Stop."  
 2 And so on.

3 **A.** Yeah.

4 **Q.** Were you told of the extent and nature of the stop  
 5 categories?

6 **A.** Well, I'm absolutely accountable for it, because I'm  
 7 accountable for everything that happened in the  
 8 department. I would also, though, ask you to consider  
 9 each of these in detail, because it comes to the point  
 10 we discussed earlier on significance.

11 For instance, the Moral and Ethical Advisory Group  
 12 existed, it had membership, when the pandemic struck.  
 13 So further membership and recruitment was not  
 14 a consideration that would have made a material  
 15 difference to planning for the pandemic.

16 The influenza strategy refresh, that was a 2011  
 17 document, it would -- that would only have been  
 18 significant if that refresh had completely changed the  
 19 strategy that the entire western world was following  
 20 that was regarded as -- by the WHO as best in class --

21 **Q.** May I pause you there? Is that the 2011 strategy --

22 **A.** Correct.

23 **Q.** -- which, in your witness statement, you state that, for  
 24 the purposes of pandemic planning was "woefully  
 25 inadequate"?

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1 Thank you.

2 Annex A:  
 3 "Pan flu programme re-prioritisation at the end of  
 4 2018.  
 5 "Work Areas.  
 6 "Pan Flu Bill."  
 7 That's a reference to the draft Bill to which you  
 8 referred.

9 "Perm Sec meetings on Pan Flu -- Continue.  
 10 "Perm Sec written updates on Pan Flu -- Continue.  
 11 "Quarterly Finance meetings -- Continue ...  
 12 "Moral and Ethical Advisory Group -- Membership and  
 13 Recruitment -- Stop.  
 14 "UK Pandemic Influenza Strategy Refresh -- Stop.  
 15 "... healthcare surge (largely complete, DA  
 16 [devolved administration] engagement to develop plans  
 17 outstanding -- Stop.  
 18 "... adult social care (largely complete for  
 19 [Pandemic Flu Readiness Board], [but] CMO actions  
 20 outstanding) -- Stop.  
 21 "PFRB paper on [the updating of the NSC] -- Stop.  
 22 "... Comms ... Stop.  
 23 "... benchmark NHS readiness internationally --  
 24 Stop.  
 25 "... engagement in Clinical Countermeasures Board --  
 70

1 **A.** Woefully inadequate. And --

2 **Q.** Thank you.

3 **A.** -- I don't think a refresh would have changed that,  
 4 because all of the independent external advice, the  
 5 World Health Organisation advice, indeed the  
 6 International Health Regulations stated that we should  
 7 not have lockdowns. In fact, in a 2017 document it  
 8 said:  
 9 "The evidence is not strong enough to warrant  
 10 advocating legislative restrictions."  
 11 This is where I need to add to what I've written in  
 12 my written statement, because I thought at the time it  
 13 was simply an oversight not to consider lockdowns.  
 14 Actually it was an explicit decision. The London  
 15 Resilience Partnership published document, May 2018, and  
 16 I quote:  
 17 "It will not be possible to halt the spread of a new  
 18 pandemic ..."  
 19 That was the attitude, it was the doctrine, and it  
 20 was wrong. So that refresh would have made very little  
 21 difference.

22 Healthcare surge is -- was largely complete. The  
 23 final action there is on involvement of the DAs. Since  
 24 healthcare is devolved that would have been -- not been  
 25 a terribly important area.

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1 Adult social care, largely complete. I'm not  
 2 exactly sure what the CMO actions outstanding are.  
 3 There's a question --  
 4 **Q.** May I --  
 5 **A.** -- my point is about materiality.  
 6 **Q.** May I just pause you there to ask you some more  
 7 questions about adult social care --  
 8 **A.** Sure. Yes.  
 9 **Q.** -- since you raise it.  
 10 **A.** Yes.  
 11 **Q.** In your statement you refer to the fact that one of the  
 12 major problems with the department's supervision of the  
 13 adult social care sector was the lack of policy  
 14 levers --  
 15 **A.** Yes.  
 16 **Q.** -- which would enable the department to ensure pandemic  
 17 preparedness --  
 18 **A.** Absolutely.  
 19 **Q.** -- in social care?  
 20 **A.** Yes.  
 21 **Q.** And as you said earlier --  
 22 **A.** But that's not what this is referring to.  
 23 **Q.** Well, I want to ask you whether or not you can say that  
 24 the adult social care sector was well prepared for  
 25 a pandemic when the department had no means of finding

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1 needs more support, it needs more resilience. And  
 2 I feel that very strongly, as does the current  
 3 Chancellor of the Exchequer, who has been clear about  
 4 that not only when he was in my job but in his current  
 5 job.  
 6 My point and my contention is that whatever the CMO  
 7 actions outstanding were here, they would not have  
 8 solved the huge challenges of adult social care in this  
 9 country, which requires significant improvement and  
 10 work.  
 11 **Q.** By January 2020, did the department have in place, the  
 12 department of social care have in place, a single  
 13 coherent plan to identify vulnerable service users  
 14 across the country, that is to say how many people are  
 15 in the care sector?  
 16 **A.** No.  
 17 **Q.** Did it have a central plan for the sharing of data  
 18 between private and public care providers and emergency  
 19 responders in order to be able to better prepare them  
 20 all for a pandemic?  
 21 **A.** Something along those lines was being developed, but it  
 22 was definitely not in place.  
 23 **Q.** Was there a single national guidance for pandemic  
 24 preparedness in the adult social care sector?  
 25 **A.** The guidance for pandemic preparedness went through

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1 out whether or not they had the right plans in place,  
 2 whether local authorities had planned sufficiently, let  
 3 alone how many numbers were in the care sector?  
 4 **A.** No, it was terrible, and --  
 5 **Q.** The department had no visibility of whether or not the  
 6 health -- adult social care sector was prepared at  
 7 all --  
 8 **A.** That --  
 9 **Q.** It wasn't within your ability?  
 10 **A.** That's not my contention. My contention is this action  
 11 here would not have solved that. The CMO could not have  
 12 solved the problems in terms of the oversight of the  
 13 adult social care sector. It was --  
 14 **Q.** Mr Hancock --  
 15 **A.** -- much bigger than that.  
 16 **Q.** -- what was the name of your department?  
 17 **A.** I've already talked about this. It's the  
 18 Department of Health and Social Care, and yet the legal  
 19 responsibilities are with local authorities. And we had  
 20 a programme, a separate programme of work under way --  
 21 that did not stop because of Brexit planning, that was  
 22 accelerated by the new Prime Minister in summer 2019 --  
 23 of reform of adult social care. We had ongoing work to  
 24 get better data that was continued in this process.  
 25 Adult social care desperately needs reform. It

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1 local authorities and so there was not a single one, no.  
 2 **Q.** Did all the LRFs, the local resilience forums, have  
 3 plans in place on the local authority level for dealing  
 4 with the impact of a catastrophic pandemic on the  
 5 elderly?  
 6 **A.** No, they were required to and, as far as I'm aware, only  
 7 two had done the work.  
 8 **Q.** Was the Department of Health and Social Care able to  
 9 verify the extent of the pandemic preparedness planning  
 10 that was being done by local authorities?  
 11 **A.** No, we didn't have the policy levers to do so, despite  
 12 having the name "Social Care" in the title.  
 13 **Q.** Did the Department of Social Care put into place  
 14 a national standard by which the plans from the local  
 15 authority could be gauged?  
 16 **A.** No.  
 17 **Q.** In relation to those local resilience forums, did the  
 18 department prepare, in fact, a pandemic flu standard at  
 19 the latter end of 2019, which for the very first time  
 20 obliged local resilience forums to compare their plans  
 21 against a national standard for influenza pandemic  
 22 planning?  
 23 **A.** Well, yes is the answer.  
 24 **Q.** It is.  
 25 **A.** And the -- and I suppose what that demonstrates --

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1 because that came into place late in 2019 --

2 **Q.** Yes, indeed --

3 **A.** -- is my central contention in this area, which is that

4 the system for how we run adult social care is flawed.

5 There was work ongoing to try to resolve it, including

6 work directly related to pandemic planning, but it was

7 in nowhere near good enough shape, and it meant that, as

8 the person trying to solve this problem, with a disease

9 that self-evidently impacted on older people most, we

10 were in an incredibly difficult position to do so when

11 the pandemic struck. Despite the enormous hard work of

12 everybody in that sector, and in the department, in

13 relation to adult social care, it was very, very

14 difficult early on. That's in part because this

15 planning was ongoing, but the systems in this country

16 for managing adult social care are not good enough, and

17 that reform -- that reform work was under way, but it

18 still hasn't been completed.

19 **Q.** So drawing some of these threads together, please,

20 Mr Hancock, would you accept the following propositions:

21 firstly, there was a long-standing bias within the

22 Department of Health and Social Care, as the risk owner

23 of the pandemic influenza risk and as the author of that

24 strategy which you described as woefully inadequate, in

25 favour of influenza, a failure to place sufficient

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1 until April 2020. There is a really important reason

2 I'm saying this. A flu plan assumes asymptomatic

3 transmission.

4 **Q.** Indeed.

5 **A.** There are some ways in which the flu plan was, in fact,

6 more appropriate as a planning document than a generic

7 document or, indeed, a document that had been written to

8 consider the impact of one of the then known

9 coronaviruses, because that plan, a coronavirus pandemic

10 plan, would have assumed no asymptomatic transmission.

11 So this underpins my point that of course it would

12 have been better to plan for a generic, you know,

13 respiratory Disease X, and that is what we should do in

14 future, however, planning for the flu -- planning for

15 flu did have some benefits, and it brings me back to my

16 central contention that, whilst this was an error, it

17 was in no way the biggest error. And it's not just that

18 there were two errors in the core plan, you know, flu

19 rather than coronavirus and wrong doctrine; the error of

20 the flawed doctrine was significantly bigger than the

21 error of targeting a flu rather than a coronavirus

22 pandemic.

23 **Q.** All right. Well, I don't need to trouble you about

24 degrees of failure. We'll come on to identifying the

25 various propositions.

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1 regard to the risk, admittedly a lesser risk, of

2 another, different, catastrophic HCID?

3 **A.** It would have been better, yes, if the plans had been

4 for a generic respiratory disease, because what matters

5 is the characteristic of the novel virus.

6 **Q.** Indeed.

7 Proposition 2: there was a failure to think through

8 properly the risks of a non-influenza pandemic. Due to

9 the inherent unpredictability of viral respiratory

10 pathogens, and their characteristics -- as you say,

11 transmission rate, high or stuttering; incubation

12 period, long or short; viral loads, great or less;

13 whether viruses congregate in the upper or lower

14 respiratory tract -- whatever they may have been,

15 because those other characteristics were simply not

16 thought about enough, the real risk of an HCID with

17 catastrophic consequences was not adequately thought

18 about either?

19 **A.** I wouldn't put it like that, and I think there's

20 an irony here. The irony is that one of the major

21 problems we had early on, which I'm sure we'll come to

22 in M2, was the fact that Covid-19 has asymptomatic

23 transmission. It's the first known coronavirus that

24 affects humans that can be transmitted asymptotically,

25 and the WHO assumption was that this wasn't possible

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1 **A.** Yeah.

2 **Q.** The third issue is one you've just touched upon, which

3 is that that approach in the risk assessment was cause

4 agnostic, it simply failed to identify a sufficiently

5 broad range of scenarios. And as you know, the risk

6 assessment process has been rewritten, thanks in the

7 main to a report from the Royal Academy of

8 Engineering --

9 **A.** Yes.

10 **Q.** -- to make that plain.

11 **A.** Yes, and there is an irony there as well, which is that

12 we were dealing with a live Ebola epidemic, with the

13 potential threat that would come to this country as

14 a pandemic, and yet at the same time the paperwork was

15 all focused on a flu pandemic.

16 **Q.** Yes.

17 **A.** So the theory written down in these strategies was

18 actually not what was playing out in the day-to-day

19 practice of infectious disease management that we were

20 undertaking as a department and that PHE was

21 undertaking.

22 **Q.** But, Mr Hancock, it's not just a question of irony, is

23 it? These failing materially hampered the

24 United Kingdom's ability to prevent death?

25 **A.** The central failing that hampered the UK's response,

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1 common with the rest of the western world, was the  
2 refusal and the explicit -- the explicit decision that  
3 it would not be possible to halt the spread of a new  
4 pandemic. That is wrong, and that is at the centre of  
5 the failure of preparation. I know that, because I was  
6 the person responsible, as the Category 1 responder,  
7 when this pandemic struck.

8 All of the other considerations are small --  
9 important but small -- compared to the colossal scale of  
10 failure in the assumption that it will not be possible,  
11 and the lack of ambition in the assumption that you  
12 can't stop the spread of a disease. We can.

13 You know, imagine if this disease had tragically  
14 killed children as much as it did old people, and maybe  
15 it transmitted twice as easily as Covid; would it then  
16 be possible to halt the spread? Of course it would. We  
17 would do whatever it took.

18 And that's where we got to. But we got there far,  
19 far too slowly, because none of the preparation included  
20 any thinking around that.

21 **Q.** That is my fourth proposition, it's the one that finds  
22 a place at the front of your witness statement, it is  
23 that there was a failure, a complete systemic failure to  
24 think about how to prevent catastrophic consequences  
25 arising at all, as opposed to how to manage catastrophic

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1 and SARS.

2 So we had diligent, hard working teams working on  
3 this pandemic preparedness, but there was an absolutely  
4 central doctrinal failure in the response of the UK and  
5 almost every other western country.

6 **Q.** Number six, coming to the government particularly,  
7 through the Cabinet Office and the DHSC: there was  
8 a failure to implement, in a general sense, the  
9 recommendations from the various earlier exercises,  
10 because the majority of them were simply not  
11 implemented, for good or ill, by the time the pandemic  
12 struck, and actions and workstreams which were  
13 identified as being necessary in the field of pandemic  
14 preparedness were not carried through to fruition?

15 **A.** Well, while that is true, my evidence to you is on  
16 materiality of what really mattered when the pandemic  
17 struck. And as we saw when we went through that list on  
18 the screen, those workstreams that were stopped,  
19 I couldn't identify any of them that would have made  
20 a material impact had another year's work been done on  
21 them. We just -- we went -- we got halfway through  
22 them.

23 What I put that down to is the team prioritising  
24 within the resources that were available to do the  
25 things that really mattered, and the thing that was most

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1 consequences which were assumed to result?

2 **A.** I couldn't agree more, and it's an absolute tragedy.  
3 **Q.** Number 5: there was an associated failure to think about  
4 countermeasures. Because, of course, flu has a shorter  
5 incubation period, it is symptomatic, there are  
6 antivirals, there are vaccines available. There was,  
7 therefore, a failure to think about, in the way that  
8 other countries, particularly in the Far East, had done,  
9 countermeasures such as mandatory quarantines?

10 **A.** Yes.

11 **Q.** Shielding?

12 **A.** Yeah.

13 **Q.** Social restrictions?

14 **A.** Yes.

15 **Q.** Border control?

16 **A.** Yes.

17 **Q.** There was, as you say, a complete lack of imagination?

18 **A.** Yes. I had to overrule the initial advice not to  
19 quarantine people being brought back from Wuhan.

20 I mean, that is -- it is madness. And it was written  
21 into the International Health Regulations that you  
22 shouldn't close borders.

23 This was not a UK problem, it was a World Health  
24 Organisation problem, and the World Health Organisation,  
25 of all people, should have learned the lessons from MERS

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1 useful to me when the pandemic struck was making sure we  
2 had a piece of legislation ready to get on to the  
3 statute book.

4 Now, we, you know, there is a lesson there as well,  
5 which is we need a new piece of legislation both for  
6 civil contingencies and we need an update to the 1984  
7 Public Health Act, and I'm very happy to give further  
8 evidence on what's needed there, but my point is that  
9 I think the team were working very hard to try to do the  
10 things that were the most material in terms of  
11 preparation.

12 What everybody missed, in the western world, was  
13 that lockdowns were going to be necessary, and that's  
14 why I'm stressing this point so much, because it is the  
15 most -- single most important thing we can learn as  
16 a country.

17 **Q.** Mr Hancock, you've just said, "I couldn't identify any  
18 of [those workstreams] that would have made a material  
19 impact". Was not one of the workstreams the need to  
20 identify data, numbers, the planning for the number of  
21 people in the adult social care sector who would be  
22 affected by a pandemic, and the planning for the  
23 required surge capacity which would be required in the  
24 event of a pandemic?

25 **A.** My --

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- 1 Q. Are you saying those didn't matter --
- 2 A. My recollection is that data work continued as part of
- 3 the adult social care reform plans.
- 4 Q. Did that work get completed by the time of the pandemic?
- 5 A. It didn't get completed but the work continued.
- 6 Q. Was a fully developed plan for surge capacity in the
- 7 adult social care sector put into place by
- 8 1 January 2020?
- 9 A. A fully developed plan, no. Your question originally,
- 10 to which I responded, was what -- the work being done.
- 11 But it hadn't been completed, no. There's a difference
- 12 between doing work and completing work.
- 13 Q. There is a difference between planning something and not
- 14 even completing the plan so that the work can't be done.
- 15 Was the planning complete to allow the surge capacity to
- 16 be developed?
- 17 A. I'm very happy to look further into the paperwork and
- 18 write to you on that point. My point -- but my point
- 19 was a -- was a more strategic one, about what really
- 20 matters in terms of protecting lives in the future, and
- 21 that's why I'm at so much pains to stress it.
- 22 Q. There were significant areas of preparation overlooked
- 23 or not progressed; would you agree?
- 24 A. Absolutely.
- 25 Q. Were the nation's preparations for a pandemic of this

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- 1 ministers and senior civil servants in civil
- 2 contingencies?
- 3 A. Yes, there's an irony here, another one, which is that
- 4 I was in the process of putting one in place with the
- 5 Blavatnik School of Government when the pandemic struck,
- 6 and we stopped that work because the pandemic became
- 7 overwhelming.
- 8 Q. Is there a case for a Cabinet minister to be appointed
- 9 to be in sole charge of EPRR?
- 10 A. Yes, across government, and then the responsibilities of
- 11 lead government departments would need to report in to
- 12 that minister, who would then act on behalf of the
- 13 Prime Minister. That's effectively the job that
- 14 Oliver Letwin did when he was in office.
- 15 Q. Therefore there needs to be a head of resilience at the
- 16 apex of an official structure, a civil servant, who will
- 17 then report to that Cabinet minister?
- 18 A. Yes, there is one subtlety that's incredibly important
- 19 here, which is that it would be a mistake if such
- 20 a structure took away the sense and the feeling of
- 21 accountability for an individual department. What you
- 22 wouldn't want is the department thinking: oh, well, the
- 23 Cabinet Office has got that covered. You need the
- 24 department to still feel that it is accountable and held
- 25 to account by the Cabinet Office, rather than replaced

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- 1 nature good enough?
- 2 A. No.
- 3 Q. Was there a serious and significant inadequacy of
- 4 preparation for a pandemic health emergency?
- 5 A. Yes.
- 6 Q. Preparing for this Tier 1 risk of a catastrophic health
- 7 emergency was at the core of your own department's
- 8 functions; would you agree?
- 9 A. Yes.
- 10 Q. Therefore, as Secretary of State, you bore and you bear
- 11 ministerial responsibility for that calamitous state of
- 12 affairs, do you not?
- 13 A. I bear responsibility for all the things that happened,
- 14 not only in my department, but also the agencies that
- 15 reported to me as Secretary of State.
- 16 Q. You will no doubt have given a great deal of thought,
- 17 and it's evident from your evidence today, Mr Hancock,
- 18 as to how to make things better.
- 19 A. Yes.
- 20 Q. You've mentioned many of them today in the course of
- 21 evidence. Are you aware of some of the matters that
- 22 Sir Oliver Letwin --
- 23 A. Yes.
- 24 Q. -- spoke about when he gave evidence? Do you agree that
- 25 there is now a need for a formal system of training for

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- 1 by the Cabinet Office, which would be suboptimal.
- 2 LADY HALLETT: Sorry, I'm not following. What are you
- 3 suggesting would be different from the present system,
- 4 Mr Hancock?
- 5 A. That you would have, as we had when Oliver Letwin was in
- 6 post, a minister responsible for resilience across the
- 7 board and for challenging the different resilience plans
- 8 that came up, and obviously that would require
- 9 an official structure underneath her or him, and -- but
- 10 the key point is that needs to be like a RED team
- 11 effort, as has been discussed, rather than letting the
- 12 departments off the hook for the areas for which they're
- 13 responsible.
- 14 LADY HALLETT: Would you have that minister solely
- 15 responsible for resilience? I've heard that
- 16 Cabinet Office ministers get quite a large portfolio on
- 17 occasions.
- 18 A. Yes. I think I -- whether or not they attended Cabinet,
- 19 what mattered actually is in practice whether they had
- 20 the ear of the Prime Minister. You could easily make it
- 21 the person who was in my old Cabinet Office job, as
- 22 number two, so long as they had a direct line to the
- 23 Prime Minister when it mattered.
- 24 MR KEITH: Is there now a case for an independent perhaps
- 25 statutory resilience academy or some such body to warn,

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1 advise, guide, in relation to EPRR, train, organise  
2 exercises and make sure that recommendations and actions  
3 are properly implemented --

4 **A.** Yes, I think there's value to that. Again, you wouldn't  
5 want to take away from the individual responsibility of  
6 the area it concerned.

7 Let me give you an example. We know, once again,  
8 have a body whose sole responsibility is preparing  
9 Britain to be resilient to health, external health  
10 threats, UKHSA, and Dame Jenny Harries is an excellent  
11 chief executive of UKHSA. You wouldn't such a body to  
12 replace UKHSA or make UKHSA feel less accountable.  
13 I want Jenny Harries and whoever is in her job to wake  
14 up every morning worrying about the next pandemic and  
15 what needs to be put in place.

16 You can of course supplement that with better  
17 resilience training at the centre as well, but you  
18 can't -- you mustn't take away from the real burning  
19 accountability of the person in that job.

20 And also one of the recommendations was that they  
21 would -- these people would make recommendations in  
22 terms of allocation of budget, because it isn't --  
23 there's obviously been a discussion of the impact of  
24 budgets in the last couple of weeks -- it isn't just  
25 about the total quantum of budget, it's about how it's

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1 infrastructure or a cyber attack or some other mass  
2 event --

3 **A.** Yes.

4 **Q.** -- or catastrophe which could befall our nation; it's  
5 now beyond time, is it not?

6 **A.** It is beyond time. My -- sorry, the reason I got into  
7 budgets is that it's only a central body that can also  
8 make recommendations in terms of allocation between  
9 different departments. As a departmental head you can't  
10 do that.

11 **Q.** Yes. Is there, therefore, also, a case for  
12 a fundamental rethink on this whole CCA 2004 structure  
13 and the lead government department model? I don't want  
14 to intrude into Module 2 issues --

15 **A.** Sure.

16 **Q.** -- but obviously, when dealing with a national crisis --

17 **A.** Yes.

18 **Q.** -- it's beyond the ability of a single department to be  
19 able to cope, because, of course, all national crises,  
20 by definition, will have an impact, a range of impacts,  
21 across government?

22 **A.** Yes. I think that you need -- I actually support the  
23 lead government department structure because you need  
24 somebody who feels accountable for looking out for that  
25 threat all of the time, but you then need a system in

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1 spent. In this country this year we've spent  
2 £53 billion on physical military defence. UKHSA's core  
3 budget is £450 million, that's less than 1%, and yet  
4 over 220,000 people died of Covid -- have died of Covid  
5 so far.

6 The impact on the health of the nation and the  
7 well-being of the nation of health protection is  
8 an order of magnitude bigger than as currently  
9 represented in the UKHSA budget, and the idea that we  
10 spend over 50 billion on defence and under 500 million  
11 on UKHSA is, for me, completely indefensible.

12 **Q.** All right. I was asking you in fact about a general  
13 resilience academy to deal with civil contingencies.

14 **A.** Yeah.

15 **Q.** You responded by reference to the United Kingdom Health  
16 Security Agency.

17 **A.** Yeah.

18 **Q.** That is, of course, involved with health emergencies --

19 **A.** Exactly.

20 **Q.** As were you.

21 **A.** So it's worth having it across the board as well.

22 **Q.** Yes. I intended to ask you, and I perhaps didn't make  
23 it sufficiently plain, whether there is a case for  
24 a resilience academy to deal with civil contingencies,  
25 for example a collapse in critical national

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1 the centre that is stronger at holding that  
2 accountability -- holding feet to the fire, and the --  
3 but the co-ordination element of it in -- when you get  
4 to a massive crisis, goes up to -- the chain to the  
5 Prime Minister anyway, and so that is a role of the  
6 Civil Contingencies Secretariat which, when you have  
7 a huge crisis like Covid, then was replaced with  
8 a Covid-specific central secretariat --

9 **Q.** But some of these issues, Mr Hancock, didn't go to you,  
10 even though you were the Secretary of State in your own  
11 lead government department.

12 **A.** Yes, but --

13 **Q.** So -- so, with respect, is there not now a need for  
14 a much stronger co-ordinating body -- not perhaps just  
15 part of the Cabinet Office, but a stronger body -- which  
16 can ensure that in the run-up to a crisis, in terms of  
17 the preparation, the preparedness, the planning, things  
18 that need to be elevated to the highest levels are?

19 **A.** Yes. The way that I put it is that the goal of it  
20 should be to hold the lead department's feet to the  
21 fire. For instance, if you had one of these bodies in  
22 the centre, if they tried to do the job of the  
23 Health Secretary as the Category 1 responder, then who  
24 guards the guardian?

25 Far better would be that they are in a position to

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1 haul in the Health Secretary and say, "Are you doing  
2 your -- doing that enough?" Because I wasn't called to  
3 the National Security Council, for instance, in order to  
4 answer those questions in my 18 months as  
5 Health Secretary before the pandemic struck.

6 **Q.** Finally I want to ask you some questions, please, about  
7 some other aspects of the system which you found to be  
8 deficient when you were faced with the terrible crisis  
9 in January of 2020.

10 **A.** Yeah.

11 **Q.** You've touched on many of them already but I just want  
12 to summarise the position in order to be able to focus  
13 minds for when we get to the next module and  
14 thereafter --

15 **A.** Yes.

16 **Q.** -- the areas that require particular and detailed  
17 consideration.

18 **A.** Yeah.

19 **Q.** There was obviously this issue, therefore, of there  
20 being a stockpile of PPE but, as it happened, given the  
21 sheer number of casualties, those who were sick and ill,  
22 and of course those who died, the stockpile was  
23 depleted --

24 **A.** Yes.

25 **Q.** -- and it was necessary for the government to try to

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1 supply chains in short order is exceptionally difficult,  
2 as we learned.

3 **Q.** All right. I don't want to ask you to address the  
4 solutions or, in fact, to identify the specific problems  
5 that arose, only to acknowledge that there were very  
6 real difficulties in these areas.

7 **A.** I see. Yes, of course.

8 **Q.** The availability of mass diagnostic testing --

9 **A.** Yes.

10 **Q.** -- you've already referred to.

11 **A.** Terrible.

12 **Q.** The availability of mass contact tracing systems.

13 **A.** Yes, there was no such thing.

14 **Q.** Obviously there are the NHS-related issues concerning  
15 resilience, bed capacity, workforce planning, all of  
16 which are issues which you've referred to --

17 **A.** Yes, there's a bigger thing there as well within the  
18 NHS, which is that, you know, whilst the discussion on  
19 how much resources the NHS should get is a highly  
20 political one, and we've seen it play out over the last  
21 couple of weeks in this Inquiry, there is actually  
22 a really big question that the nation needs to ask  
23 itself, which is that -- you wouldn't ever send the  
24 whole of your army out into battle at once. You have  
25 spare capacity in case there's a crisis. You have what

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1 secure further supplies through just-in-case contracts  
2 and deal with the mayhem of the international markets.

3 **A.** Yes.

4 **Q.** Is there, therefore, an issue which requires further  
5 consideration in relation to how we make sure that next  
6 time such stocks as there are, such stockpiles as there  
7 are for the particular pandemic which may eventuate, are  
8 sufficient or at least that there is an ability to  
9 improve the numbers, to increase the numbers --

10 **A.** Yes.

11 **Q.** -- in a way that doesn't leave the Secretary of State,  
12 as you were, having to make up the deficit?

13 **A.** So we started buying PPE in January 2020, long before it  
14 was certain this would become a global pandemic, but the  
15 problems with the stockpile were very significant, and  
16 I'm sure that we'll come to this in future modules.  
17 What is vital for preparation is that there are  
18 stockpiles that are accessible, pickable, in the  
19 technical language, that can be distributed quickly and  
20 can be distributed to all health and social care  
21 settings. And, as I say, I think there should be  
22 a legal requirement on health and social care settings  
23 to hold a significant amount of PPE to be able to get  
24 through the early weeks of a future pandemic, because  
25 the sheer logistical complexity of setting up these

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1 they call redundancy in the military sense. Yet every  
2 single day we send our whole army of the NHS out into  
3 the field and there is no redundancy. We run the NHS  
4 incredibly tight. It's an incredibly efficient  
5 organisation in the grand scheme of things. Despite  
6 obvious areas that can be improved, it is overall run  
7 very tight, and that means that there simply isn't the  
8 resilience when a crisis comes. But that would require  
9 a materially huge increase in the already very, very  
10 large NHS budget. But other countries choose to spend  
11 a higher proportion of GDP on healthcare and have that  
12 redundancy, and it means that they are better able to  
13 respond.

14 But it also comes back to doctrine, because no  
15 health system of any size would be able to respond  
16 unless you suppress a virus when it's as bad as  
17 Covid-19.

18 **Q.** But as my Lady has already observed in another context,  
19 there are choices that will have to be made, and there  
20 is, therefore, an issue about resilience and about bed  
21 capacity and surge capacity and so on --

22 **A.** Absolutely.

23 **Q.** -- for the future?

24 **A.** Absolutely.

25 **Q.** All right.

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1 Then in your statement you address issues such as  
2 the changes over time in the public health structures?

3 **A.** Yes.

4 **Q.** There's an issue about the necessary degree of  
5 co-ordination across the United Kingdom, given the fact  
6 that health security is a devolved issue --

7 **A.** Yes.

8 **Q.** -- but at the same time, of course, viruses honour no  
9 boundaries.

10 Then, finally, you say that --

11 **A.** Well, they honour geographic boundaries, they honour no  
12 administrative boundaries. The fact that we are  
13 an island is an advantage that we should use much more  
14 aggressively in future in preventing a pandemic coming  
15 here.

16 **Q.** All right.

17 You refer finally to the need to examine more  
18 closely the degree of required international  
19 co-ordination?

20 **A.** Yes.

21 **Q.** I don't want you to develop that point.

22 There remains the final issue, which I think I'd be  
23 grateful for your views on, which is the degree to which  
24 you materially assisted in the development of what  
25 turned out to be life-saving vaccine production.

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1 the vaccines and that people have the confidence to take  
2 them. So there was a huge amount of preparation work in  
3 that area that I was directly involved in, and that  
4 ended up being one of the areas where we performed  
5 incredibly well and we, of course, had the first vaccine  
6 in the world.

7 **Q.** Mr Hancock, my final question: do you know why no  
8 pathogenic outbreak-related exercise or any governmental  
9 policy or guidance or paper paid any regard to the  
10 impact or consequences of a pandemic on the vulnerable,  
11 on members of our community in our minority ethnic  
12 sectors, or on the marginalised, or otherwise suffering  
13 from inequalities? There appears to have been  
14 absolutely no thought given at all, at any time, other  
15 than in relation to the obvious point that there would  
16 be a clinical risk, to what the likely impact would be  
17 of a pandemic sectorally, and therefore no thought was  
18 given to how the plans might be adjusted to cater for  
19 that significant risk.

20 **A.** It saddens me enormously that the central work that the  
21 CMO was planning to do when I appointed him in  
22 October 2019 was to focus on the reduction of the  
23 completely unacceptable health inequalities that exist  
24 in this country. The life expectancy of a man born in  
25 Blackpool is 15 years less than a man born in

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1 **A.** Yes.

2 **Q.** We heard evidence from Jeremy Hunt MP as to how he  
3 assisted to the process by which -- the process of the  
4 UK Vaccine Network when he was Secretary of State.

5 **A.** Right.

6 **Q.** Were you also materially concerned in ensuring that we  
7 had the proper structures in place for future  
8 development of vaccines when you were  
9 Secretary of State?

10 **A.** Yes, I thought this was very important. And in fact, in  
11 terms of pandemic preparedness, given the reassurances  
12 that we were well prepared, this was the area I put most  
13 effort into, and it -- a lot of the preparedness work  
14 was very helpful here. The Oxford vaccine was  
15 essentially built on a project that started with  
16 an attempt to get a vaccine for Ebola. That was before  
17 my time.

18 I worked to try to enhance the domestic  
19 manufacturing capability, and I did a huge amount of  
20 work also on stopping anti-vax content. I was worried  
21 about that for normal everyday vaccines like MMR and the  
22 flu jab, but it was also very important ahead of  
23 a pandemic. Because the point is that once you have the  
24 right doctrine of suppressing a virus until the vaccine  
25 can make us safe, you've got to make sure that you get

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1 Buckinghamshire, and I appointed Chris Whitty to the CMO  
2 job based on his proposal that he wanted to do  
3 everything that we could to address this. So health  
4 inequalities were right at the forefront of his and my  
5 agenda.

6 Of course the different impact clinically of a virus  
7 on different groups is absolutely front of mind, and  
8 implicit in all of the planning.

9 **Q.** Well, that's obvious, as I've suggested to you --

10 **A.** It has to be. But in terms of the social and  
11 socio-economic impacts, all I would say is that  
12 an assumption that you're not going to stop a pandemic  
13 running through the population is implicitly  
14 an assumption and a decision that those most vulnerable  
15 to it will be hardest hit. So the single best thing we  
16 can do to protect those who are most vulnerable is stop  
17 viruses from killing hundreds of thousands of people.

18 It brings me -- and we end on the central -- my  
19 central contention, which is you've got to work out --  
20 there are costs to lockdown, you've got to work out  
21 whether the impact of the virus is going to be worse  
22 than the costs of lockdown, and if it is going to be  
23 worse, as was the case with Covid-19, you've got to hit  
24 it hard and very, very early.

25 **Q.** But, Mr Hancock, as you now have acknowledged, our

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1 system of preparedness for being able to deal with  
2 a pandemic was materially hindered and weakened, and the  
3 sad reality is that, as part of that failure, there was  
4 no consideration of the needs of the most vulnerable at  
5 all?

6 **A.** There was consideration on a clinical basis of the needs  
7 of the most vulnerable, but not on a socio-economic  
8 basis.

9 If I may add finally, this was of course  
10 an unprecedented pandemic in anybody's lifetime, and  
11 those who worked so hard to respond to it had to respond  
12 from the basis of the preparation that there was. And  
13 they did work incredibly hard, and I think everybody in  
14 the health area that I was responsible for gave their  
15 all with humility in the face of this virus,  
16 an unprecedented event. But that just underlines why  
17 it's so important that we get the right lessons out of  
18 this Inquiry.

19 **Q.** Lions led by structural donkeys, Mr Hancock; personally  
20 everyone gave their all but the system was not fit for  
21 purpose, was it?

22 **A.** That's absolutely right, and it goes -- that is a -- was  
23 a problem across the western world, and it goes back  
24 a long, long way in the assumptions underpinning how we  
25 plan for these things, and it must never happen again.

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1 **Q.** You have already indicated to Mr Keith that the 2011  
2 doctrine strategy was woefully inadequate?

3 **A.** Yes.

4 **Q.** And you put that in your statement?

5 **A.** Yes.

6 **Q.** I just want to read that one paragraph from your  
7 statement to flesh that out.

8 **A.** Yes.

9 **Q.** This is your words:

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

19 **A.** Yes.

20 **Q.** Yes? So you're emphasising the lack of learning and the  
21 emphasis around social distancing measures?

22 **A.** Yes.

23 **Q.** That would, of course, include lockdowns?

24 **A.** Absolutely.

25 **Q.** Okay. You have also elsewhere, paragraph 29, referred

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1 **MR KEITH:** My Lady, that concludes my questioning of  
2 Mr Hancock. There is one area submitted by Covid-19  
3 Bereaved Families for Justice UK and Northern Ireland  
4 Covid-19 Bereaved Families for Justice, for which you  
5 have given permission.

6 **LADY HALLETT:** Mr Weatherby.

7 Sorry, you've not quite finished, Mr Hancock.

8 **THE WITNESS:** No problem.

9 **Questions from MR WEATHERBY KC**

10 **MR WEATHERBY:** Yes, thank you very much.

11 Mr Hancock, I ask you a few questions on behalf of  
12 the Covid-19 Bereaved Families for Justice, which  
13 represents the interests of many, many bereaved families  
14 around the United Kingdom.

15 It's centred around the Pandemic Flu Bill, which was  
16 one of the two key workstreams that were kept going when  
17 most of the rest of the refresh, as we've heard it  
18 called, was paused because of Brexit; is that right? So  
19 that gives the importance with which you looked at the  
20 Pandemic Flu Bill and the --

21 **A.** Yes, and I would say it was one of the most important  
22 things to come out of Operation Cygnus.

23 **Q.** Okay. I just want to explore the background of that and  
24 what was in it very, very briefly indeed.

25 **A.** Yes.

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1 to the WHO as an authoritative source?

2 **A.** Yes.

3 **Q.** So you're giving respect to the view of the WHO; yes?

4 **A.** Well, it is the --

5 **Q.** Yes.

6 **A.** -- UN agency in this area. It needs radical reform but,  
7 nevertheless, it is what it is.

8 **Q.** We'll leave that one for a different day, but you were  
9 regarding that as an authoritative source.

10 In 2018, at precisely the time that this work on the  
11 Pandemic Flu Bill was being completed or being looked  
12 at, considered, the WHO, as part of its global influenza  
13 programme, published an update to a document which had  
14 been around since 2005 entitled *A checklist for pandemic  
15 influenza risk and impact management*. I just want to  
16 take you to one passage of that.

17 **A.** Okay.

18 **Q.** And it's INQ000187748, please, and page 1. Have you got  
19 it in front of you there?

20 **A.** I've got the title screen but not the paragraph.

21 **Q.** No, no. I just want to orientate us all. This is the  
22 WHO document 2018. I'm going to take you to page 11 in  
23 a minute.

24 In the interests of time I'm just going to flag up  
25 one other reference, which is at page 6, where this

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1 document refers to the importance of prevention and  
 2 mitigation and not simply response and recovery.  
 3 **A.** Right.  
 4 **Q.** So by 2018, the WHO were putting out guidance which  
 5 underlines the necessity for prevention and mitigation  
 6 and not just response and recovery, which I think is one  
 7 of your points, isn't it, as one of the problems with  
 8 the UK's doctrine?  
 9 **A.** Well, I haven't seen this document. It depends what you  
 10 mean by prevention and mitigation, because the initial  
 11 containment and an attempt to contain the virus was part  
 12 of the UK's plans. The problem with the UK plan was  
 13 that once we got to community transmission, it was  
 14 wrongly assumed it wasn't possible to stop the spread.  
 15 **Q.** Yes. Okay.  
 16 **A.** Mitigation in this context tends to mean dealing with  
 17 the consequences, which is not -- which is not good  
 18 enough.  
 19 **Q.** Well, that, with respect, is response, rather than  
 20 mitigation.  
 21 **A.** Well, I'd be very happy to read the document and  
 22 consider it.  
 23 **Q.** Well, okay.  
 24 Can I take you to page 11, please, and we will just  
 25 have a quick look at this, because this is the important

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1 **Q.** Next part, this document splits the guidance into  
 2 essential, what the WHO regards as essential, and what  
 3 is desirable.  
 4 **A.** Yeah.  
 5 **Q.** This is under "Essential", the first bullet point:  
 6 "Review existing legislation, policies or other  
 7 government instruments relevant to pandemic influenza  
 8 risk management ...", et cetera.  
 9 Yes?  
 10 **A.** Yes.  
 11 **Q.** That's what you're doing --  
 12 **A.** Yes.  
 13 **Q.** -- around 2018 with the Pandemic Flu Bill?  
 14 **A.** Yes.  
 15 **Q.** Then the second bullet point --  
 16 **A.** Yeah, all that.  
 17 **Q.** This is the important point.  
 18 **A.** That was all in -- yeah.  
 19 **Q.** Yeah.  
 20 "Assess the legal basis for all public health  
 21 measures that are likely to be proposed during  
 22 a pandemic response, such as:  
 23 "- isolation or quarantine of infected individuals,  
 24 people suspected of being infected, or people from areas  
 25 where pandemic influenza infection is established ..."

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1 passage of it, with respect to the Pandemic Flu Bill.  
 2 So this is paragraph 2.2 within this document, and it's  
 3 headed "Legal and policy issues", which is why it's  
 4 relevant to what I'm asking you about with the Bill.  
 5 **A.** Yeah.  
 6 **Q.** So the "Rationale":  
 7 "Public health measures during a pandemic are  
 8 designed to reduce the spread of the pandemic virus and  
 9 save lives. In some circumstances, it may be necessary  
 10 to overrule existing laws or (individual) human rights  
 11 in order to implement measures that are in the best  
 12 interests of community health."  
 13 Then I'll skip the next sentence, again in the  
 14 interests of time.  
 15 **A.** Yeah.  
 16 **Q.** At the end of that paragraph:  
 17 "These decisions need a legal framework to ensure  
 18 transparent assessment and authority for the measures  
 19 being considered, as well as coherence with relevant  
 20 international laws ..."  
 21 **A.** Yes.  
 22 **Q.** So here's the WHO saying that you need to consider the  
 23 measures and then you need to have the legal backing in  
 24 place before the problem strikes; yes?  
 25 **A.** Yes.

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1 So a legal measure in place for an emergency to  
 2 restrict the ordinary rights of people who are infected  
 3 or may be infected; yes?  
 4 **A.** Yes.  
 5 **Q.** Second bullet point:  
 6 "- travel or movement restrictions" --  
 7 **A.** Yeah.  
 8 **Q.** -- "(ie on leaving or entering areas where pandemic  
 9 influenza infection is established) ..."  
 10 So travel and movement --  
 11 **A.** Yeah.  
 12 **Q.** -- would include lockdowns?  
 13 **A.** Yeah.  
 14 **Q.** "- closure of educational institutions ..."  
 15 **A.** Yeah.  
 16 **Q.** And:  
 17 "- prohibition of mass gatherings."  
 18 **A.** Yeah.  
 19 **Q.** Okay. So all relatively straightforward in concept --  
 20 **A.** Just one point I would challenge, which is you said  
 21 "travel restriction -- or movement restrictions, that  
 22 means lockdown". That's not right.  
 23 **Q.** No, no.  
 24 **A.** What it doesn't have in there is a stay at home order,  
 25 because the isolation or quarantine of infected

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1 individuals is for, as it says, infected individuals.  
 2 **Q.** Okay, I said "would include lockdowns". In parentheses  
 3 that is:  
 4 "... on leaving or entering areas where pandemic  
 5 influenza infection is established) ..."  
 6 **A.** No, that's -- a lockdown is where people are required by  
 7 law to stay at home, which is different.  
 8 **Q.** I'm not going to fence with you over that one.  
 9 **A.** No, but it really matters, because if the question is,  
 10 "Given that the WHO published this in 2018 why didn't we  
 11 have it in place?", right, if that's the question, the  
 12 pandemic flu draft Bill, which became the  
 13 Coronavirus Act, and the Public Health Act 1984 has the  
 14 legal framework for all of this in it, however the  
 15 review compliance with obligations under IHR -- sentence  
 16 in the top bullet point -- that IHR includes the rule  
 17 that you should not close your borders in a pandemic,  
 18 and the fact that the second bullet point does not  
 19 include a stay at home order precisely supports my point  
 20 that there was not consideration given, even at the WHO  
 21 level, to the requirement for lockdown.  
 22 **Q.** Okay.  
 23 **A.** Because a travel restriction is not lockdown.  
 24 **Q.** Okay, I haven't got the time to go into the  
 25 International Health Regulations with you. We can

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1 **Q.** -- duties within the mental health system and the health  
 2 system, and an indemnity in terms of healthcare?  
 3 **A.** Yeah.  
 4 **Q.** Now, which of that list that we've just looked at from  
 5 the WHO guidance is in this Pandemic Flu Bill,  
 6 Mr Hancock?  
 7 **A.** I don't know, but I do know that of that list in the WHO  
 8 guidance many of those are in the Public Health Act  
 9 1984, because it was the Public Health Act 1984 that we  
 10 used as the legal basis for restrictions.  
 11 **Q.** Yes. So in fact it's clause 14, is the temporary  
 12 closure of educational institutions. So the only one of  
 13 that list that made its way into this Bill is the  
 14 restriction or temporary closure of educational  
 15 facilities.  
 16 **A.** Right.  
 17 **Q.** So you've referred to other Acts, but this is the  
 18 workstream which is refreshing the -- or supposed to be  
 19 refreshing or updating the doctrine, and this is the  
 20 Bill which is supposed to be there to give you  
 21 an armoury in an emergency situation, and it doesn't  
 22 follow this authoritative source from the WHO. How was  
 23 that allowed to happen?  
 24 **A.** Because the other recommendations from the WHO were  
 25 already in law in this country, in the Public Health

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1 perhaps deal with that in a different way.  
 2 **A.** Sure.  
 3 **Q.** But here you have a list of straightforward, sensible  
 4 options which the WHO referenced to the spread of the  
 5 pandemic or stopping the spread of the pandemic --  
 6 **A.** Yes.  
 7 **Q.** -- and they are options which are likely to be proposed  
 8 in an emergency situation such as a pandemic; yes?  
 9 **A.** That's what it said.  
 10 **Q.** Yes.  
 11 **A.** That wasn't the policy of the UK at the time.  
 12 **Q.** It wasn't the policy of the UK at the time, indeed,  
 13 because we get to the Pandemic Flu Bill -- and in light  
 14 of what you've just said I think we will need to put it  
 15 up, just the contents page, and it's INQ000023118,  
 16 please. So this is the Bill as drafted --  
 17 **A.** Yeah.  
 18 **Q.** -- dated 2020, in fact, so this is after the work  
 19 presumably is completed. What we see here is the Bill  
 20 has clauses which relate to the emergency registration  
 21 of health professionals?  
 22 **A.** Yes.  
 23 **Q.** A raft of provisions dealing with the easing of ordinary  
 24 business as usual --  
 25 **A.** Yes.

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1 Act 1984.  
 2 If I may say so, I essentially think that the core  
 3 point you're making, which is that we should have been  
 4 ready and had legal powers in place and we should be  
 5 ready to lock down, that I agree with wholeheartedly,  
 6 and I agree with it, and I think that, you know, on --  
 7 to do justice -- you know, nothing can bring the people  
 8 who died back, and each and every one, but we must learn  
 9 that lesson, that we need to take the measures necessary  
 10 early to stop a future pandemic from killing people.  
 11 **Q.** Yes.  
 12 **A.** But to say they're not in this Bill and -- without  
 13 considering what other Bills there might already be  
 14 doesn't really prove that point.  
 15 **Q.** Okay, well, I'm sure we can look at the legislation as  
 16 we go along, but this is the workstream which is putting  
 17 the --  
 18 **A.** I know, but I used that legislation extensively,  
 19 I understand that the Public Health Act 1984 very well  
 20 and what I can tell you is that the WHO recommendations  
 21 in 2018, other than on temporary closure of educational  
 22 institutions, those powers are available, as far as  
 23 I understand it, in the Public Health Act already.  
 24 **Q.** Finally, just in terms of the devolved nations --  
 25 **A.** Yes.

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1 Q. -- it's right, isn't it, that this legislation was  
 2 developed, this draft legislation was developed with  
 3 some input from the devolved nations?  
 4 A. Yes.  
 5 Q. It's also right that none of them used it in the event?  
 6 A. Because they had their own other legislation already on  
 7 the statute book.  
 8 Q. Yes.  
 9 A. I mean, I actually think that we could do -- part of the  
 10 reason for a need to reform the 1984 Act is to have  
 11 a UK-wide approach, because I think that, whilst it's  
 12 totally appropriate to devolve health and the NHS,  
 13 because of the nature of how pandemics spread, it would  
 14 be far better to respond to the next pandemic on  
 15 a UK-wide basis rather than an England, Scotland, Wales  
 16 and Northern Ireland basis, and I think that way we'd  
 17 save more lives.  
 18 Q. Yes.  
 19 Finally this, are you able to point to any document  
 20 or any briefing or any meeting where the fact of powers  
 21 or legislation being elsewhere was a factor in what was  
 22 included in this draft Bill?  
 23 A. Oh, yes, of course. That was the -- important  
 24 consideration in what to put into the Bill, because one  
 25 of the things that Parliamentary counsel who draft Bills

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1 A. Yes.  
 2 Q. -- are of course very different to Covid?  
 3 A. Yes. What I stated was the clinical fact, as I was  
 4 advised at the -- during the debate about asymptomatic  
 5 transmission, which no doubt we'll cover in M2 because  
 6 it was absolutely central to the challenges of the early  
 7 response to the pandemic.  
 8 MR KEITH: Thank you.  
 9 My Lady, that concludes Mr Hancock's evidence.  
 10 LADY HALLETT: Thank you very much, Mr Hancock. That  
 11 completes the evidence you'll be giving, certainly in  
 12 this module. Thank you for your help.  
 13 THE WITNESS: Okay. Thank you.  
 14 (The witness withdrew)  
 15 LADY HALLETT: 2 o'clock.  
 16 (1.00 pm)  
 17 (The short adjournment)  
 18 (2.00 pm)  
 19 LADY HALLETT: Ms Blackwell.  
 20 MS BLACKWELL: Good afternoon, my Lady.  
 21 The next witness is Mr Duncan Selbie, who is  
 22 appearing this afternoon at the Inquiry through a link  
 23 from the Kingdom of Saudi Arabia. I hope, my Lady, you  
 24 can see Mr Selbie on your screen.  
 25 LADY HALLETT: I can, thank you.

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1 absolutely hate is legislating in an area where policy  
 2 is already legislated for --  
 3 Q. Yes.  
 4 A. -- so that is a material consideration.  
 5 MR WEATHERBY: Yes. That's all I ask, thank you.  
 6 LADY HALLETT: Thank you.  
 7 MR KEITH: My Lady, we've received an email from Covid-19  
 8 Bereaved Families for Justice Cymru who wish, I think  
 9 perhaps vicariously, to ask permission for a point to be  
 10 put to Mr Hancock, who said in the course of his  
 11 evidence that coronavirus was the first coronavirus  
 12 known to be -- or the first coronavirus that could be  
 13 transmitted asymptotically. The position is, as the  
 14 chart that you directed be prepared amply demonstrates,  
 15 that MERS and SARS were also -- are also  
 16 asymptotically transmitted, and therefore there is  
 17 clear evidence to correct that position.  
 18 I don't want to give evidence about it, but there is  
 19 that material there in the chart.  
 20 Further questions from LEAD COUNSEL TO THE INQUIRY  
 21 MR KEITH: Perhaps I could be permitted to ask you one  
 22 question, Mr Hancock, in light of the question from  
 23 Covid-19 Bereaved Families for Justice Cymru.  
 24 The transmission rates in relation to MERS and  
 25 SARS-1 --

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1 MS BLACKWELL: Mr Selbie, would you please take the  
 2 affirmation.  
 3 MR DUNCAN SELBIE (affirmed)  
 4 (Evidence via videolink)  
 5 Questions from COUNSEL TO THE INQUIRY  
 6 MS BLACKWELL: Thank you.  
 7 Mr Selbie, thank you for the assistance that you've  
 8 given to the Inquiry so far. You have provided  
 9 a witness statement, which we can see at INQ000192268.  
 10 Now, that's appearing on my screen. Is it also  
 11 appearing on your screen?  
 12 A. Yes, it is now. It's rather small, but yes.  
 13 Q. All right. It's being enlarged. Is that helping at  
 14 all?  
 15 A. Yes, that's better.  
 16 Q. Excellent. Whenever I show a document to you, I'll make  
 17 sure that the document presenter makes it as large as  
 18 possible for you.  
 19 Can you confirm, please, Mr Selbie, that that is  
 20 your witness statement?  
 21 A. Yes.  
 22 Q. Thank you.  
 23 We perhaps we don't need to go to it but it is  
 24 signed at page 14.  
 25 Is that statement, Mr Selbie, true to the best of

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1 your knowledge and belief?  
 2 **A.** Yes, it is.  
 3 **Q.** Thank you very much. We can take that down.  
 4 I will ask you questions and I hope that all of them  
 5 are clear and that you understand them. If you don't,  
 6 then please just let me know, and I will ask it again or  
 7 try and rephrase it.  
 8 If you need a break at any time, Mr Selbie, please  
 9 just let us know, and we will break for your  
 10 convenience.  
 11 Please keep your voice as loud as you can so that  
 12 the stenographer can hear you for the transcript.  
 13 **A.** Yes.  
 14 **Q.** Can you also confirm, please, Mr Selbie, that you have  
 15 read the witness statements provided to the Inquiry by  
 16 Professor Dame Jenny Harries and also  
 17 Professor Isabel Oliver?  
 18 **A.** Yes. Ms Blackwell, I'm terribly sorry, there was  
 19 an interruption for about three seconds. I hope this  
 20 isn't going to happen.  
 21 **Q.** So do I.  
 22 **A.** Could you repeat the question, please?  
 23 **Q.** Yes, of course.  
 24 I was asking, Mr Selbie, if you can confirm that  
 25 you've read the witness statements of

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1 executive of Public Health England from July of 2012 to  
 2 August of 2020.  
 3 **A.** Yes.  
 4 **Q.** Thank you.  
 5 In her witness statement to the Inquiry,  
 6 Professor Dame Sally Davies has expressed a view that UK  
 7 public health institutes that deal with infectious  
 8 disease outbreaks should be professionally led by  
 9 a clinical scientist.  
 10 It's right, Mr Selbie, that you don't hold any  
 11 medical or scientific qualifications, do you?  
 12 **A.** No, I don't, and that is unusual for a national public  
 13 health institute.  
 14 If I may, I should have said that I'm also the  
 15 president of IANPHI, which is the International  
 16 Association of National Public Health Institutes. It's  
 17 the world's gathering of the Dame Jennies, if you like,  
 18 in 115 institutes around the world, and I think I might  
 19 have been unique in not being clinically or public  
 20 health qualified.  
 21 **Q.** Do you feel in any way that that hampered you in  
 22 carrying out your role as chief executive of Public  
 23 Health England?  
 24 **A.** Well, I've thought deeply about this, and, you know,  
 25 with all genuine humility, no, I don't think it did,

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1 Professor Dame Jenny Harries and Professor Isabel Oliver  
 2 on behalf of the UKHSA?  
 3 **A.** Yes, I have.  
 4 **Q.** Thank you very much.  
 5 Do you broadly agree with what has been set out in  
 6 those witness statements so far as Public Health England  
 7 is concerned?  
 8 **A.** Yes.  
 9 **Q.** Thank you.  
 10 I want to begin by setting out your professional  
 11 background and qualifications so far as they're relevant  
 12 to this Inquiry.  
 13 You have qualifications in health and hospital  
 14 management and health and social care management. You  
 15 held various NHS posts in Scotland and London between  
 16 1980 and 1986. Then in 1997 you became chief executive  
 17 of South West London and St George's Mental Health NHS  
 18 Trust. In January 2002 did you become chief executive  
 19 of the South East London Strategic Health Authority, and  
 20 in November 2003 you worked for the Department of  
 21 Health, initially as the director general of programmes  
 22 and performance for the NHS, then as director general of  
 23 NHS Commissioning.  
 24 In July of 2007 you became chief executive of  
 25 Brighton and Sussex University Hospitals and then chief

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1 because being a chief executive is not the same thing as  
 2 being a clinical scientist or an academic. I think it  
 3 could prove to be a great advantage, potentially, to  
 4 have that background, but that's not what a chief  
 5 executive is there to do. And I'm very experienced as  
 6 a chief executive, I've made lots of good decisions and  
 7 lots of less good decisions, but I'm definitely very  
 8 experienced, and that was the basis on which I was  
 9 appointed. And I've never pretended to be otherwise.  
 10 You know, my interview included the Chief Medical  
 11 Officer at the time and, as you know, it involved  
 12 bringing together quite a complex set of bodies into  
 13 a -- and to create something new, something that hadn't  
 14 happened before in this country. So I'll cease there.  
 15 **Q.** All right. Thank you very much for that answer.  
 16 Indeed, we have been through the extensive experience  
 17 that you had of acting as a chief executive before  
 18 taking up that post at Public Health England.  
 19 But I suspect that you may have been asked a similar  
 20 question when you gave an interview in 2013 to  
 21 *The Lancet*, because, asked about your experience in  
 22 public health, your answer appears to have been:  
 23 "You can fit my public health credentials on  
 24 a postage stamp ..."  
 25 Is that right?

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1 **A.** I did say that. It was a bit unkind of them. It was  
 2 meant to be a light-hearted introduction, and I have had  
 3 a lot of involvement with health inequalities in public  
 4 health, because in my years as the director general of  
 5 performance, I was instrumental in six priorities for  
 6 the NHS, one of them being health inequalities, it was  
 7 about the NHS, cardiovascular, cancer and so on. Then  
 8 in my strategic health authority days I had a director  
 9 of public health for the strategic health authority, and  
 10 with mental health it was essentially a public health  
 11 agenda, which we might talk about, but Professor Marmot  
 12 I think would recognise that if you get it right for  
 13 mental health you get it right for the public's health.

14 So it was a little unkind, but if you read the whole  
 15 of that interview it was balanced out, and I think the  
 16 communications director at the time said, "I wish you  
 17 hadn't said that", but it was meant to be light-hearted.

18 **Q.** Thank you.

19 **A.** And respectful, it was meant to be respectful about what  
 20 I didn't know.

21 **Q.** Yes. Well, thank you very much for that answer,  
 22 Mr Selbie.

23 I know, because I've spoken to you before you took  
 24 your affirmation and began to give evidence, that you  
 25 were able to follow the evidence yesterday from

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1 local and regional teams.

2 So I'm going to ask you, Mr Selbie, if you have any  
 3 reflections on the impact of all those structural  
 4 changes, in particular on the following issues: firstly,  
 5 the clarity and understanding of EPRR roles and  
 6 responsibilities. Was there, in your view, any  
 7 confusion as a result of the -- what I'm going to  
 8 describe as rather complicated overlapping and/or  
 9 blurred statutory responsibilities?

10 **A.** So I think initially there was a lot of learning to be  
 11 done, because this was new for local government.  
 12 Dame Jenny spoke yesterday about that being quite  
 13 a difficult transition, and I agree with that, but it  
 14 was about moving, if you like, from a place where  
 15 directors of public health had been for many, many years  
 16 to a place where they could make a bigger difference and  
 17 could have a bigger impact. So I think it was very  
 18 worthwhile, very brave and courageous of the public  
 19 health directors to make that shift, but it did bring  
 20 with it a whole lot of new relationships within  
 21 councils, with colleagues, as well as with the health  
 22 sector, and over time that became of some concern and  
 23 the Health Select Committee asked us to look at this and  
 24 to be more assured about these arrangements, and I think  
 25 you've -- you know, I've seen the -- I have been

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1 Professor Dame Jenny Harries.

2 **A.** Yes.

3 **Q.** So I'm able to take some of my questioning in short  
 4 fashion with you today.

5 You will have seen that we covered evidence with  
 6 Dame Jenny yesterday about the rather complex  
 7 restructuring of public health in England brought about  
 8 by the Health and Social Care Act of 2012 and the key  
 9 differences between the HPA and PHE.

10 So we established the following: that the HPA was  
 11 an executive non-departmental body, and was replaced by  
 12 PHE, which was an executive agency of the then  
 13 Department of Health; that PHE brought together, under  
 14 the management of a single organisation, the previous  
 15 distinct strands of public health, namely public  
 16 protection, public health improvement, and healthcare,  
 17 public health; that PHE worked with local authorities  
 18 who were given new responsibility for improving the  
 19 health of local populations, that role having been  
 20 transferred from the PCTs; and that Public Health  
 21 England also worked with the directors of public health  
 22 who for England were employed by local authorities as  
 23 strategic leaders for public health and health  
 24 inequalities in local communities. We also looked at  
 25 the various structural changes over time to the PHE

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1 reminded of the assurance exercise that we went through  
 2 in 2016, which was quite positive, but it did involve  
 3 still a lot of further training and bespoke  
 4 interventions in different parts of the country.

5 So I don't think -- I think inevitably, because it  
 6 was a big change, but it was a very worthwhile change,  
 7 in my heart I will always say I believe that that was  
 8 the right thing to do, but it did take time, and it did  
 9 involve a lot of new learning for a lot of people.

10 **Q.** In terms of funding, although ministers had promised to  
 11 ringfence the public health budget for local  
 12 authorities, we heard that the public health grant was  
 13 reduced in real terms by 14% between 2015 and 2021.  
 14 Were you aware of that at the time?

15 **A.** Yes, it was very disappointing and, you know, I spoke  
 16 with the then Secretary of State, Jeremy Hunt, and then,  
 17 as I say, with the ministers that were responsible for  
 18 public health. It was -- it was actually -- it was  
 19 a very disappointing time. In 2015, Mr Hunt managed to  
 20 negotiate a lot more money for the NHS, but the Treasury  
 21 made it a condition of that that Department of Health  
 22 reduced its budget, and there was really only two places  
 23 that the Department of Health could look for that. One  
 24 was Health Education England, and of course we needed  
 25 more doctors and nurses and we had to train more. So it

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1 was Public Health England. And I had a conversation  
2 with Mr Hunt where he asked me for 50% of the budget in  
3 order to fund the NHS, and obviously that wasn't going  
4 to happen, because local government were then  
5 responsible for essential services, like school nursing  
6 and addiction services and most walk-in clinics, and all  
7 sorts of things that were terribly important, and  
8 of course -- but there was a negotiation and the  
9 Treasury won that argument and there was an initial  
10 £200 million reduction. I'm afraid that then led to  
11 every year after that further reductions.

12 I might add one thing that Dame Jenny didn't -- or  
13 wasn't -- didn't come out sufficiently. When this money  
14 was originally earmarked for local(?) government, it was  
15 essentially only what PCTs had been spending, and there  
16 was great variation across the country, and even though  
17 we had three attempts to try and get a good fix on what  
18 was being spent in the NHS, when we eventually settled  
19 it there was a seven-fold difference. We built  
20 inequality in from the outset.

21 The plan was that over time, through growth, we  
22 would even that out, and that was what was so terribly  
23 disappointing about what happened in 2015, because the  
24 ability to even that out was then taken -- taken away.

25 **Q.** So what was the practical effect of that consistent  
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1 where local authorities would reallocate ringfenced  
2 public health budgets to other services. Do you know,  
3 for instance, Mr Selbie, whether or not pandemic  
4 planning or local risk assessments in relation to  
5 pandemic planning was one of the areas that was likely  
6 to suffer from the lack of funding? In other words,  
7 were local authorities in the business of taking money  
8 that might have been used for those matters and putting  
9 it elsewhere to more acute problems?

10 **A.** So there was a lot of concern that local government,  
11 under huge financial pressure, would want to use the  
12 public health grant. As small as it was, it was  
13 enabling of other things. And we instituted  
14 an arrangement with the National Audit Office where the  
15 use of the grant had to be approved by the director of  
16 public health and was signed off by the director of  
17 public health as having been appropriately used. This  
18 was to try and give some protection to directors of  
19 public health against directors of finance or chief  
20 executives who wanted to take the money.

21 What I can't tell you is whether that affected EPRR  
22 in a significant way. I'd like to think not, because  
23 these were very small resources anyway, and they were  
24 all involved in local health resilience partnerships,  
25 where that sort of gap I think would become apparent.  
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1 reduction in budget? How did that manifest itself  
2 within public health?

3 **A.** Well, again, Dame Jenny yesterday, and I definitely  
4 agree with this, says local government are the most  
5 fiscally able of all the public health services. They  
6 have managed to manage on less more than anyone else,  
7 and they are very good at that. But you're talking very  
8 small amounts of money that have huge impacts locally.  
9 So £1,000,000 reduction in a year on a budget could mean  
10 that they couldn't support a children's centre or might  
11 not be able to continue to offer home support for people  
12 with long-term conditions, so a whole series of effects.

13 So, you know, the budget -- the actual grant of  
14 £3 billion or so was a fraction of the spend in the NHS,  
15 so any reduction on that was going to have a bigger --  
16 you know, have a bigger impact.

17 I tell you, it was just depressing that this --  
18 because at that time it was so energising that we had  
19 this opportunity at a local level to bring together  
20 local knowledge, local leadership, with specialist  
21 support from Public Health England, lots of expertise,  
22 to try and do the right thing in a very sort of local  
23 way. But you have to fund that if you want to see that  
24 happen.

25 **Q.** Yes. We've heard of a practice called "top slicing",  
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1 **Q.** All right, thank you.

2 I'm going to return later on in my questioning to  
3 the system of subsidiarity and local preparedness, but  
4 just touching upon directors of public health, was there  
5 a shortage of directors of public health due to  
6 retirements and recruitment problems?

7 **A.** It did fluctuate. In the early days -- again,  
8 Dame Jenny made the point that quite a number of the  
9 more experienced, closer to retirement directors of  
10 public health took the opportunity to retire at the  
11 point of the change, and then there was a cohort  
12 involved that did move over that just didn't find that  
13 it worked for them, it was such a different environment  
14 to the NHS they'd been used to, and they either went  
15 back to the NHS in some role or went on to do something  
16 else. So over time you saw -- well, we paid a lot of  
17 attention, as Public Health England, to this in  
18 training, bringing on, professionally developing younger  
19 potentially future directors of public health, and  
20 I think it's all in Dame Jenny's statement about  
21 different programmes we put together.

22 We had about -- well, we had exactly 152 local  
23 authorities. We had about 130 directors because small  
24 authorities used to share a director and that was  
25 perfectly normal. So I'm not up to date with the exact  
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1 numbers, but I do think it was reasonably healthy,  
2 reasonably healthy, towards the sort of 2017, 2018,  
3 2019 years.

4 **Q.** Do you agree with the view that the links between NHS  
5 staff and public health specialists became fractured,  
6 which also affected community infection prevention and  
7 control?

8 **A.** Yeah, I think it became more difficult. And one of my  
9 greatest regrets was that in strengthening the  
10 relationship between public health -- Public Health  
11 England but previously HPA -- and the local government  
12 came at some expense of having removed that capability  
13 and that experience from the NHS, not just at PCT level,  
14 but at strategic health authority or whatever the  
15 management arrangements were at that time. And I was  
16 very concerned about that, and in 2018/2019 reintroduced  
17 directors of public health into the -- what was then the  
18 seven leadership teams of the NHS, and there had been  
19 an interregnum of, what would that be, at least  
20 five years, so I definitely think that we lost our way  
21 about the NHS, and they were very, very glad to have  
22 this back.

23 Now, what did this mean for infection protection and  
24 control? I don't have enough visibility on that.  
25 I would -- I accept that it was, that the focus was

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1 where we were asked to, "Please don't say that" or "Can  
2 you take that out" or "Can you redact that".

3 In effect, when you look at the media about Public  
4 Health England over the years, I don't think you'd have  
5 any doubt about our willingness to speak out and --  
6 you know, the libertarian end of politics in -- in  
7 Britain wished we didn't exist and, you know, they were  
8 always complaining about what we were advocating for.

9 So I don't -- I don't think -- I don't think that,  
10 and Dame Jenny spoke yesterday about the particular  
11 protection that we had for our scientists and our public  
12 health professionals of all different forms. Although  
13 part of the civil service, they -- we had a special code  
14 approved by the Treasury because the Civil Service code  
15 doesn't allow civil servants to speak to the media  
16 without ministerial authority, and that did not apply to  
17 Public Health England. I was very proud of that. That  
18 was one of the early successes, to explain that actually  
19 our voice may not have been loud enough at times or we  
20 might not have got it right and others might have said  
21 that, you know, we should have been doing other things  
22 or concentrating on other things, but there was never  
23 any doubt in my mind that we were -- you know, and  
24 I would have resigned, unquestionably. It was  
25 absolutely the heartbeat. We were independent to

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1 diminished, that the sort of public health focus on this  
2 was, if you like, less -- so it was more about what  
3 hospitals were doing, because they've always had a big  
4 focus on this. I know this to be true. But I think  
5 community services very much relied on their -- their --  
6 when they had their public health responsibilities, for  
7 this.

8 But I genuinely -- you'd have to ask NHS England  
9 I think, because they were actually responsible for  
10 this.

11 **Q.** The Inquiry has heard that some parts of the English  
12 public health community have raised concerns about the  
13 extent to which Public Health England, as an executive  
14 agency of the Department of Health, was able to act as  
15 an independent advocate for public health and to set its  
16 own strategic priorities. Do you want to say anything  
17 about the lack of or perceived lack of independence of  
18 Public Health England from the government?

19 **A.** Well, I never felt constrained. I mean, there was never  
20 a moment when -- in fact, there wasn't a single occasion  
21 in the eight years that a politician of any -- required  
22 a change to anything that Public Health England produced  
23 or published. We did negotiate about timing, and there  
24 were issues about, you know, other things going on at  
25 the time, but there was never a moment, not one moment

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1 science and evidence, we were not independent of  
2 government, and that is often misunderstood. There's  
3 not a national public health agency on the planet that  
4 is independent of its government, because you can't  
5 separate politics from public health. But independence  
6 to science and evidence, definitely.

7 **Q.** All right.

8 With such a broad public health remit, how did  
9 Public Health England under your stewardship as chief  
10 executive decide which public health strategies to  
11 prioritise each year?

12 **A.** So the heart of it was the global burden of disease  
13 which was the, if you like, health profile of the  
14 country, what was killing people, what was taking people  
15 away early in an avoidable way, and then  
16 Michael Marmot's work was hugely instrumental about,  
17 well, that might be what people are experiencing but it  
18 doesn't tell you much about why or what you can do about  
19 it.

20 So we tried to balance cross health improvement and  
21 health protection. You've heard from many that these  
22 are inseparable things, you can't have a protected  
23 population unless you have a healthy one, and so we set  
24 priorities balanced across the wider determinants with  
25 the biggest priorities.

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1 So, for example, we would tackle -- of course we  
2 would tackle tobacco use and we would tackle obesity,  
3 but we also had HIV and TB, the start to life -- that  
4 was Michael Marmot's biggest advice to me that we should  
5 focus on, the beginning of life.

6 So it was a combination of those two sources of the  
7 best public health evidence that's available that helped  
8 us to make these judgments.

9 We made those judgments with the Department of  
10 Health. You know, we didn't just say and publish them.  
11 So we negotiated, we spoke to NHS England, we spoke to  
12 partners, the third sector, and of course with  
13 ministers, and with the Chief Medical Officers.

14 So the priorities were, if you like, agreed  
15 priorities but those were the two sources for how we  
16 came about them.

17 **Q.** As you know, Matt Hancock gave evidence to the Inquiry  
18 this morning, and although he wasn't asked about this in  
19 evidence, at paragraph 99 of his statement he talks  
20 about the conglomeration of different public health  
21 issues within Public Health England and, in his view, it  
22 was a mistake to create Public Health England as a body  
23 responsible for tackling non-communicable public health  
24 like obesity as well as communicable diseases and  
25 preparing for pandemics, because his view is that it was

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1 inequalities, and so there are many different ways in  
2 which you can organise to best effect, and different  
3 countries approach this in different ways, some have  
4 separation, most are moving towards integration, but  
5 it's not really that -- for me, the question is: how do  
6 you deploy against the essential health functions set  
7 out by Geneva, which include all these different areas,  
8 in your context, in the way where you can get the  
9 best -- if you like, the best from that investment?

10 There's not an answer that says, "And it is this". But  
11 I do not agree with the prior Secretary of State that  
12 you can separate these. You have to find a way of  
13 bringing them together. That may be organisationally,  
14 or there might be other ways in which that might be  
15 done. But you can't, frankly -- anyway, I'm going on  
16 too much.

17 **LADY HALLETT:** Mr Selbie, sorry to interrupt. Could you  
18 also try and speak a bit slower? Don't worry, you're  
19 not the first witness to speak too quickly. So if you  
20 could just try, I know it's difficult.

21 **A.** I'm so sorry. Normally I spoke very slowly, so it's  
22 just my -- forgive me, I will try.

23 **MS BLACKWELL:** I think maybe you're getting a little bit  
24 animated, Mr Selbie, so it's probably --

25 **A.** I shall turn it down.

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1 inevitable in those circumstances that the organisation,  
2 Public Health England, would spend more attention on  
3 tackling issues in front of it rather than worrying  
4 about the next pandemic.

5 Do you agree that more attention of Public Health  
6 England was spent on tackling non-communicable public  
7 health issues rather than pandemic preparedness?

8 **A.** So I've thought a lot about this, of course. I don't  
9 think -- no, I don't believe that. Our first priority,  
10 beginning and end, was health protection. That was our  
11 raison d'être, it was what we did, 24 hours, seven days  
12 a week, and you've got the data about the thousands and  
13 thousands of outbreaks of -- and the sort of big events  
14 that happened over those years, and Dame Jenny spoke  
15 about them, but I would have added others to them as  
16 well, that were managed by Public Health England health  
17 protection, with partners but very much with our  
18 expertise. At no point, not ever, did we compromise on  
19 that. I don't say that with hindsight. I say that  
20 with -- how could I describe it? It was our core  
21 purpose. But you cannot keep people safe unless you  
22 address the wider determinants, and you have witness  
23 statements, I thought the one from Richard Horton was  
24 particularly good, about how you can't tackle health  
25 protection without tackling health improvement and

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1 **Q.** I want to move on, please, to ask you about Public  
2 Health England's responsibilities for preparing for and  
3 responding to pandemics, and remind you of what you say  
4 at paragraph 46 of your witness statement. You say:

5 "... in my view, [Public Health England] carried its  
6 emergency health protection work up to the point of  
7 January 2020 in the way that it was asked to do by  
8 Ministers. It is also my view that although [Public  
9 Health England] was not mandated or funded for at scale  
10 pandemic readiness and response, [it] did deliver on the  
11 tasks and responsibilities which were mandated by  
12 [Department of Health and Social Care] and the [Chief  
13 Medical Officer] throughout the first phases of the  
14 Covid-19 pandemic ..."

15 What did you mean when you said that in your view  
16 Public Health England was not mandated for at-scale  
17 pandemic readiness and response?

18 **A.** So the big gap was mass testing, and mass contact  
19 tracing, because the flu plan didn't ever envisage that  
20 that would be necessary, and all the thinking that --  
21 I know you've explored extensively, about MERS and the  
22 technical -- the high-consequence infectious disease, if  
23 you like, none of that was -- required a mass response.  
24 It required what we called in Public Health England  
25 a large-scale response, but the numbers were in the few

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1 hundreds, not what was eventually required, and there  
2 had never been any discussion, at any point, with  
3 anyone, in my discussions with the Secretary of State,  
4 the Chief Medical Officer, before and current, or in any  
5 place about the scale of pandemic that we faced.

6 So when I look at the budget for Public Health  
7 England, it is one quarter of 1%, it is actually 0.23 of  
8 1% of the NHS budget. It doesn't even add up to the  
9 cost of a small hospital. And for this, we ran  
10 amazing -- I mean, I don't wish -- with -- but,  
11 you know, gold standard science at Porton Down and  
12 Colindale and our regional laboratories and everything  
13 else that we've been speaking about this afternoon. It  
14 was just not ever part of the remit, you know, it was  
15 never part of what we were asked to do.

16 My reflection about the -- and I know it's  
17 Module 2 -- is that notwithstanding that I'm intensely  
18 proud of what Public Health England were able to do in  
19 those first few months, because everybody --  
20 everybody -- had to pull together. And one of the  
21 benefits of Public Health England was that we had scale  
22 and allowed us to, say, draw on everyone to come  
23 together.

24 Have I answered your question? Please do come back.  
25 I may not have.

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1 But I never thought into: well, what happened -- how  
2 do you prevent that, how do you prevent such a thing  
3 happening? And I -- it's definitely for discussion.

4 **Q.** All right. The assumption that lay behind the strategy  
5 was that 50% of the population may well be infected. If  
6 one takes that assumption, what was Public Health  
7 England's responsibility in terms of the assumption that  
8 lay behind the strategy? What plans and preparations  
9 and assessments was Public Health England expected to  
10 do?

11 **A.** So our plan was to -- in the first phases, was the  
12 detection and the assessment phases, so first of all  
13 I do recognise the numbers, so our responsibility was to  
14 know what was coming through the surveillance systems  
15 that we had and then to develop the assay, the test  
16 necessary, adapt if necessary, and then roll that out to  
17 laboratories, principally in the NHS. Again, something  
18 we might want to explore, but in my statement -- and  
19 I think in Dame Jenny's -- about the difference between  
20 public health microbiology and diagnostic microbiology,  
21 which is often misunderstood. And so our role, in  
22 addition to EPRR of course and supporting the whole --  
23 the country with guidance and the necessary sort of  
24 public health advice, was essentially and first of all  
25 knowing what was coming towards us and then being able

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1 **Q.** I think you have to a certain extent.

2 I want to ask you some questions about the UK  
3 Influenza Pandemic Preparedness Strategy of 2011, about  
4 which I know you will be familiar. Because whilst  
5 Public Health England may not have had any mandate from  
6 the DHSC in relation to mass testing or contact tracing,  
7 and indeed there's no provision in that strategy for  
8 those levels of preparedness, the Inquiry has heard from  
9 several witnesses, including Mr Hancock this morning,  
10 that one of the major flaws in that strategy was  
11 doctrine that lay behind it, that it was based on  
12 a premise that it would not be possible to halt the  
13 pandemic and that the plan was really a clean-up plan  
14 rather than a plan to prevent the spread.

15 Do you agree, firstly, that that was a major flaw in  
16 the plan, in the strategy?

17 **A.** I'm not really qualified to say about what the doctrine  
18 might have been, because I would have looked to medical  
19 scientific colleagues to be able to respond to that.

20 What I would say is that -- and I agreed with  
21 Dame Jenny on this -- it was entirely sensible for the  
22 country to have an influenza pandemic plan. Even if  
23 that's not what we then faced, it would have been  
24 negligent not to have had such a plan. And pretty much  
25 every country I think would agree with that.

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1 to get a test out to the NHS so that they could do the  
2 diagnostics.

3 **Q.** Was Public Health England in a position from 2011, when  
4 this strategy was in place, to ensure the capacity for  
5 testing up to 50% of the population, if this indeed took  
6 place?

7 **A.** Well, no, because you wouldn't -- my understanding is  
8 that you wouldn't be testing 50% of the population. You  
9 would be testing for surveillance and research purposes.  
10 You would be testing just to know what was happening and  
11 you would be doing ongoing surveillance to be looking  
12 for any changes in the virus.

13 **Q.** Yes.

14 **A.** So emphatically it wasn't what we then faced, but ...  
15 was that clear enough?

16 **Q.** Yes. So is it your evidence, Mr Selbie, that in terms  
17 of the assumptions as set out in the strategy, Public  
18 Health England would have been in a position to provide  
19 that level of testing if the assumption that was set out  
20 in the strategy had come to fruition?

21 **A.** I sincerely believe that.

22 **Q.** Do you agree that it was another flaw to the plan that  
23 it only dealt with influenza and, despite there being  
24 a line within the strategy suggesting that the plan had  
25 to be flexible, that in fact there was no advice as to

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1 how that flexibility should be practically employed, and  
2 that a better plan would have been a generic respiratory  
3 plan?

4 **A.** I do.

5 **Q.** All right.

6 Finally, were you aware that during the course of  
7 the period of time that passed between 2011 and the  
8 onset of the Covid pandemic, that this plan was never  
9 updated? Were you aware of that at the time?

10 **A.** No, it didn't really get past my consciousness. I know  
11 you heard yesterday about NIERP. NIERP?

12 **Q.** Yes.

13 **A.** Which was our -- and that was constantly updated, and  
14 that was, if you like, our agnostic response plan which,  
15 by 2016, incorporated ConOps, which I know you talked  
16 about yesterday, and was developed every year -- sorry,  
17 refreshed every year from lessons learned exercises, all  
18 sorts of events that had happened. And we had assurance  
19 processes that I think were very good and were then sent  
20 up for external assurance to the Department of Health.  
21 But the actual flu plan, no, that never -- it wasn't  
22 conscious -- on my conscience, no.

23 **Q.** Is it right that the all threats plan NIERP had been  
24 exercised and updated from time to time but the pandemic  
25 influenza response plan set out in 2014 had not been

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1 inception and the Covid pandemic hitting?

2 **A.** Yes, of course, and I'm accountable for that.

3 **Q.** All right. Thank you.

4 I'd like to move on now to look at some minutes from  
5 an oversight meeting which took place in October  
6 of 2017.

7 They are at INQ000179643, please. Can we go to the  
8 entry at 17/126, which I think is at page 5.

9 This is the PHE Emergency Response and EPRR  
10 Oversight Group. At 17/126 we can see this, that:

11 "The Group discussed the plans and raised several  
12 comments regarding the co-ordination with NHS plans. It  
13 was noted that engagement with [NHS England] was  
14 critical as they would be responsible for the patient  
15 pathway. There was also an issue with private  
16 laboratory testing where PHE is not notified of  
17 results."

18 Then if we can go, please, a little further down to  
19 127 and 128:

20 "It was queried how the plan fitted in with the work  
21 undertaken by the HCID programme. [somebody] noted that  
22 further discussions with [someone else] and Mike Jacobs  
23 (NHS) are needed urgently to ensure this plan fits in  
24 with HCID work to ensure there is no contradiction in  
25 plans."

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1 updated since that was first published, as set out by  
2 Dame Jenny yesterday? Do you agree?

3 **A.** Yes, I recognise that. My point is that the NIERP was  
4 the operational plan that we could apply in any -- and  
5 did, in many sorts of different scenarios. But the 2014  
6 flu plan, because it reflected the 2011 DH plan, there  
7 was, I think, a sense that we would wait until -- and  
8 then there were various things that happened over those  
9 subsequent years, not least Brexit, that I think just  
10 kept pushing that back.

11 If I could turn the clock back, and I wish I could  
12 on so many fronts, then, you know, obviously we'd just  
13 say, "Well, hold on, that just needs to be" -- but it  
14 would have still been a flu plan. It would have still  
15 been a plan that didn't assume what then happened.

16 **Q.** Yes. You will be aware that we established yesterday  
17 with Dame Jenny that the flu plan was out of date in  
18 several respects, not only in relation to the structures  
19 within Public Health England which had changed between  
20 2014 and the onset of Covid, but also the wrong  
21 description of the threats committee, which itself was  
22 abolished by 2019.

23 Are you concerned, Mr Selbie, that there was in  
24 place during your watch an important plan that was not  
25 updated in any respect over the six years between its

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1 And:

2 "The meeting agreed the plan could be published as  
3 an internal draft to staff with the caveat that the  
4 document is interim and not to be shared outside of the  
5 organisation. DT to link with GD regarding wording for  
6 the draft release of the document to ensure staff are  
7 aware of its status."

8 I hope that you were able to follow that, Mr Selbie.

9 **A.** Yes, yes.

10 **Q.** This is a discussion of a group in relation to the MERS  
11 plan, wasn't it?

12 **A.** Right, that's what I wanted just to clarify with you.

13 **Q.** Okay. I want to just explore with you the fact that  
14 these notes suggest that as of October 2017 this plan  
15 wasn't finalised because there were some outstanding  
16 queries about how the plan fitted in with work  
17 undertaken by the HCID programme.

18 Are you able to help us with what those concerns  
19 were, looking at these notes now?

20 **A.** I'm afraid not. I imagine JH is Jenny Harries, and  
21 of course Mike Jacobs was the lead clinician for the  
22 HCID centre at the Royal Free, and was very involved --  
23 we were all very involved with each other over the Ebola  
24 outbreak, and so my sense of what you are saying is that  
25 there was a natural "We need to get this together, we

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1 need to make sure that it's co-ordinated, that people --  
 2 you know, that there's alignment". I believe it did  
 3 actually work out because we used it in 2018 for the  
 4 MERS case and we used it subsequently for other --  
 5 monkeypox being the one that I can most remember. But  
 6 I can't remember the detail of at that time what the  
 7 concern might be. But I'm satisfied as much as I can be  
 8 that they were talking to each other, which is what  
 9 I would hope for.

10 **Q.** Yes. Whilst it's laudable perhaps that there is  
 11 an attempt to organise joined-up thinking with the High  
 12 Consequence Infectious Disease Programme --

13 **A.** Yes.

14 **Q.** -- our understanding is that in fact this plan was never  
 15 finalised, it remained as an interim plan and, although  
 16 you suggest that it could have been utilised during the  
 17 MERS outbreak in 2018, the information that the Inquiry  
 18 has is that these discussions that were expected to be  
 19 undertaken did not in fact lead to the plan being  
 20 finalised. Does that accord with your recollection of  
 21 what might have happened?

22 **A.** I regret I don't, I can't say, and I would -- what  
 23 I would be doing is be asking UKHSA if they could  
 24 clarify that, because I'm surprised by that.

25 **Q.** Well, that's what we will do. But I think you've  
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1 fatality rate, may not have effective treatment and is  
 2 often difficult to recognise or detect rapidly, has the  
 3 ability to spread in the community and within healthcare  
 4 settings, and requires an enhanced individual,  
 5 population and system response to ensure it's managed  
 6 effectively, efficiently and safely?

7 **A.** Yes, I recognise that.

8 **Q.** Thank you.

9 Is it right that both SARS and MERS have been  
 10 defined as HCID?

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

12 **Q.** And it may seem like an obvious question, Mr Selbie, but  
 13 why do HCIDs require a different response plan compared  
 14 to other infectious diseases like influenza?

15 **A.** I think because it is -- they are by definition rare,  
 16 which is one of the criteria, that they are genuinely  
 17 unusual, and this was one of the great strengths of  
 18 Porton Down and Colindale is we had specific facilities  
 19 to be able to quickly know what it is we were dealing  
 20 with. Quick was really important because, you know, if  
 21 you had something that was terribly violent, you needed  
 22 to get the staff properly protected and fast. So these  
 23 things don't happen that often, but when they do the  
 24 thing is to contain them and to manage them; read across  
 25 for that what happened with, you know, C-19.  
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1 probably answered my next question: if this plan  
 2 remained as an interim plan and had not been finalised  
 3 between this discussion in October of 2017 and the onset  
 4 of the Covid pandemic, that would surprise you, and that  
 5 would be something which you would not approve of?

6 **A.** I wouldn't approve of that, but I would say that my  
 7 understanding is that it worked rather well, without --  
 8 you know, in the sense that we practised it in 2018 and  
 9 2019 through actual lived experience of pathogens that  
 10 were handled through that pathway. So my surprise is  
 11 that it wasn't finalised, and yes, I would be -- I would  
 12 not be happy that it had not been finalised.

13 **Q.** Thank you.

14 I want to turn to ask you some questions now about  
 15 the HCID programme. This was a network that was  
 16 established in 2015/2016, at least in part due to the  
 17 need to establish -- need for it to be established  
 18 during Ebola -- specialised facilities around the UK  
 19 where patients with highly infectious or transmissible  
 20 diseases could be treated.

21 **A.** Yes.

22 **Q.** Is it correct, Mr Selbie, that in the United Kingdom  
 23 a high-consequence infectious disease is defined  
 24 according to the following criteria: it's an acute  
 25 infectious disease that typically has a high case  
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1 **Q.** All right, thank you.

2 In an annual remit letter from the DHSC to PHE for  
 3 the year of April 2016 to March 2017, there is this  
 4 entry:

5 "Working with government and NHS England to develop  
 6 a joint programme of work and production of plans for  
 7 the public health system's response to high-consequence  
 8 infectious disease incidents. Expect to be completed in  
 9 2017 to 2018 with interim outputs throughout 2016 to  
 10 2017."

11 Now, that suggests a clear intention for the system  
 12 to be in place by 2017/2018, but the Inquiry understands  
 13 that, as of March 2017, that work had not been completed  
 14 and the system had not been set up. Is that something  
 15 which you have personal knowledge of?

16 **A.** No, I don't, but may I just quickly say that we had what  
 17 you called a quarterly accountability meeting with the  
 18 Department of Health where we would review progress  
 19 against all the different elements of the remit letter:  
 20 those of course on track, those that were ahead and  
 21 those that were not, and what we were doing about those  
 22 that were not. So I expect the Department of Health  
 23 will have a record of that particular matter and what  
 24 the -- what was the story about that at that time.

25 It was Public Health England that asked for an EPRR  
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1 element to those quarterly accountability reviews,  
2 because it was such an important part of our work. But  
3 may I -- can I decline to say? I don't know, I can't  
4 say, but I do know who would know, if you like, and that  
5 would be the Department of Health.

6 **Q.** Thank you.

7 Exercise Broad Street, which took place in January  
8 of 2018, was an exercise sponsored by the HCID programme  
9 board, and in it PHE and NHS England participated and  
10 an observer from DHSC also attended. It was  
11 a discussion-based exercise conducted at PHE Colindale  
12 in London to consider the future definitive HCID service  
13 in England and the challenges that an HCID incident  
14 could present professional partners with.

15 Do you remember that exercise taking place,  
16 Mr Selbie?

17 **A.** Well, only because I've read about it in the evidence  
18 pack.

19 **Q.** Right.

20 **A.** But I wasn't personally involved at that time.

21 **Q.** You will have read, then, that one of the concerns  
22 raised during the exercise was that the total turnaround  
23 time for getting a diagnosis was 24 hours, which was  
24 considered to be too long, and the aim was to try and  
25 reduce that time to below six hours, which would improve

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1 Can I say that I agree with all of that, about the  
2 need to have probably a small number but geographically  
3 sensible capability around the country so that it wasn't  
4 all dependent on getting a sample into Wiltshire.

5 I do know, as you know, that we do have these  
6 laboratories in -- I'll get it wrong, but Manchester,  
7 Bristol, oh, Birmingham. Anyway, a memory test. But  
8 it's therefore with --

9 **Q.** Four centres, I think, yes.

10 **A.** -- that capability, I'm sure. I'm sure with that.  
11 I knew about the number, about where the -- in Cambridge  
12 as well.

13 So, and I'm very surprised it would take 24 -- these  
14 days it would take 24 hours to do anything of that  
15 nature.

16 **Q.** What I want to ask you about, Mr Selbie, is what  
17 happened to this particular issue, as well as other  
18 matters that were raised during the course of the  
19 programme about community sampling and diagnostic  
20 testing and guidance when the programme was shut down,  
21 who took over those issues, partly raised in this  
22 exercise and partly part of the workstream that was  
23 created during the course of the HCID programme.

24 **A.** So I'm afraid I can't help with why was the programme  
25 closed. Dame Jenny Harries was what we called the SRO,

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1 the efficiency and cost effectiveness of the service.

2 One of the strongly featured comments was about  
3 getting patient samples from the point of sampling to  
4 the testing laboratory, and at that time it required  
5 a courier service, which was neither optimal nor  
6 consistent across England.

7 One delegate, you will have read, was quoted as  
8 saying "We recognised this for years. We need a common  
9 courier system that has capacity".

10 A preference was also expressed for near patient  
11 sample testing because multiple sample testing --

12 **A.** Yes.

13 **Q.** -- locations could reduce transport time, thereby  
14 reducing total diagnostic turnaround times, and it was  
15 suggested that transferring samples to PHE Porton may  
16 not be optimal due to its geographical location, and  
17 that a northern and southern hub would be a more viable  
18 option.

19 **A.** Yes.

20 **Q.** Dame Jenny Harries told us in her witness statement that  
21 the HCID programme was closed in April of 2018. Do you  
22 remember the closing of that programme taking place?

23 **A.** I -- not at that time, but again I've read the -- you  
24 included in the evidence pack the minute of the meeting  
25 that, if you like, recognised that decision.

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1 which meant she was responsible for making sure that any  
2 actions that flowed from that -- hadn't been  
3 completed -- was put into what we might call business as  
4 usual, being picked up through the EPRR oversight and  
5 the delivery team supporting, brought up to -- and the  
6 management team as necessary.

7 I never had any cause for concern or raised with me  
8 at any point that there was a need for my intervention.  
9 I was con -- I mean, I was supported by an exceptional,  
10 talented team. I mean, I'm not going to talk through  
11 all of them, but of course Jenny was one of them. But  
12 I had many Jennies who were professionally at the height  
13 -- you know, so if -- and they were all very capable of  
14 coming to me and saying if they were concerned about  
15 an outstanding action or some investment that they  
16 needed. No, to my memory, no such concern was raised.

17 **Q.** Given what we've just seen about concerns raised over  
18 the timing of testing --

19 **A.** Yes.

20 **Q.** -- did you, during your stewardship of Public Health  
21 England, ever look into contacts with private  
22 laboratories to assist with surge testing?

23 **A.** No. No. We did lots of work through, as you talked  
24 yesterday with Dame Jenny, about our income that we  
25 generated commercially and, you know, providing that was

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1 within health protection, you know, it was like skills  
2 and capabilities that we had or wished to develop, then  
3 we would work with whoever wanted to work with us, and  
4 that would include the private sector, but there was  
5 never any discussion in those years about using the  
6 private sector in that way.

7 **Q.** Do you think that there should have been?

8 **A.** No, not particularly. There was no -- there was no --  
9 I mean, Public Health England didn't regulate or  
10 accredit or in any way constrain the private sector or  
11 any academic provider of laboratory science from doing  
12 what they wished to do, provided they could meet the  
13 standards set by the Health and Safety Executive.

14 So of course there's lots of private laboratory  
15 work, but it wasn't necessary in that context at that  
16 time for public health microbiology. We had sufficient  
17 capability, sufficient capacity for the -- for what was  
18 asked of us.

19 I mean, I love the private sector, they've got so  
20 much to offer, they've got so much to give, but in that  
21 context in that setting it wasn't a necessary -- it  
22 wasn't necessary.

23 **Q.** But looking at the PHE pandemic flu strategy of 2014 and  
24 the UK pandemic flu strategy of 2011 --

25 **A.** Yes.

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1 the influenza strategy.

2 **Q.** I want to --

3 **A.** Sorry, it was reference capability that I was searching  
4 for.

5 **Q.** Reference capability, thank you.

6 **A.** Reference, surveillance and research.

7 **Q.** Yes.

8 Moving back, please, to the system of subsidiarity,  
9 what were Public Health England's responsibilities so  
10 far as local risk assessment and local pandemic planning  
11 were concerned?

12 **A.** Well, this was principally through something created --  
13 again I'll try and be brief -- the local health  
14 resilience partnerships created in 2013 which were  
15 a creature based on local resilience forums that had  
16 preceded for, you know, quite large geographical areas  
17 and they covered the same areas that the police and the  
18 fire service and others covered. But there's lots and  
19 lots of partners in health, as you have gathered, so the  
20 local health resilience partnership was a way of, like,  
21 vocalising that at a local level, and that was jointly  
22 chaired between a local authority within the area, so  
23 a director of public health, and NHS England.

24 Public Health England advised, attended where  
25 possible, but essentially local risk assessment was --

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1 **Q.** -- wasn't it obvious that a huge expansion of testing  
2 would have been necessary if that had come to fruition,  
3 and that the existing capability that Public Health  
4 England had over those years was not sufficiently  
5 scalable?

6 **A.** No, that was not my understanding. If we had had  
7 an influenza pandemic, Public Health England was  
8 genuinely perfectly capable of doing the detection  
9 assessment, the creation of the test, and the roll-out  
10 of that. The assumption was that the go-to for clinical  
11 diagnostics was the NHS, and if you look at healthcare  
12 systems around the world, it's the healthcare system  
13 that provides the clinical diagnostics, not the public  
14 health system. To my knowledge, there is not a public  
15 health agency that does clinical diagnostics anywhere in  
16 the world. CDC US, the China CDC, from Pakistan to  
17 Ethiopia, the clinical diagnostics is a healthcare  
18 responsibility.

19 So there was never any requirement -- what public  
20 health microbiology does is research, surveillance  
21 and ... oh, forgive me, but the initial diagnostic of  
22 the -- what the pathogen is, and then making sure people  
23 know what they need to do. But it would not -- it is  
24 not right that there was ever any assumption that Public  
25 Health England would require mass testing capability for

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1 and the management of and response -- was through the  
2 local health resilience partnerships. I'm trying to  
3 remember my acronyms. And there was a very powerful  
4 contribution from Public Health England about expertise  
5 and the sharing of sort of good practice and so on, but  
6 that was handled locally between the NHS and local  
7 government.

8 **Q.** So would Public Health England provide expertise to the  
9 local resilience forums or the local authorities in  
10 terms of their own assessment locally of pandemic risks  
11 and that sort of thing?

12 **A.** Yes, yes, and in 2018 we produced, with the Association  
13 of Directors of Public Health, good practice guidance  
14 for -- jointly for local authorities and the NHS.

15 **Q.** Did Public Health England ever assess whether or not the  
16 local resilience forums or the local authorities were  
17 themselves performing acceptable risk assessments and  
18 had in place adequate and responsible plans for  
19 a pandemic hitting?

20 **A.** Yes, we did, and we were asked to do that by the Health  
21 Select Committee -- I mentioned this earlier -- and so  
22 we were, if you like, detailed by the Department of  
23 Health to undertake such an exercise. It was quite  
24 sensitive, because local government are not national  
25 government, they are government in their own right, and

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1 they're quite protective of who comes along and audits  
 2 what it is they're doing. So it took us a short while,  
 3 but we did agree an exercise with local government and  
 4 with the NHS which was completed in 2016. It was  
 5 anonymised for the purposes of the -- what got  
 6 published, but everybody got to see their own results,  
 7 and then there was discussion that went on between the  
 8 centre of the region of Public Health England, the local  
 9 area team or whatever they were called at the time in  
 10 the NHS, and with local government. That was published  
 11 by the Health Select Committee, I think in 2018. There  
 12 was a plan to refresh that assessment in 2020, which  
 13 then never happened because of Covid.

14 **Q.** And did the pandemic preparedness and planning that fell  
 15 to local authorities include plans for social care?

16 **A.** Yes, well, local government are largely responsible for  
 17 social care, and so yes. Yes. To the extent that they  
 18 did, I don't -- you know ... I can almost imagine what  
 19 you're going to ask me next.

20 **Q.** Well, I'd like to put to you something which  
 21 Matt Hancock told the Inquiry this morning, which was:  
 22 when the pandemic struck, he was told that local  
 23 authorities were required to have pandemic preparedness  
 24 plans and, when he asked to see them, his Minister for  
 25 Social Care found out that there were only two local

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1 on quite a regular basis and we -- and we basically, we,  
 2 you know, we cared for each other, you know, there was  
 3 no -- there was no -- you know, we shared openly. And  
 4 Public Health England was, like, you know, the  
 5 mother ship for, you know, certain capabilities that you  
 6 wouldn't be able to replicate everywhere, very available  
 7 to the four nations.

8 **Q.** I want to turn now to ask you about public health  
 9 resilience and health inequalities. You've already made  
 10 reference to Professor Sir Michael Marmot, who, as you  
 11 probably know, has given evidence to this Inquiry,  
 12 together with Professor Clare Bambra, on the issue of  
 13 health inequalities.

14 **A.** Yes.

15 **Q.** The Inquiry has also received, as you know, a statement  
 16 from the editor-in-chief of *The Lancet*, Richard Horton,  
 17 who talks in his witness statement of the fact that the  
 18 science that has guided government responses has come  
 19 mostly from infectious disease specialists and epidemic  
 20 modellers, who understandably frame the health emergency  
 21 in terms of their two disciplines. But he talks about  
 22 the fact that what happened with Covid was not really  
 23 a pandemic but was twin epidemics clustered together,  
 24 because Covid-19 itself was very challenging but, when  
 25 you take that into account in terms of the state of the

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1 authorities which had reported to have these plans in  
 2 place, which he considered to be wholly inadequate.  
 3 I'd just like your reflection on that evidence.

4 **A.** Well, so would I, if that was the actual case, but I've  
 5 just -- I've just said, you know, in 2016 we assured  
 6 that these local health resilience partnerships, all 36  
 7 of them, had plans, that they were assessed against,  
 8 I think, 13 criteria -- I can't tell you if social care  
 9 was one of them -- but they were then, if you like,  
 10 peer reviewed, externally assured and published and  
 11 followed through.

12 But -- I didn't listen to the Secretary of State  
 13 this morning, the former Secretary of State, but I would  
 14 definitely concur that we -- you know, social care was  
 15 just not on our radar, and there's no getting away from  
 16 that.

17 **Q.** To what extent did Public Health England engage with  
 18 other public health agencies in the devolved nations?

19 **A.** Oh, regularly. We had very regular -- we had networks  
 20 for health protection, so I had Professor Sir  
 21 Paul Cosford -- who, you know, late died, a very  
 22 profoundly senior and much loved director of health  
 23 protection -- and he would co-ordinate the colleagues in  
 24 the four nations. We talked about lots of other things.  
 25 I went personally to Cardiff and Edinburgh and Belfast

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1 health of the nation, then that made it even more  
 2 difficult to cope with.

3 Do you agree with that?

4 **A.** I do. He actually used the phrase "syndemic".

5 **Q.** Syndemic, yes.

6 **A.** And I know my academic qualifications are marginal, but  
 7 I did publish in the last year with the Deputy  
 8 Director-General of the WHO on this issue, on: it wasn't  
 9 a pandemic as such, it was a syndemic, for all the  
 10 reasons that are set out by Michael Marmot. And I said  
 11 earlier I was very taken by what Richard Horton had to  
 12 say, because he's right, you know, you have to take  
 13 account of all of these if you want to truly make  
 14 a difference; you can't just say, you know, "We'll do  
 15 something about cardiovascular disease or cancer" if  
 16 you're not doing it for those that are most vulnerable,  
 17 the people at most risk.

18 So I won't get back on to my ... but essentially  
 19 I completely and utterly agree with that.

20 **Q.** Thank you.

21 I'd like to display, please, document INQ000211268,  
 22 which is a report of the inquiry panel on health equity  
 23 for the north of England chaired by Margaret Whitehead.  
 24 It's entitled, "Due North: The report of the Inquiry of  
 25 Health Equity for the North", and it's dated September

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1 of 2014.

2 If we could look, please, at page 6, which explains  
3 why the report was commissioned, it says this:

4 "Life is not grim up North, but, on average, people  
5 here get less time to enjoy it. Because of poorer  
6 health, many people in the North have shorter lifetimes  
7 and longer periods of ill health than in other parts of  
8 the country. That health inequalities exist and persist  
9 across the North of England is not news, but that does  
10 not mean that they are inevitable.

11 "While the focus of the Inquiry is on the North, it  
12 will be of interest to every area and the country as  
13 a whole."

14 Then it talks about the fact that the inquiry was  
15 commissioned by Public Health England.

16 Do you remember this inquiry being commissioned?

17 **A.** Oh, yes, very much.

18 **LADY HALLETT:** Sorry, forgive me for interrupting. Roughly  
19 how long more?

20 **MS BLACKWELL:** This is my final topic. I do know that  
21 permission has been provisionally granted to Covid-19  
22 Bereaved Families for Justice to ask about one topic.

23 **LADY HALLETT:** I'm wondering if it might be sensible --  
24 I gather the stenographer is having a tough time. Not  
25 surprised.

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1 inequalities are at page 74. Can we have a look at  
2 that, please. We can see on the left-hand side that  
3 the Inquiry's overarching assessment of the main causes  
4 of the observed problem of health inequalities within  
5 and between north and south are:

6 "Differences in poverty, power, and resources needed  
7 for health;

8 "Differences in health damaging environments, such  
9 as poorer living and working conditions and  
10 unemployment;

11 "Differences in the chronic disease and disability  
12 left by the historical legacy of heavy industry and its  
13 decline; [and]

14 "Differences in opportunity to enjoy positive health  
15 factors and protective conditions that help maintain  
16 health, such as good quality early years education;  
17 economic and food security; control over decisions that  
18 affect your life; social support and feeling part of the  
19 society in which you live."

20 Now, the Inquiry recognises that some of the  
21 recommended actions in this report could only be taken  
22 forward by central government, but if we look at  
23 recommendation 4, which is at page 19, there were  
24 specific actions identified for Public Health England.

25 Thank you. To:

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1 **MS BLACKWELL:** I'm sorry.

2 **LADY HALLETT:** Given we've got about five or ten minutes  
3 left, a five-minute break, or longer?

4 So remember that question, Ms Blackwell.

5 **MS BLACKWELL:** I will, I'll keep it in my mind.

6 **LADY HALLETT:** I'll be back in five minutes.

7 (3.10 pm)

(A short break)

9 (3.15 pm)

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

11 Mr Selbie, can you see and hear me again?

12 **A.** Yes, I can.

13 **Q.** I think there's a slight delay between the picture that  
14 we have of you and the sound, but I'm going to carry on  
15 because I only have so few questions left now. I think  
16 it might have caught up now in any event.

17 Could we display page 30, please, of this report,  
18 which we hope will show us two maps of the life  
19 expectancy amongst males and females by local authority  
20 between 2009 and 2012, females on the left, males on the  
21 right, and we can see that the red areas show the lowest  
22 life expectancy on both maps, and they are pretty much  
23 mirrored one to the other.

24 **A.** Yes.

25 **Q.** The actual findings as to the causes of health

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1 "Conduct a cumulative assessment of the impact of  
2 welfare reform and cuts to local and national public  
3 services;

4 "[to] Support local authorities to produce a health  
5 inequalities risk mitigation strategy;

6 "[to] Help to establish a cross-departmental system  
7 of health impact assessment;

8 "[to] Support the involvement of health and  
9 well-being boards and public health teams in the  
10 governance of local enterprise partnerships and combined  
11 authorities;

12 "[to] Contribute to a review of current systems for  
13 the central allocation of public resources to local  
14 areas;

15 "[to] Support the development of a network of health  
16 and well-being boards across the North of England with  
17 a special focus on health equity;

18 "[and to] Collaborate on the development of  
19 a charter to protect the rights of children."

20 Now, I don't seek to ask you, Mr Selbie, to deal  
21 with each of those recommendations individually, but  
22 given that these were present in a report in 2014, are  
23 you able --

24 **A.** Yes.

25 **Q.** -- in broad terms to explain what action Public Health

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1 England took to reduce these health inequalities in the  
2 north of England after these recommendations were  
3 received?

4 **A.** So this is one of actually a number of reports signed(?)  
5 by Public Health England direct looking at the health of  
6 the nation, and the issue about the north is not that it  
7 possesses -- it's about intensity. There are  
8 inequalities everywhere, but the intensity is greater.

9 I remember very well, it does feel like a long time  
10 ago, that we had regional response, because we had  
11 a regional director for the north, who worked with  
12 Margaret and local authorities who had a lot of the  
13 influence here with the city -- thinking about  
14 Andy Burnham in particular for Manchester, but there  
15 were other mayors, Liverpool, that we were speaking to  
16 about the sort of expert advice and support that Public  
17 Health England can provide.

18 This is ultimately an issue of resources. I --  
19 you know, we were not able to make the sort of  
20 investments happen that would make the biggest  
21 difference here. It's a ... it's evident that, you  
22 know, these inequalities remain as tough and may be  
23 widening, if Professor Marmot is right about this.

24 Public Health England was not in a position to  
25 direct resources, but we were in a position to highlight

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1 for the want of Public Health England. We made advice  
2 available on all sorts of areas that this report speaks  
3 to, including air quality and gambling and pretty much  
4 everything in between.

5 But in my witness statement I make the point that  
6 politics and public health are inseparable, that you  
7 simply can't get these sorts of things addressed without  
8 political commitment. Not just about money, but about  
9 the commitment to do difficult, and difficult is  
10 difficult for governments, it's been particularly  
11 difficult for this government, and we've seen ...

12 So I would say evidently inequalities have not  
13 improved and therefore we have not succeeded in our  
14 mission, but I would not accept that it wasn't for want  
15 of trying and for drawing out the evidence about: if you  
16 did this, you could expect to see this impact.

17 And, finally, people publish things, they say  
18 things, they go out and they say what they care about,  
19 but these days I'm not interested in that, I'm  
20 interested in: show me your budget and then I'll know  
21 what you care about. Don't show me your strategy and  
22 don't tell me that you care about health improvement and  
23 inequalities; show me a budget and then I'll know  
24 whether you do. And I'm afraid that I would say that  
25 there has not been a sufficient interest and focus,

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1 and make transparent, if you like, bring visibility to  
2 this, and about, you know, the actions that might make  
3 the greatest difference.

4 I'm trying very hard not to rumble along, but we did  
5 produce all sorts of evidence about what would make the  
6 biggest difference for those that were in these  
7 circumstances that Margaret Whitehead describes.

8 **Q.** Thank you.

9 I think I know the answer to this question, but do  
10 you agree with Professors Marmot and Bambra that over  
11 the course of the ten years preceding the Covid pandemic  
12 that life expectancy, and in particular healthy life  
13 expectancy, worsened for those who were living in  
14 poverty?

15 **A.** I think that's a very reasonable position.

16 **Q.** And so during the life of Public Health England, do you  
17 believe that it succeeded in its mission to reduce  
18 health inequalities?

19 **A.** Evidently not. But what we did do was draw -- make it  
20 transparent, bring it into consciousness, we produced  
21 evidence, reviews, we gave advice, we tried to get  
22 government to focus on the things that would make the  
23 biggest difference. We made good progress in certain  
24 areas like TB and HIV and Hep C, we made less good  
25 progress in areas like childhood obesity, but it wasn't

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1 because the spending does not reflect that.

2 **Q.** Thank you, Mr Selbie.

3 My Lady, that completes my questioning and, subject  
4 to my Lady confirming that Covid-19 Bereaved Families  
5 for Justice do have permission to ask a question around  
6 the Chief Nursing Officers' meeting of October 2014,  
7 then I will hand over to Ms Munroe King's Counsel.

8 **LADY HALLETT:** Ms Munroe.

9 **Questions from MS MUNROE KC**

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

11 The question is in fact -- that was yesterday's  
12 question.

13 **LADY HALLETT:** I was going to say --

14 **MS BLACKWELL:** Oh, I'm so sorry.

15 **LADY HALLETT:** -- I thought I was having déjà vu, that's why  
16 I looked over to you.

17 **MS BLACKWELL:** I was wondering how it was going to be  
18 relevant. I'm so sorry.

19 **LADY HALLETT:** Don't worry, she didn't mislead me,  
20 Ms Munroe.

21 **MS MUNROE:** Thank you.

22 Mr Selbie, can you hear and see me?

23 **A.** Yes, I can, Ms Munroe.

24 **Q.** Thank you very much. I ask questions on behalf of  
25 Covid-19 Bereaved Families for Justice throughout the

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1 country.  
 2 It is in relation to a document that you have  
 3 already been referred to today, the MERS plan. I wonder  
 4 if we could have that on the screen, please. It's  
 5 INQ000179069. Can you see that, Mr Selbie?  
 6 **A.** I can, yes.  
 7 **Q.** Ah, that's actually the meeting. It's the document  
 8 itself. I'm told it's INQ000 --  
 9 **A.** I can see the document.  
 10 **Q.** You can see the document?  
 11 **A.** Yes, I can, yes.  
 12 **Q.** Thank you. It's entitled "Public Health England  
 13 Response Plan for Possible, Presumptive and Confirmed  
 14 [MERS] cases", and the purpose of -- it's a guidance,  
 15 and the purpose is that it's an internal document to be  
 16 used by PHE "to inform planning for potential MERS  
 17 cases".  
 18 **A.** Yes.  
 19 **Q.** Now, this was from 2017, it's during a period of time of  
 20 your tenure with PHE. Would you agree, Mr Selbie, that  
 21 that particular plan sets out in some considerable  
 22 detail matters such as infection control guidance and  
 23 management of both symptomatic and significantly  
 24 asymptomatic MERS patients and healthcare workers?  
 25 **A.** Yes.

1 that the HCID pathway was in fact utilised for the early  
 2 cases of Covid, yes.  
 3 **MS MUNROE:** Thank you very much, Mr Selbie.  
 4 Thank you, my Lady, those are my questions.  
 5 **LADY HALLETT:** Thank you very much, Ms Munroe.  
 6 **MS BLACKWELL:** My Lady, that completes the evidence of  
 7 Mr Selbie, and the evidence for today.  
 8 **LADY HALLETT:** Thank you very much, Mr Selbie. I don't want  
 9 what the time difference is, but I hope we haven't  
 10 affected your day too disastrously. Thank you very much  
 11 for your help.  
 12 **THE WITNESS:** Thank you. Thank you.  
 13 **(The witness withdrew)**  
 14 **LADY HALLETT:** 10 o'clock tomorrow?  
 15 **MS BLACKWELL:** Thank you, my Lady.  
 16 **LADY HALLETT:** 10 o'clock tomorrow. Thank you.

17 (3.31 pm)

18 **(The hearing adjourned until 10 am**  
 19 **on Wednesday, 28 June 2023)**  
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 24  
 25

1 **Q.** Would you also agree, Mr Selbie, that when -- and again  
 2 we don't need to bring it on the screen because it's  
 3 a guidance you're familiar with, but for reference  
 4 purposes, my Lady, it's page 14 of the guidance -- it  
 5 includes measures within this guidance that we all  
 6 became very familiar with during the course of 2020, and  
 7 they include isolation and self-isolation in the  
 8 community, contact tracing, communications and  
 9 restricting interactions between those affected and the  
 10 wider public, such as transport restrictions,  
 11 prohibitions of attendance in public spaces, et cetera;  
 12 that's all part and parcel of the guidance, isn't it?  
 13 **A.** Yes.  
 14 **Q.** Now, appreciating, Mr Selbie, what you have said this  
 15 afternoon in answer to questions from Ms Blackwell about  
 16 this MERS plan, that there needed to be clarification  
 17 with UKHSA, that notwithstanding, given that Covid-19  
 18 was initially classified as an airborne HCID, would you  
 19 have expected the MERS plan to have been utilised in  
 20 some form for Covid-19, as it had been for MERS and  
 21 monkeypox, as you've referenced, and are you able to say  
 22 whether it was in any form utilised?  
 23 **A.** Yes and yes. So what you were describing would be  
 24 regular health protection activity at a scale that we  
 25 were well used to dealing with. It is my understanding

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