Tuesday, 27 June 2023

(10.00 am)

LADY HALLETT: Morning, Mr Keith.

MR KEITH: Good morning, my Lady. Matt Hancock MP, please.

MR MATT HANCOCK (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY

MR KEITH: Could you give the Inquiry, please, your full name.

A. Yes, my full name is Matthew John David Hancock.

Q. Mr Hancock, thank you for attending today. Whilst you give evidence, could you please speak up so that we may all hear you clearly, and also so that the stenographer can hear you for the purposes of the transcript.

If I ask a question that is not clear, please don't hesitate to ask me to repeat it. There will be a break in the course of the morning's evidence session.

You have kindly provided a witness statement dated 20 April of this year; is that right?

A. That's right, yes.

Q. Could we have, please, on the screen INQ000181825, and page 14, please. Page 24, I think, is the last page. It's signed, I think, on 12 May, therefore, and it was accompanied by the usual statement of truth.

Mr Hancock, you were Paymaster General and Minister for the Cabinet Office between 11 May 2015 and

July 2016.

A. Yes.

Q. During that time, were you, therefore, responsible ministerially for an important part of this pandemic preparedness structure, namely the National Security Risk Assessment process?

A. Yes, I was formerly the junior minister responsible for that, both for the secret part and for the National Risk Register. I reported to Oliver Letwin, and he in practice led on those areas, but nevertheless I had junior oversight of them.

Q. Is that because the senior minister in that regard is the Chancellor of the Duchy of Lancaster, which he was, and you were the junior ministerial colleague as Minister for the Cabinet Office?

A. I was effectively the number two in the Cabinet Office, yes.

Q. Then did you become Secretary of State at the Department of Health and Social Care between 9 July 2018, when you took over from Jeremy Hunt MP, and 26 June 2021, when you resigned?

A. Yes.

Q. My Lady, for the purposes of -- for those who may be listening to Mr Hancock's evidence, I'm going to make clear that your appearance today is obviously concerned

with the discharge of your functions as the Minister for the Cabinet Office and as Secretary of State in the Department of Health and Social Care pre-pandemic.

A. Yes.

Q. We are concerned today only with the issues of emergency planning and preparedness, and so may I make clear that I will not be asking you questions about the detail of non-pharmaceutical interventions, lockdowns, the government's response, or the test and trace or procurement or PPE issues which arose after the pandemic struck.

LADY HALLETT: They will come in later modules, just so people understand.

MR KEITH: They will all be in later modules, particularly Module 2 in the autumn, for which Mr Hancock has provided a draft statement.

EPRR pandemic planning. The functions of the Secretary of State, Mr Hancock, in relation to pandemic planning, are wide-ranging and complex, are they not? There is quite a lot to be concerned with in this field.

A. Yes, and that is in addition to the very broad responsibilities overall as Secretary of State.

Q. You are responsible or were responsible in broad terms for health and social care, and that includes, therefore, health protection, health improvement, the

healthcare systems, the social care systems, although that's largely in the hands of local authorities, and most importantly perhaps the NHS, so it's a very wide brief indeed.

A. I wouldn't say most importantly the NHS, I would say that there are many, many areas of importance, and actually one of the challenges of the job is to try to put your attention to the most important areas, because it is so broad.

Q. Is a vital function of the Secretary of State to deal with health emergencies?

A. Absolutely, and going into the job, I had some experience at a more junior level of dealing with crises and emergencies, and so I took my responsibilities as the -- as the principal responder to a pandemic very seriously.

Q. Does dealing with health emergencies include dealing with infectious diseases?

A. Yes, of course.

Q. And being ready to deal with them? Being ready to deal with the risk of infectious diseases?

A. Absolutely.

Q. So when concerned in the field of emergency preparedness, resilience, civil contingencies, where there is a health emergency it is the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

A. No.

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

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

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

A. There was at a departmental level.

Q. Departmental --

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

have been the normal place to have had such discussion.

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

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

Q. All right.

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

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

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

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

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

A. Yes.

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

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

Q. Indeed.

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

A. Correct.

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

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

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

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

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

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

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

A. Yeah.

Q. May we please have INQ000183334 on the screen.

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

Could we please have page 1.

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

A. That's a director general.

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

Page 10.

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

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

Then the first bullet point:

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

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

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

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

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

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

INQ000184105, please.

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

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

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

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

A. Yes.

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

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

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

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

A. Yes.

Q. Then paragraph 7, please.

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

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

A. Yes.

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

A. Yes.

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

that you became aware of Exercise Cygnus --

A. Yeah.

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

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

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

Q. Of course.

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

A. Yes.

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

A. Yes.

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

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

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

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

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

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

Q. Coming back to the internal briefing --

A. Yes.

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

A. Yes.

Q. When you were told, however, by your civil servants that the United Kingdom was well prepared --
A. Yes.
Q. -- what did they say, when you asked them, as you presumably did, "Well, in what way" --
A. Yes.
Q. -- "are we prepared?"
A. Yes.
Q. What did they say about the various other parts of the preparedness structure, stockpiles --
A. Yes.
Q. -- diagnostic testing, plans for quarantining or shielding or to deal with the impact of a pandemic, or the supply of antivirals, all of which are other aspects of the system of preparedness?
A. I'm --
Q. What were you told?
A. I was told that we had plans in these areas. So, for instance, on stockpiles, I was told that we had a very significant stockpile of PPE, and we did. The problem was that it was extremely hard to get it out fast enough when the crisis hit.

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

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

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

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

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

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

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

I need to put on the record, if I may, my Lady, that my written statement -- I've got an update on my written statement, having continued to look through the documents. In --
Q. Mr Hancock, we'll return, if we may, to correcting one or two parts of your witness statement --
A. Okay.
Q. -- a little later. I'm aware that there are one or two areas that you want to say something more about in light of documentation which you have been provided with more recently.
A. Yeah.
Q. Can I bring you back, though, please, to the debate with your civil servants about the state of preparedness?
A. Yeah.
Q. Did you observe to your civil servants or ask, "Well, there is a significant stockpile, but it's only for flu"?
A. Well, in the case of PPE, the distinction between a flu pandemic and a coronavirus pandemic is really second order. A respiratory disease pandemic requires very similar or, in many, many cases, the same PPE, irrespective of the virology. What matters is the

characteristic of the virus.
Q. Indeed. Did you ask whether or not the stockpile about which you received assurances would be adequate for a non-influenza pandemic?
A. I don't recall whether I did or not, but I also know that if I'd asked the question, I would have been -- I hopefully would have been told it's adequate for other respiratory diseases as well, because indeed it was, because we used it.
Q. Did you ask whether or not the antivirals --
A. Yes.
Q. -- in the main a brand antiviral called Tamiflu --
A. Yes.
Q. -- which was supplied in -- was available in large quantities, whether that was suitable for a non-influenza pandemic?
A. I don't know whether I asked or I was briefed, but I was certainly aware that that was only useful against a flu, not a coronavirus.
Q. Did you ask or were you made aware that the testing, the diagnostic testing which was in place was on a very small order, and of course was testing designed to deal with a limited high-consequence infectious disease, primarily one involving an outbreak in health settings?
A. Yes, I knew that the testing system was small, and the

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

For instance, large-scale testing did not exist, and a large-scale contact tracing did not exist, because it was assumed that as soon as there was community transmission, it wouldn't be possible to stop the spread and, therefore, what's the point in contact tracing? That was completely wrong, and in my view is the absolutely central lesson, is: of course the difference between a flu and a coronavirus is important, but it is a -- but it is not nearly as important as getting the doctrine right so in future we're ready to suppress a pandemic, unless the costs of lockdown are greater than the costs that the pandemic would bring.

Q. Perhaps we'll return to the issue of the -- or the doctrinal arguments about lockdowns a little later.

A. If I may, the reason to bring it up is because it had consequences in all the areas you've set out: stockpiles, testing, antivirals, contact tracing and much more widely.

Q. Those were, now, the acknowledged consequences of the doctrinal failure, Mr Hancock.

A. Yes.

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

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

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

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

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

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

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

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

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

A. Yes.

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

A. Well, there was no recommendation to resolve those

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

Q. You were the Secretary of State.

A. Yes.

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

A. Yes.

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

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

A. That's right.

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

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

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

A. Yes.

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

A. Yes.

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

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

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

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

Q. Indeed.

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

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

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

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

A. So --

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

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

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

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

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

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

A. They were both --

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

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

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

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

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

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

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

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

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

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

Q. -- I ask the questions.

A. Of course.

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

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

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

A. As I understand it, yes.

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

A. That is correct, yes.

Q. All right.

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

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

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

A. I was not aware of that, no.

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

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

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

Q. All right.

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

A. Yes.

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

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

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

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

a lot of risks and threats.
Q. But, Mr Hancock, why didn't you say to your civil servants -- this was a major exercise into the United Kingdom's pandemic influenza preparedness, it was one of the largest command post exercises ever held, it made a number of important recommendations, 22 in fact in all --
A. Yeah.
Q. -- across the whole board of the United Kingdom's plans and capabilities. And by June 2020 -- after the pandemic had struck, of course -- the DHSC acknowledged that of the 22 recommendations, eight had been fully addressed, six had been partially addressed, and work to address eight more was still ongoing.

How could that have been missed? How could those recommendations not have been put into place between July 2018, when you took that post, and 2020, when the chickens came home to roost?
A. Well, the answer to that question -- there's two ways of answering that question. The first is that as a secretary of state you have a limited set of resources, and you have to make sure that those resources are targeted at the threats that you face, and one of those risks was a disorganised Brexit and it was incumbent on the department to make sure that we were as

well prepared for that as possible.

The second way of answering the same question is that it isn't really about the numbers of recommendations from Cygnus, it's about what those recommendations were, and the problem with Cygnus is it did not spot the central problem in pandemic planning. So I'm -- having looked through those recommendations that were not put in place, I'm not sure they would have helped much when the chickens, as you say, came home to roost. Because Cygnus did not recommend that we should be prepared to stop the spread of a pandemic. It made all sorts of recommendations for how to deal with the worst-case scenario happening.

Therefore, I am not at all convinced that we would have been much better placed to face this pandemic had all of those recommendations been put into place, because -- because there was a much bigger error.
Q. All right. But those exercises take place for good reason, do they not?
A. Yes, but they still -- but it still didn't spot the main problem.
Q. Are they important matters, Mr Hancock?
A. Of course.
Q. And were recommendations made, a number of them, as a result of that exercise?

A. Yes.
Q. And did your department fail to implement all those recommendations?
A. I'm not denying any of that. I'm explaining, firstly, the different pressures that you have on resources, and Brexit was real and a pressure, and I'm also explaining the consequences of those decisions, and I'm -- I'm trying to articulate that there was a much bigger problem that we must -- and the central lesson that I think we need to learn.
Q. Well, we'll come to that in a moment.

The report into Exercise Cygnus was not published, was it, in July 2017, when it reported?
A. No.
Q. Could we have, please, INQ000057514, and page 2.
A. Yeah.
Q. You were asked in May of 2020 -- of course after the pandemic had struck -- whether or not you agreed that the report into Exercise Cygnus from July 2017 should be published.
A. Yes.
Q. We can see, the top left-hand corner of the page, number 2, "SoS", Secretary of State?
A. Yes.
Q. If you could scroll back out, please, the issue is --

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

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

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

A. Yes.

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

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

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

Paragraph 8:

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

Is that a partly concealed reference to the fact

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

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

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

A. Yes.

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

A. Yes.

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

A. That's correct, yes.

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

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

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

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

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

"- Mitigation ..."

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

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

That wasn't quite right, was it?

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

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

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

A. Yes.

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

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

Q. Page 7, please, paragraph 15:

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

around social care preparedness had been acted on."
That was right, wasn't it?
A. Yes.
Q. One of the areas, the important workstreams which had not been concluded or even in part developed was to do with the capacity of the adult social care sector to be able to deal with --
A. That's not quite right.
Q. -- the demands of a pandemic?
A. As part of the work ongoing when I was Secretary of State, preparedness in social care was one of those workstreams, yes.
Q. Work was done, wasn't it, in order to try to see whether or not the department could make itself better informed as to the sheer number of people in the adult --
A. Yes.
Q. -- social care sector? Work was done on producing some policy papers that would be of use to local authorities, who of course are primarily responsible for the adult social care sector, but no work was done, was it, in relation to preparing the individual care homes for the necessary surge in numbers attendant upon a pandemic?
A. Work was done in the first two areas you mention. This report, the article, was inaccurate. However, the responsibility for ensuring preparedness in social care

formally fell to local authorities, and there was work required of local authorities to put in place pandemic preparedness plans. When the pandemic struck, and I was told that local authorities were required to have pandemic preparedness plans, I asked to see them, and my minister for social care, Helen Whately, found that there were only two, which she saw, and reported, to me, them to be wholly inadequate.
One of the central challenges in social care is that whilst I had the title Secretary of State for Health and Social Care, the primary responsibility, legal responsibility, contractual responsibility for social care falls to local councils. In a national crisis, this is a very significant problem, because, as I put it in my witness statement, we -- I had the title, I was accountable, but I didn't have the levers to act. And we didn't even have the data, and this is the work that was ongoing before the pandemic, which is why this statement here from The Guardian, reported from The Guardian is inaccurate, there was work ongoing to try to find out even the basics of the provision of social care.
For instance, how many care homes are operating right now in the UK? That was a fact that we did not know at that time. And I'm glad to say now there's far

better data, but that was one of the workstreams.
And, you know, it's -- it was very important, and that work continued.
Q. Some work was done by the department to make itself better informed, in particular in relation to the numbers of persons in care homes and the working arrangements in the adult social care sector, but the vital work directly concerned with the preparation of those care homes, which was part of the workstream meant to be done by the Pandemic Flu Readiness Board, was not done, was it?
A. That's not --
Q. Those two plans were all that there was on the local authority side, and the surge planning in relation to the adult social care sector fell far behind that done for the NHS, did it not?
A. That work nevertheless was done, and being done, and it is a -- in fact, this discussion is an example of the challenge of why it's so hard for policy in social care when the accountability falls, understandably, to the Secretary of State, but in this case pandemic preparedness was a legal responsibility at the local level, and whilst we at the health department could require that, the money for social care from central government goes through a different department, and so

the requirement to produce those plans fell to the local authorities and they were in very large part not concluded before the pandemic struck. And that is -- that is a major problem with how social care's run in this country.
Q. The obligation to get ready did not rest solely on the local authority, did it?
A. The obligation for the policy rested with me. The obligation for delivery in social care rests with local authorities. They're the ones who contract individual care homes.
Q. The Department of Health and Social Care understood that an important line of work, a workstream, to be carried out by the Pandemic Flu Readiness Board and the Pandemic Influenza Preparedness Programme board, was ensuring that the adult social care sector was ready in terms of plans, what would they do in the event of a pandemic, and surge capacity, how would they physically cope --
A. Yeah.
Q. -- with the impact of a catastrophic pandemic?
A. Yeah --
Q. Those were the obligations on the Department of Health and Social Care and they were not completed, were they?
A. They were to be delivered through local authorities, which proved extremely difficult, and that is

a structural problem with how social care has been organised in this country since 1948.

Q. That may be so, Mr Hancock, but it was a responsibility that the Department of Health and Social Care was aware of, otherwise it wouldn't have directed that these workstreams be drawn up at all?

A. Absolutely.

Q. Right.

A. Absolutely.

Q. The NSC(THRC), the National Security Council Ministerial sub-committee on Threats, Hazards, Resilience and Contingencies was the committee to which you referred earlier, the committee chaired by the then Prime Minister, who had ordered the setting up of the Pandemic Flu Readiness Board?

A. Yes.

Q. The terms of reference for that board required the Secretary of State for Health to report progress to the National Security Council THRC committee on the work of the Pandemic Flu Readiness Board.

Could we have, please, INQ000022743.

LADY HALLETT: I think if we're going to a slightly different topic, Mr Keith --

MR KEITH: Yes, my Lady.

LADY HALLETT: -- I think, probably, if that's convenient

for you?

MR KEITH: Yes, indeed.

LADY HALLETT: We take regular breaks because we have a brave stenographer who copes with us all, but ...

Very well, I shall return at 25 past -- half past.

(11.12 am)

(A short break)

(11.30 am)

LADY HALLETT: Mr Keith.

MR KEITH: Mr Hancock, I was about to put to you the terms of reference for the Pandemic Flu Readiness Board.

They are at INQ000022743, page 1, please.

The first paragraph on page 1 provides the background to the setting up of the board, and refers back to that meeting about which you gave evidence earlier, the NSC(THRC) meeting in February 2017.

The board and the discussion reaffirmed the government's commitment to ensuring the UK was prepared to manage the health effects of severe pandemic influenza as defined by the reasonable worst-case scenario, and the wider consequences.

"Since the demise of the Pandemic Flu Implementation Group, there has been no dedicated group with responsibility for preparations for the cross-government impacts of pandemic influenza."

Mr Hancock, the Pandemic Flu Readiness Board was co-chaired, of course, by your then department, DHSC, and the Cabinet Office. But it was the only board which provided "oversight for a programme which will deliver the plans and capabilities to manage the wider consequences of pandemic influenza".

Then on page 2, please, paragraphs 5 and 6, "Roles and Responsibilities of Members":

"5. The membership of the Board is intended to reflect the breadth of the Government's responsibility for the potential consequences of an influenza pandemic on the nation. Members of the Board will represent the interests of their department ..."

Then at 6:

"The Board will report progress to NSC(THRC) [that's the ministerial committee which set up the board] via the Secretary of State for Health and Minister for the Cabinet Office, who will receive regular progress updates in parallel."

It is obvious that the Department of Health and the Cabinet Office regarded it as essential that the work being done by this sole cross-government body, the only body dealing with cross-government pandemic influenza preparedness, provide regular updates to the ministerial committee which set it up.

There were two NSC(THRC), that's the overarching committee, two such committee meetings attended by officials.

How many of those overarching meetings, NSC(THRC) meetings, did you go to in order to inform them of those regular progress updates?

A. Personally?

Q. Personally.

A. None that I can remember. I attended the National Security Council from time to time when the agenda included areas that I was responsible for. I was not a standing attendee. But I don't recall ever being asked to attend to report on this.

Q. Did you know of the existence of the NSC(THRC), the ministerial -- overarching ministerial committee to which you were expected to report?

A. Yes, I attended it. That's essentially the National Security Council.

Q. No, the NSC(THRC), the threats, hazards, resilience and contingencies committee.

A. Yes, that's a subcommittee. That one is a subcommittee of the National Security Council.

Q. How many of those subcommittee meetings did you attend?

A. I can't recall.

Q. Did you attend any?

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

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

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

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

It's dated 27 March 2019, and it concerns the reallocation of work. Paragraph 1, to Sir Chris Whitty:

"You are aware that, following re-organisation and re-prioritisation of DHSC work due to EU Exit no deal planning, pan flu preparedness and high consequence infectious disease ... policy has moved to your portfolio of responsibilities on a temporary basis."

Then at paragraph 3:

"ExCo ..."

What is ExCo?

A. That's the executive committee of the Department for Health and Social Care chaired by the permanent secretary. That's the committee that effectively runs the department on an executive basis.

Q. But subject to the supervisory role of the departmental board to which you referred earlier, perhaps?

A. Yes, and of course working to ministerial priorities and decisions.

Q. "ExCo agreed that the Department would need to do less work in some areas in order to free up resource for EU Exit preparations. As a result, Emma Reed and Clara Swinson agreed a range of work related to pan flu and HCID that would be scaled back or paused before this policy area transferred across to you. Annex A summarises the work areas that are continuing and those

which are on hold."

So this paragraph makes plain that at the highest level in your department, subject only to the supervisory review of the board and yourself, not just that there was a prioritisation across government in favour of EU exit work, but that a range of work related to pan flu and HCID would be scaled back or paused.

That was a policy decision of great significance, was it not?

A. It was a policy decision. I would query whether it had great significance.

As you can see from the numbers on this page, the numbers of people working in this area, the numbers of movement, is small, and my second observation is that this work was following a wrong -- the wrong approach, and I'm not sure it would have been any use in the pandemic. That's my judgment from having been the man in the -- you know, the person in the hot seat when the pandemic struck.

Q. Do you recall that debate before ExCo?

A. Yes, I recall the debate, because I discussed it with the permanent secretary, because whilst he was responsible for the running of the department, he of course would then check with me that I was content with the proposals that he'd put together, and there

were many other areas of work that had to be stopped in order to prepare for Brexit as well. I mean, this wasn't the only area, there were a whole series of them.

Q. So you were aware and you agreed that a range of work relating to pan flu and HCID would have to be scaled back or paused?

A. Yes, and I wasn't enthusiastic about it but I signed it off, and the reason that I signed off the overall reshaping of the department is because we had a very real and material threat, should a disorganised Brexit happen, that we needed to be prepared for. And it comes back to the point about context, that there are many, many bad things you have to prepare for when you're the -- in the health department.

Q. Moving forward eight months to the eve of the pandemic, in November 2019, INQ000023089, the minutes for the Pandemic Flu Readiness Board:

"The Pandemic Flu Readiness Board ... has not met since November 2018 due to reprioritisation in 2019 to plan for a potential no-deal EU Exit."

So the sole cross-government body set up by direction of the Prime Minister did not meet at all, did it, between November 2018 and 27 November 2019?

A. That's what this paper says.

Q. Were you aware, Mr Hancock, that for a whole year the

board did not even meet?

A. I do not recall being aware of that, no. But also -- but I do know that work under the board's guidance continued, because I was engaged in some of the work, as we've discussed, especially but not only on vaccine manufacturing.

Q. Page 5, paragraphs 7 and 8.

"... PFRB had committed to meet every 6-8 weeks until the key outputs of the work programme were delivered. It is proposed that in 2020 [it] meets every 3 months. This will ensure that progress can be communicated to key planning partners through updated documentation where appropriate."

So it was understood, wasn't it, that although it had committed to meet every six to eight weeks, the failure to meet for a whole year fell very far short of what it had apparently committed itself to doing?

A. That's what I understand too from reading these papers, yeah.

Q. It says:

"NHS(THRC) [it should be NSC(THRC)] -- Under the PFRB's current governance arrangements, the Board reports on progress to NSC(THRC)."

The board which you -- the subcommittee which you cannot recall attending.

"Due to EU Exit pressures, NSC(THRC) were not updated at the end of Year 2, March 2019."

So it didn't not just not meet, it wasn't even updated at the end of Year 2, March 2019, the second full year of its operations, was it?

A. Evidently, from reading these papers. I wasn't aware of these papers at the time.

Q. Then of course after the pandemic struck -- INQ000023114 -- on 15 January 2020:

"Pandemic Influenza Preparedness Programme Work Stream Updates (Last Updated: 15 January 2020)"

The healthcare workstream:

"Progress has slowed ..."

For a number of reasons.

"2 -- Community Care.

"Progress on the community healthcare side has slowed ..."

For a number of reasons.

Then over the page, please, or further down the page, "Excess deaths", that was one of the workstreams on which work was completed, wasn't it?

(Pause)

You referred earlier in your evidence to the fact that you were aware that was a workstream on which work was done?

A. Work was done, I'm not sure that it was completed, because we had to do further work on it when the pandemic struck. That's why I was pausing, to try to recollect and express that correctly.

Q. Over the page, "Sector Resilience":

"There has been no further work on this work stream as the statements of preparedness are finalised ... it was agreed that the sharing of the business checklist should be paused as a result of the need to communicate other risks, including EU Exit."

What is sector resilience, Mr Hancock?

A. Well, sector resilience is ensuring that there is resilience especially of supply chains.

Q. Where?

A. Well, in --

Q. Which sectors?

A. In this case pharmaceutical in particular, but also non-pharmaceutical goods required for the health and social care sector.

Q. Health and social care sectors?

A. Within the department, that would have been the purview.

Q. Yes.

"Cross Cutting Enablers.

"All England clauses and supporting documentation complete including explanatory note and assessment of

impacts."

Is that a reference to the drafting of the Bill to which you made reference earlier?

A. The ... it -- it appears so. That's what -- "4 Nations Bill" was used as the shorthand --

Q. Yes, there is a reference to clauses and supporting documentation. So that appears to --

A. That appears so. On the previous one, on number 4, of course, the work that was intended to be prepared for a no-deal Brexit was itself important, incredibly important, when it came to the pandemic. So this paper doesn't quite capture -- capture it. It captures the planning, and later --

Q. Is that a reference to the fact that work was done on securing and safeguarding medicinal supply chains --

A. Yes.

Q. -- to deal with a no-deal EU exit?

A. Yes.

Q. But that issue of supply chains, Mr Hancock, was just one, wasn't it, of a very much larger number of areas in which work was required across the health sector and the adult social care sector? Not unimportant, but it was just one of the areas, wasn't it, where work was required?

A. I wouldn't put it like that. If I may, the way I'd say

it is that the work done for a no-deal Brexit on supply chains for medicines was the difference between running out of medicines in the peak of the pandemic and not running out. We came extremely close, within hours, of running out of medicines for intensive care during the pandemic, it wasn't widely reported at the time, and I think the only reason that we didn't run out is because of the work that Steve Oldfield and his team did, which they did during 2019 in preparation for a no-deal Brexit, but became extremely useful in saving lives during the pandemic.

At the point at which the pandemic struck, because of the no-deal Brexit work, we knew more about the pharmaceutical supply chain in the UK than at any time in history, and we had relationships with the pharmaceutical suppliers, and the data to know exactly who had what available and where, and the extent of that information was the difference between running out and not running out of drugs in intensive care in the pandemic.

Now, that, of course, wasn't the intention of the work, but it was the consequence of the work. So when it comes to the question of the overall impact of Brexit, absolutely the paperwork is very clear that some of the preparation work was stopped and a small number

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

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

A. That is one point. I agree.

Q. Thank you.

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

Q. Than the others.

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

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

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

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

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

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

Do you recall that?

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

Q. All right.

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

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

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

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

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

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

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

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

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

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

A. Yes.

Q. -- faced the pandemic in January 2020.

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

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

So, yes, I totally accept that.

Q. And a PIPP paper, a Pandemic Influenza Preparedness Programme board paper dated October 2019, on the eve of the pandemic -- may we have INQ000023070, page 1, paragraph 1:

"This paper:

"- [reminded] the ... Board of the pan flu programme re-prioritisation that took place at the end of 2018 ..."

And:

"- sets out the progress made on those areas of work that continued and new priorities that arose ..."

At paragraph 3, there is a reference to an annex. Perhaps we could have a look at that annex, please. It's at the end. If you could go back up, please, to the start of the annex, thank you.

(Pause)

Thank you.

Annex A:

"Pan flu programme re-prioritisation at the end of 2018.

"Work Areas.

"Pan Flu Bill."

That's a reference to the draft Bill to which you referred.

"Perm Sec meetings on Pan Flu -- Continue.

"Perm Sec written updates on Pan Flu -- Continue.

"Quarterly Finance meetings -- Continue ...

"Moral and Ethical Advisory Group -- Membership and Recruitment -- Stop.

"UK Pandemic Influenza Strategy Refresh -- Stop.

"... healthcare surge (largely complete, DA [devolved administration] engagement to develop plans outstanding -- Stop.

"... adult social care (largely complete for [Pandemic Flu Readiness Board], [but] CMO actions outstanding) -- Stop.

"PFRB paper on [the updating of the NSC] -- Stop.

"... Comms ... Stop.

"... benchmark NHS readiness internationally -- Stop.

"... engagement in Clinical Countermeasures Board -- Stop."

And so on.

A. Yeah.

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

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

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

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

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

A. Correct.

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

A. Woefully inadequate. And --

Q. Thank you.

A. -- I don't think a refresh would have changed that, because all of the independent external advice, the World Health Organisation advice, indeed the International Health Regulations stated that we should not have lockdowns. In fact, in a 2017 document it said:

"The evidence is not strong enough to warrant advocating legislative restrictions."

This is where I need to add to what I've written in my written statement, because I thought at the time it was simply an oversight not to consider lockdowns. Actually it was an explicit decision. The London Resilience Partnership published document, May 2018, and I quote:

"It will not be possible to halt the spread of a new pandemic ..."

That was the attitude, it was the doctrine, and it was wrong. So that refresh would have made very little difference.

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

Adult social care, largely complete. I'm not exactly sure what the CMO actions outstanding are. There's a question --

Q. May I --

A. -- my point is about materiality.

Q. May I just pause you there to ask you some more questions about adult social care --

A. Sure. Yes.

Q. -- since you raise it.

A. Yes.

Q. In your statement you refer to the fact that one of the major problems with the department's supervision of the adult social care sector was the lack of policy levers --

A. Yes.

Q. -- which would enable the department to ensure pandemic preparedness --

A. Absolutely.

Q. -- in social care?

A. Yes.

Q. And as you said earlier --

A. But that's not what this is referring to.

Q. Well, I want to ask you whether or not you can say that the adult social care sector was well prepared for a pandemic when the department had no means of finding

out whether or not they had the right plans in place, whether local authorities had planned sufficiently, let alone how many numbers were in the care sector?

A. No, it was terrible, and --

Q. The department had no visibility of whether or not the health -- adult social care sector was prepared at all --

A. That --

Q. It wasn't within your ability?

A. That's not my contention. My contention is this action here would not have solved that. The CMO could not have solved the problems in terms of the oversight of the adult social care sector. It was --

Q. Mr Hancock --

A. -- much bigger than that.

Q. -- what was the name of your department?

A. I've already talked about this. It's the Department of Health and Social Care, and yet the legal responsibilities are with local authorities. And we had a programme, a separate programme of work under way -- that did not stop because of Brexit planning, that was accelerated by the new Prime Minister in summer 2019 -- of reform of adult social care. We had ongoing work to get better data that was continued in this process. Adult social care desperately needs reform. It

needs more support, it needs more resilience. And I feel that very strongly, as does the current Chancellor of the Exchequer, who has been clear about that not only when he was in my job but in his current job.

My point and my contention is that whatever the CMO actions outstanding were here, they would not have solved the huge challenges of adult social care in this country, which requires significant improvement and work.

Q. By January 2020, did the department have in place, the department of social care have in place, a single coherent plan to identify vulnerable service users across the country, that is to say how many people are in the care sector?

A. No.

Q. Did it have a central plan for the sharing of data between private and public care providers and emergency responders in order to be able to better prepare them all for a pandemic?

A. Something along those lines was being developed, but it was definitely not in place.

Q. Was there a single national guidance for pandemic preparedness in the adult social care sector?

A. The guidance for pandemic preparedness went through

local authorities and so there was not a single one, no.

Q. Did all the LRFs, the local resilience forums, have plans in place on the local authority level for dealing with the impact of a catastrophic pandemic on the elderly?

A. No, they were required to and, as far as I'm aware, only two had done the work.

Q. Was the Department of Health and Social Care able to verify the extent of the pandemic preparedness planning that was being done by local authorities?

A. No, we didn't have the policy levers to do so, despite having the name "Social Care" in the title.

Q. Did the Department of Social Care put into place a national standard by which the plans from the local authority could be gauged?

A. No.

Q. In relation to those local resilience forums, did the department prepare, in fact, a pandemic flu standard at the latter end of 2019, which for the very first time obliged local resilience forums to compare their plans against a national standard for influenza pandemic planning?

A. Well, yes is the answer.

Q. It is.

A. And the -- and I suppose what that demonstrates --

because that came into place late in 2019 --
Q. Yes, indeed --
A. -- is my central contention in this area, which is that the system for how we run adult social care is flawed. There was work ongoing to try to resolve it, including work directly related to pandemic planning, but it was in nowhere near good enough shape, and it meant that, as the person trying to solve this problem, with a disease that self-evidently impacted on older people most, we were in an incredibly difficult position to do so when the pandemic struck. Despite the enormous hard work of everybody in that sector, and in the department, in relation to adult social care, it was very, very difficult early on. That's in part because this planning was ongoing, but the systems in this country for managing adult social care are not good enough, and that reform -- that reform work was under way, but it still hasn't been completed.
Q. So drawing some of these threads together, please, Mr Hancock, would you accept the following propositions: firstly, there was a long-standing bias within the Department of Health and Social Care, as the risk owner of the pandemic influenza risk and as the author of that strategy which you described as woefully inadequate, in favour of influenza, a failure to place sufficient

regard to the risk, admittedly a lesser risk, of another, different, catastrophic HCID?
A. It would have been better, yes, if the plans had been for a generic respiratory disease, because what matters is the characteristic of the novel virus.
Q. Indeed.

Proposition 2: there was a failure to think through properly the risks of a non-influenza pandemic. Due to the inherent unpredictability of viral respiratory pathogens, and their characteristics -- as you say, transmission rate, high or stuttering; incubation period, long or short; viral loads, great or less; whether viruses congregate in the upper or lower respiratory tract -- whatever they may have been, because those other characteristics were simply not thought about enough, the real risk of an HCID with catastrophic consequences was not adequately thought about either?
A. I wouldn't put it like that, and I think there's an irony here. The irony is that one of the major problems we had early on, which I'm sure we'll come to in M2, was the fact that Covid-19 has asymptomatic transmission. It's the first known coronavirus that affects humans that can be transmitted asymptomatically, and the WHO assumption was that this wasn't possible

until April 2020. There is a really important reason I'm saying this. A flu plan assumes asymptomatic transmission.
Q. Indeed.
A. There are some ways in which the flu plan was, in fact, more appropriate as a planning document than a generic document or, indeed, a document that had been written to consider the impact of one of the then known coronaviruses, because that plan, a coronavirus pandemic plan, would have assumed no asymptomatic transmission.

So this underpins my point that of course it would have been better to plan for a generic, you know, respiratory Disease X, and that is what we should do in future, however, planning for the flu -- planning for flu did have some benefits, and it brings me back to my central contention that, whilst this was an error, it was in no way the biggest error. And it's not just that there were two errors in the core plan, you know, flu rather than coronavirus and wrong doctrine; the error of the flawed doctrine was significantly bigger than the error of targeting a flu rather than a coronavirus pandemic.
Q. All right. Well, I don't need to trouble you about degrees of failure. We'll come on to identifying the various propositions.

A. Yeah.
Q. The third issue is one you've just touched upon, which is that that approach in the risk assessment was cause agnostic, it simply failed to identify a sufficiently broad range of scenarios. And as you know, the risk assessment process has been rewritten, thanks in the main to a report from the Royal Academy of Engineering --
A. Yes.
Q. -- to make that plain.
A. Yes, and there is an irony there as well, which is that we were dealing with a live Ebola epidemic, with the potential threat that would come to this country as a pandemic, and yet at the same time the paperwork was all focused on a flu pandemic.
Q. Yes.
A. So the theory written down in these strategies was actually not what was playing out in the day-to-day practice of infectious disease management that we were undertaking as a department and that PHE was undertaking.
Q. But, Mr Hancock, it's not just a question of irony, is it? These failing materially hampered the United Kingdom's ability to prevent death?
A. The central failing that hampered the UK's response,

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

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

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

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

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

consequences which were assumed to result?

A. I couldn't agree more, and it's an absolute tragedy.

Q. Number 5: there was an associated failure to think about countermeasures. Because, of course, flu has a shorter incubation period, it is symptomatic, there are antivirals, there are vaccines available. There was, therefore, a failure to think about, in the way that other countries, particularly in the Far East, had done, countermeasures such as mandatory quarantines?

A. Yes.

Q. Shielding?

A. Yeah.

Q. Social restrictions?

A. Yes.

Q. Border control?

A. Yes.

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

A. Yes. I had to overrule the initial advice not to quarantine people being brought back from Wuhan. I mean, that is -- it is madness. And it was written into the International Health Regulations that you shouldn't close borders.

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

and SARS.

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

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

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

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

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

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

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

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

A. My --

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

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

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

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

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

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

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

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

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

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

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

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

A. Yeah.

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

A. Yeah.

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

A. Exactly.

Q. As were you.

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

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

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

A. Yes.

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

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

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

A. Sure.

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

A. Yes.

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

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

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

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

A. Yes, but --

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

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

Far better would be that they are in a position to

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

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

A. Yeah.

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

A. Yes.

Q. -- the areas that require particular and detailed consideration.

A. Yeah.

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

A. Yes.

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

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

A. Yes.

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

A. Yes.

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

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

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

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

A. I see. Yes, of course.

Q. The availability of mass diagnostic testing --

A. Yes.

Q. -- you've already referred to.

A. Terrible.

Q. The availability of mass contact tracing systems.

A. Yes, there was no such thing.

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

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

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

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

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

A. Absolutely.

Q. -- for the future?

A. Absolutely.

Q. All right.

Then in your statement you address issues such as the changes over time in the public health structures?
A. Yes.
Q. There's an issue about the necessary degree of co-ordination across the United Kingdom, given the fact that health security is a devolved issue --
A. Yes.
Q. -- but at the same time, of course, viruses honour no boundaries.
Then, finally, you say that --
A. Well, they honour geographic boundaries, they honour no administrative boundaries. The fact that we are an island is an advantage that we should use much more aggressively in future in preventing a pandemic coming here.
Q. All right.
You refer finally to the need to examine more closely the degree of required international co-ordination?
A. Yes.
Q. I don't want you to develop that point.
There remains the final issue, which I think I'd be grateful for your views on, which is the degree to which you materially assisted in the development of what turned out to be life-saving vaccine production.

A. Yes.
Q. We heard evidence from Jeremy Hunt MP as to how he assisted to the process by which -- the process of the UK Vaccine Network when he was Secretary of State.
A. Right.
Q. Were you also materially concerned in ensuring that we had the proper structures in place for future development of vaccines when you were Secretary of State?
A. Yes, I thought this was very important. And in fact, in terms of pandemic preparedness, given the reassurances that we were well prepared, this was the area I put most effort into, and it -- a lot of the preparedness work was very helpful here. The Oxford vaccine was essentially built on a project that started with an attempt to get a vaccine for Ebola. That was before my time.
I worked to try to enhance the domestic manufacturing capability, and I did a huge amount of work also on stopping anti-vax content. I was worried about that for normal everyday vaccines like MMR and the flu jab, but it was also very important ahead of a pandemic. Because the point is that once you have the right doctrine of suppressing a virus until the vaccine can make us safe, you've got to make sure that you get

the vaccines and that people have the confidence to take them. So there was a huge amount of preparation work in that area that I was directly involved in, and that ended up being one of the areas where we performed incredibly well and we, of course, had the first vaccine in the world.
Q. Mr Hancock, my final question: do you know why no pathogenic outbreak-related exercise or any governmental policy or guidance or paper paid any regard to the impact or consequences of a pandemic on the vulnerable, on members of our community in our minority ethnic sectors, or on the marginalised, or otherwise suffering from inequalities? There appears to have been absolutely no thought given at all, at any time, other than in relation to the obvious point that there would be a clinical risk, to what the likely impact would be of a pandemic sectorally, and therefore no thought was given to how the plans might be adjusted to cater for that significant risk.
A. It saddens me enormously that the central work that the CMO was planning to do when I appointed him in October 2019 was to focus on the reduction of the completely unacceptable health inequalities that exist in this country. The life expectancy of a man born in Blackpool is 15 years less than a man born in

Buckinghamshire, and I appointed Chris Whitty to the CMO job based on his proposal that he wanted to do everything that we could to address this. So health inequalities were right at the forefront of his and my agenda.
Of course the different impact clinically of a virus on different groups is absolutely front of mind, and implicit in all of the planning.
Q. Well, that's obvious, as I've suggested to you --
A. It has to be. But in terms of the social and socio-economic impacts, all I would say is that an assumption that you're not going to stop a pandemic running through the population is implicitly an assumption and a decision that those most vulnerable to it will be hardest hit. So the single best thing we can do to protect those who are most vulnerable is stop viruses from killing hundreds of thousands of people.
It brings me -- and we end on the central -- my central contention, which is you've got to work out -- there are costs to lockdown, you've got to work out whether the impact of the virus is going to be worse than the costs of lockdown, and if it is going to be worse, as was the case with Covid-19, you've got to hit it hard and very, very early.
Q. But, Mr Hancock, as you now have acknowledged, our

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

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

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

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

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

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

LADY HALLETT: Mr Weatherby.

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

THE WITNESS: No problem.

Questions from MR WEATHERBY KC

MR WEATHERBY: Yes, thank you very much.

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

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

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

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

A. Yes.

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

A. Yes.

Q. And you put that in your statement?

A. Yes.

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

A. Yes.

Q. This is your words:

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

A. Yes.

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

A. Yes.

Q. That would, of course, include lockdowns?

A. Absolutely.

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

to the WHO as an authoritative source?

A. Yes.

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

A. Well, it is the --

Q. Yes.

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

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

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

A. Okay.

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

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

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

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

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

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

Q. Next part, this document splits the guidance into essential, what the WHO regards as essential, and what is desirable.
A. Yeah.
Q. This is under "Essential", the first bullet point:
"Review existing legislation, policies or other government instruments relevant to pandemic influenza risk management ...", et cetera.
Yes?
A. Yes.
Q. That's what you're doing --
A. Yes.
Q. -- around 2018 with the Pandemic Flu Bill?
A. Yes.
Q. Then the second bullet point --
A. Yeah, all that.
Q. This is the important point.
A. That was all in -- yeah.
Q. Yeah.
"Assess the legal basis for all public health measures that are likely to be proposed during a pandemic response, such as:
"- isolation or quarantine of infected individuals, people suspected of being infected, or people from areas where pandemic influenza infection is established ..."

So a legal measure in place for an emergency to restrict the ordinary rights of people who are infected or may be infected; yes?
A. Yes.
Q. Second bullet point:
"- travel or movement restrictions" --
A. Yeah.
Q. -- "(ie on leaving or entering areas where pandemic influenza infection is established) ..."
So travel and movement --
A. Yeah.
Q. -- would include lockdowns?
A. Yeah.
Q. "- closure of educational institutions ..."
A. Yeah.
Q. And:
"- prohibition of mass gatherings."
A. Yeah.
Q. Okay. So all relatively straightforward in concept --
A. Just one point I would challenge, which is you said "travel restriction -- or movement restrictions, that means lockdown". That's not right.
Q. No, no.
A. What it doesn't have in there is a stay at home order, because the isolation or quarantine of infected

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Thank you.

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

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

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

Professor Dame Jenny Harries.

A. Yes.

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

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

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

local and regional teams.

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

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

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

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

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

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

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

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

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

Q. So what was the practical effect of that consistent

reduction in budget? How did that manifest itself within public health?

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

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

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

Q. Yes. We've heard of a practice called "top slicing",

where local authorities would reallocate ringfenced public health budgets to other services. Do you know, for instance, Mr Selbie, whether or not pandemic planning or local risk assessments in relation to pandemic planning was one of the areas that was likely to suffer from the lack of funding? In other words, were local authorities in the business of taking money that might have been used for those matters and putting it elsewhere to more acute problems?

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

What I can't tell you is whether that affected EPRR in a significant way. I'd like to think not, because these were very small resources anyway, and they were all involved in local health resilience partnerships, where that sort of gap I think would become apparent.

Q. All right, thank you.

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

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

We had about -- well, we had exactly 152 local authorities. We had about 130 directors because small authorities used to share a director and that was perfectly normal. So I'm not up to date with the exact

numbers, but I do think it was reasonably healthy, reasonably healthy, towards the sort of 2017, 2018, 2019 years.

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

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

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

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

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

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

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

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

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

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

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

Q. All right.

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

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

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

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

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

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

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

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

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

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

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

inequalities, and so there are many different ways in which you can organise to best effect, and different countries approach this in different ways, some have separation, most are moving towards integration, but it's not really that -- for me, the question is: how do you deploy against the essential health functions set out by Geneva, which include all these different areas, in your context, in the way where you can get the best -- if you like, the best from that investment? There's not an answer that says, "And it is this". But I do not agree with the prior Secretary of State that you can separate these. You have to find a way of bringing them together. That may be organisationally, or there might be other ways in which that might be done. But you can't, frankly -- anyway, I'm going on too much.

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

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

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

A. I shall turn it down.

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

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

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

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

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

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

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

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

Q. I think you have to a certain extent.

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

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

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

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

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

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

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

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

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

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

Q. Yes.

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

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

A. I sincerely believe that.

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

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

A. I do.

Q. All right.

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

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

Q. Yes.

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

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

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

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

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

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

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

inception and the Covid pandemic hitting?

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

Q. All right. Thank you.

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

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

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

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

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

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

And:

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

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

A. Yes, yes.

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

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

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

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

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

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

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

A. Yes.

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

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

Q. Well, that's what we will do. But I think you've

probably answered my next question: if this plan remained as an interim plan and had not been finalised between this discussion in October of 2017 and the onset of the Covid pandemic, that would surprise you, and that would be something which you would not approve of?

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

Q. Thank you.

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

A. Yes.

Q. Is it correct, Mr Selbie, that in the United Kingdom a high-consequence infectious disease is defined according to the following criteria: it's an acute infectious disease that typically has a high case

fatality rate, may not have effective treatment and is often difficult to recognise or detect rapidly, has the ability to spread in the community and within healthcare settings, and requires an enhanced individual, population and system response to ensure it's managed effectively, efficiently and safely?

A. Yes, I recognise that.

Q. Thank you.

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

A. Yes, I believe so.

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

A. I think because it is -- they are by definition rare, which is one of the criteria, that they are genuinely unusual, and this was one of the great strengths of Porton Down and Colindale is we had specific facilities to be able to quickly know what it is we were dealing with. Quick was really important because, you know, if you had something that was terribly violent, you needed to get the staff properly protected and fast. So these things don't happen that often, but when they do the thing is to contain them and to manage them; read across for that what happened with, you know, C-19.

Q. All right, thank you.

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

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

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

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

It was Public Health England that asked for an EPRR

element to those quarterly accountability reviews, because it was such an important part of our work. But may I -- can I decline to say? I don't know, I can't say, but I do know who would know, if you like, and that would be the Department of Health.

Q. Thank you.

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

Do you remember that exercise taking place, Mr Selbie?

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

Q. Right.

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

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

the efficiency and cost effectiveness of the service.

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

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

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

A. Yes.

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

A. Yes.

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

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

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

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

Q. Four centres, I think, yes.

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

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

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

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

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

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

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

A. Yes.

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

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

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

Q. Do you think that there should have been?

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

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

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

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

A. Yes.

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

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

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

the influenza strategy.

Q. I want to --

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

Q. Reference capability, thank you.

A. Reference, surveillance and research.

Q. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

authorities which had reported to have these plans in place, which he considered to be wholly inadequate.

I'd just like your reflection on that evidence.

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

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

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

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

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

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

A. Yes.

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

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

Do you agree with that?

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

Q. Syndemic, yes.

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

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

Q. Thank you.

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

of 2014.

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

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

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

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

Do you remember this inquiry being commissioned?

A. Oh, yes, very much.

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

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

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

MS BLACKWELL: I'm sorry.

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

So remember that question, Ms Blackwell.

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

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

(3.10 pm)

(A short break)

(3.15 pm)

MS BLACKWELL: Thank you, my Lady.

Mr Selbie, can you see and hear me again?

A. Yes, I can.

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

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

A. Yes.

Q. The actual findings as to the causes of health

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

Q. Thank you.

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

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

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

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

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

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

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

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

because the spending does not reflect that.

Q. Thank you, Mr Selbie.

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

LADY HALLETT: Ms Munroe.

Questions from MS MUNROE KC

MS MUNROE: Thank you, my Lady.

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

LADY HALLETT: I was going to say --

MS BLACKWELL: Oh, I'm so sorry.

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

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

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

MS MUNROE: Thank you.

Mr Selbie, can you hear and see me?

A. Yes, I can, Ms Munroe.

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

country.

It is in relation to a document that you have already been referred to today, the MERS plan. I wonder if we could have that on the screen, please. It's INQ000179069. Can you see that, Mr Selbie?

A. I can, yes.

Q. Ah, that's actually the meeting. It's the document itself. I'm told it's INQ000 --

A. I can see the document.

Q. You can see the document?

A. Yes, I can, yes.

Q. Thank you. It's entitled "Public Health England Response Plan for Possible, Presumptive and Confirmed [MERS] cases", and the purpose of -- it's a guidance, and the purpose is that it's an internal document to be used by PHE "to inform planning for potential MERS cases".

A. Yes.

Q. Now, this was from 2017, it's during a period of time of your tenure with PHE. Would you agree, Mr Selbie, that that particular plan sets out in some considerable detail matters such as infection control guidance and management of both symptomatic and significantly asymptomatic MERS patients and healthcare workers?

A. Yes.

Q. Would you also agree, Mr Selbie, that when -- and again we don't need to bring it on the screen because it's a guidance you're familiar with, but for reference purposes, my Lady, it's page 14 of the guidance -- it includes measures within this guidance that we all became very familiar with during the course of 2020, and they include isolation and self-isolation in the community, contact tracing, communications and restricting interactions between those affected and the wider public, such as transport restrictions, prohibitions of attendance in public spaces, et cetera; that's all part and parcel of the guidance, isn't it?

A. Yes.

Q. Now, appreciating, Mr Selbie, what you have said this afternoon in answer to questions from Ms Blackwell about this MERS plan, that there needed to be clarification with UKHSA, that notwithstanding, given that Covid-19 was initially classified as an airborne HCID, would you have expected the MERS plan to have been utilised in some form for Covid-19, as it had been for MERS and monkeypox, as you've referenced, and are you able to say whether it was in any form utilised?

A. Yes and yes. So what you were describing would be regular health protection activity at a scale that we were well used to dealing with. It is my understanding

that the HCID pathway was in fact utilised for the early cases of Covid, yes.

MS MUNROE: Thank you very much, Mr Selbie.

Thank you, my Lady, those are my questions.

LADY HALLETT: Thank you very much, Ms Munroe.

MS BLACKWELL: My Lady, that completes the evidence of Mr Selbie, and the evidence for today.

LADY HALLETT: Thank you very much, Mr Selbie. I don't want what the time difference is, but I hope we haven't affected your day too disastrously. Thank you very much for your help.

THE WITNESS: Thank you. Thank you.

(The witness withdrew)

LADY HALLETT: 10 o'clock tomorrow?

MS BLACKWELL: Thank you, my Lady.

LADY HALLETT: 10 o'clock tomorrow. Thank you.

(3.31 pm)

(The hearing adjourned until 10 am on Wednesday, 28 June 2023)

INDEX