

Thursday, 13 July 2023

1
2 (10.00 am)
3 **LADY HALLETT:** Ms Blackwell.
4 **MS BLACKWELL:** Good morning, my Lady. May I please call
5 Marcus Bell.
6 **MR MARCUS BELL (affirmed)**
7 **Questions from COUNSEL TO THE INQUIRY**
8 **MS BLACKWELL:** Mr Bell, may I begin by thanking you for the
9 assistance you've so far given to the Inquiry. I know
10 that you have made witness statements both in relation
11 to this module and also Module 2.
12 We can see on screen the witness statement that's
13 most referable to this module. Can you confirm, please,
14 that it's true to the best of your knowledge and belief?
15 **A.** I can.
16 **Q.** Thank you. We can see that on page 6 it has been signed
17 by you on 20 April of this year.
18 Thank you, we can take that down.
19 Mr Bell, you joined the Cabinet Office in 2016, you
20 became director of the Race Disparity Unit and also the
21 Disability Unit, and from September of 2020 you have
22 been director of the government Equality Hub, which is
23 based in the Cabinet Office and is focused on disability
24 policy, ethnic disparities, gender equality, LGBT rights
25 and the overall framework of equality legislation for

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1 the decision was taken to keep it on.
2 So it had its origins as effectively a statistical
3 unit focused on ethnicity data, and the Race Disparity
4 Unit collects and publishes a very large amount of
5 ethnicity data on its website, ethnicity facts and
6 figures, which we still maintain. But after an initial
7 phase focused on data, the Race Disparity Unit grew
8 a policy function on top, because if you publish data
9 about ethnic disparities, the public expects the
10 government to tackle them, and so the Race Disparity
11 Unit became both a policy and a statistical unit focused
12 on collecting and publishing high quality data about
13 ethnicity but also trying to influence public policy on
14 that supporting ministers. So that was and is its
15 function.
16 **Q.** Thank you.
17 What about the Disability Unit?
18 **A.** So the Disability Unit was created in late 2019, so
19 November 2019, and the idea there was to bring more of
20 a strategic focus to disability policy at the heart of
21 government, so that's been the Disability Unit's focus:
22 to try and improve the quality of cross-cutting policy
23 on disability from the Cabinet Office.
24 **Q.** Finally, the Government Equalities Office, or the GEO.
25 **A.** Right, so GEO is more long-standing than either of those

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1 the United Kingdom. Is that right?
2 **A.** That's correct.
3 **Q.** Thank you.
4 The Equality Hub was created in September of 2020,
5 so in fact it postdates the end of the Module 1 time
6 period, but I will during the course of my questioning
7 this morning ask you about your experience within the
8 hub.
9 I want to begin, however, by seeking your assistance
10 in describing the three units that made up the hub that
11 were joined together in September of 2020, starting off
12 with the Race Disparity Unit.
13 So from your experience in it, can you describe to
14 the Inquiry what that unit did, what was its remit?
15 **A.** Right, so the Race Disparity Unit focuses on ethnicity
16 disparities, so that's differences of treatment or
17 outcome affecting people from different ethnic minority
18 backgrounds, and as you said it was set up in 2016.
19 **Q.** Mr Bell, can I just ask you slow down a little bit,
20 please. You speak rather quickly.
21 **A.** So sorry.
22 As you said, it was set up in 2016, following
23 an initiative by the then Prime Minister, and it was
24 actually originally intended to be a time-limited
25 project, it was only supposed to last for a year, but

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1 other two units, so it's been around since 2007, and its
2 focus, again as you said in your opening remarks, is on
3 gender equality, LGBT rights and the framework of law
4 and guidance around equality.
5 **Q.** What is the Social Mobility Commission and where does
6 that currently sit?
7 **A.** So the Social Mobility Commission is an independent
8 arm's length body, so it's an independent commission
9 though it's appointed by ministers. Its focus is on
10 improving social mobility and its secretariat, so the
11 staff who support it, are part of the Equality Hub. So
12 that's the join with the other things we've been
13 describing.
14 **Q.** Right. What was the rationale in combining the three
15 units which you've described?
16 **A.** I think the rationale was two-fold. So one was that
17 there are connections between the different issues that
18 the different units focus on, so people can experience
19 discrimination based on race and gender at the same
20 time, and so it was thought to be a good idea to bring
21 the units together for that reason.
22 I think there was also an efficiency argument,
23 because the different units had teams focused --
24 separate teams focused on, for example, communications
25 and analysis and other issues, and it was thought to be

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1 more efficient to bring them together within a single
 2 organisation.

3 **Q.** As we've said, the knitting together of the three units
 4 took place in September of 2020, so, as this module is
 5 well aware, that was during the outbreak of Covid-19.
 6 Is that a decision and the rationale that you've just
 7 set out, was that something which had been thought of
 8 before the onset of Covid-19, or was it something that
 9 happened as a result of Covid-19 perhaps?

10 **A.** I don't think it primarily happened as a result of
 11 Covid-19. So I think that there was -- before
 12 September 2020 there was informal collaboration between
 13 the different units, both on Covid and on other issues.
 14 I think it was -- it was felt by the Secretary of State
 15 at the time, Liz Truss, that the work would be done
 16 better if it was managed together, so I think that was
 17 the main reason, but I don't think it was particularly
 18 driven by Covid, even though obviously that was going on
 19 at the time.

20 **Q.** So that was just a coincidence in terms of the timing
 21 that it came together?

22 **A.** I think so. And it's worth saying that the -- of the
 23 different units that you've been describing, the Race
 24 Disparity Unit and the Disability Unit were very heavily
 25 engaged in Covid work in 2020. I think the Government

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1 **Q.** Right.

2 **A.** -- whether that's in education or health or the armed
 3 forces or benefits, and there's no way that all of that
 4 can be managed properly by a small unit in the centre of
 5 government, so inevitably we have to prioritise. So for
 6 the most part we look to individual government
 7 departments to manage their own equality issues. We
 8 provide guidance from time to time to departments from
 9 the centre, and we also focus at any one time on
 10 a limited number of issues that are a particular
 11 priority for ministers.

12 **Q.** Going back in time to the ten years leading up to the
 13 onset of Covid-19, and bearing in mind the dates at
 14 which you have explained to the Inquiry that the
 15 separate three units were set up, are you able to help
 16 us in terms of the level of consideration, consultation
 17 and involvement that the Race Disparity Unit, the
 18 Disability Unit and the Government Equalities Office had
 19 in pandemic planning with other government departments?

20 **A.** Yeah, so I know from my own experience in the Race
 21 Disparity Unit and the Disability Unit, which I was
 22 leading at the time, that we had no involvement in
 23 pre-pandemic preparedness within government.
 24 I understand from GEO colleagues -- so I wasn't the
 25 director of GEO at the time, but I understand from GEO

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1 Equalities Office was engaged but less so.

2 **Q.** Right, thank you.

3 Is it right that the Equality Hub has three key
 4 areas of responsibility? The first is policies that are
 5 solely the responsibility of the Equality Hub,
 6 for example legislating to ban conversion practices.
 7 Second, policies and pilot programmes that are developed
 8 within the Equality Hub and then handed over to other
 9 government departments to lead, such as the
 10 LGBT bullying plan, which is now the responsibility of
 11 the Department for Education. And, third, advising and
 12 supporting other government departments to deliver
 13 policies drawing upon the experience that's held within
 14 the Equality Hub.

15 **A.** I think that's correct, and I think the easiest way of
 16 explaining this is that every single public policy issue
 17 has an equality dimension to it.

18 **Q.** I'm sorry, I'm going to have to ask you to slow down.
 19 The stenographer has to follow what you're saying and
 20 you are very quickly spoken.

21 **A.** I'm sorry. I will try and slow it down.

22 **Q.** Thank you.

23 **A.** So I think the best way of explaining that is that every
 24 single public policy issue has an equality dimension to
 25 it --

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1 colleagues that they did not have any involvement
 2 either.

3 **Q.** With your role as director of the Race Disparity Unit
 4 and the Disability Unit, was pandemic preparedness on
 5 your radar at all?

6 **A.** I would say it wasn't. Perhaps if I just say a brief
 7 word about what was on our radar and why.

8 So we agreed a set of priorities in the Race
 9 Disparity Unit with ministers, and that came from two
 10 sources. So one was data. So, as I said, we collect
 11 a very large volume of data about ethnic disparities, so
 12 one source was data showing where disparities were
 13 greatest, the other was a kind of judgement call from
 14 ministers about what were the issues that they
 15 particularly wanted us to focus on.

16 So among the issues that we were --

17 **LADY HALLETT:** Please slow down.

18 **A.** I'm so sorry.

19 **LADY HALLETT:** It's not just our brave stenographers, I also
 20 try to make a note. So it was a judgement call by
 21 ministers -- sorry, I interrupted.

22 **A.** A combination of data and a judgement call by ministers.
 23 So among the issues that we were focused on, they
 24 included school exclusions, adoption, mental health and
 25 university entrance, because those are all issues where

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1 there was a significant ethnic disparity from the data,
2 but also some willingness from ministers to address
3 them.

4 **MS BLACKWELL:** Thank you.

5 I'd like to display, please, the strategy from 2011,
6 the United Kingdom pandemic preparedness strategy, and
7 in particular the analysis of impact on equality which
8 accompanied the strategy. Thank you very much.

9 If we could have a look at page 1, please.
10 Thank you.

11 Just to remind ourselves of this document, which has
12 been mentioned to my Lord before today.

13 "The Equality Act 2010 mandates a duty within the
14 public sector to:

15 "- eliminate discrimination, harassment,
16 victimisation and any other conduct that is prohibited
17 by or under the Act;

18 "- advance equality of opportunity between persons
19 who share a relevant protected characteristic and
20 persons who do not share it; and

21 "- foster good relations between persons who share
22 a relevant protected characteristic and those who do not
23 share it."

24 Then the next paragraph sets out a definition of
25 what protected characteristics are, and says:

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1 **A.** I believe we didn't, no.

2 **Q.** Right.

3 Since Covid-19 and the improvements -- given the
4 impact that it's had on the country, the improvements to
5 this and other documents and -- both in terms of
6 preparedness and the resilience of the country, has
7 there been contact with the Equality Hub, as it now is,
8 to seek its consultation in terms of the preparation of
9 documents and plans going forwards?

10 **A.** Well, we were very heavily engaged on Covid work
11 specifically from, I think, the sort of early months of
12 2020 onwards. So, I mean, I think particularly from
13 May 2020 onwards. And my minister, Kemi Badenoch, made
14 a statement to Parliament in June 2020 about the work
15 that we were then going to do, and I think we had a very
16 extensive involvement with the Department of Health and
17 its various agencies over the two years which followed.

18 **Q.** Is the Equality Hub expecting to provide, for instance,
19 guidance to the Cabinet Office groups who are now
20 charged with the responsibility of taking forwards
21 pandemic preparedness and resilience matters?

22 **A.** We're very happy to, and we did publish recommendations
23 about some key lessons learned from the pandemic from
24 an equality perspective in the report that we published
25 in December 2021.

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1 "The Department of Health's ... Analysis of Impact
2 on Equality ... process is a key element of
3 demonstrating how it is meeting the duty. It also
4 considers other groups that may experience disadvantage
5 and barriers to accessing services as well as poorer
6 experience and outcomes."

7 So, just pausing there, please, did you have any
8 impact or involvement in the preparation of the
9 Department of Health's analysis of impact on equality at
10 any point?

11 **A.** Well, in relation to mental health issues, as I said, we
12 were working on that in 2019, yes. In relation to the
13 issues covered by this document, no, not in 2019, but
14 also, of course, this document was prepared in 2011,
15 when neither the Race Disparity Unit nor the
16 Disability Unit existed.

17 **Q.** No, of course, and the Inquiry has heard that there were
18 plans afoot to update it but matters did not come to
19 fruition prior to Covid-19 hitting the United Kingdom.

20 But in preparation for its update, did you, in
21 either the Race Disparity Unit or the Disability Unit,
22 have any contact from those who were charged with
23 updating this document to make contact with you and to
24 seek your views as to any assistance you could give in
25 provision of information for the updated document?

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1 **Q.** Well, I'm going to come to those in a moment, Mr Bell.
2 Before I do, you will be aware that Professors Marmot
3 and Bambra have provided both a written report and
4 evidence to the Inquiry in terms of health inequalities,
5 and part of the evidence that they've given to my Lady
6 was that, in their opinion, in terms of this document
7 and the analysis of impact on equality report, the
8 analysis undertaken was fairly limited in terms of
9 identifying the multiple issues faced by different
10 social groups, and that there is little in this document
11 provided on what action should be taken to mitigate any
12 differential impacts. Do you agree with that
13 assessment?

14 **A.** I think those are fair comments, yes, and perhaps it
15 might be helpful if I said a little bit about what
16 I would expect to see in equality impact assessments.

17 **Q.** That was going to be my next question, so yes, please.

18 **A.** Right, okay.

19 So clearly it's primarily the responsibility of lead
20 departments, as I said, to prepare equality impact
21 assessments, so we see quite a lot of them, and
22 sometimes they're done well and sometimes they're done
23 less well. But I think the three things that I would
24 particularly expect to see in a good equality impact
25 assessment are clarity about the outcomes that the

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1 department is seeking to achieve or prevent, so I think
2 that's the first thing. I think the second thing is
3 an analysis of the maintain protected characteristics
4 that might be impacted. And third is good data about
5 how far different protected characteristics are impacted
6 by whatever the department is seeking to achieve.

7 So I think those are three things that I would
8 expect to see in a good equality impact assessment.

9 **Q.** Has the Equality Hub provided that opinion and guidance
10 to any of the lead government departments?

11 **A.** So the Equality and Human Rights Commission, who I think
12 you're seeing later on, they publish guidance about
13 equality impact assessments. We write to departments
14 from time to time about what an effective approach is to
15 equality impact assessments, and I believe the most
16 recent time was in 2021 when Kemi Badenoch wrote to
17 ministers about equality impact assessments.

18 I think it's worth saying that we also have a more
19 informal arrangement called the PSED Network --

20 **Q.** The what, sorry?

21 **A.** PSED Network, the Public Sector Equality Duty Network,
22 which is a network of officials dealing with equality
23 issues around government, who we -- from time to time we
24 meet them and discuss what an effective approach is and
25 what works and what works less as well.

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1 which year?

2 **A.** I think 2021.

3 **Q.** Thank you. It contains a summary of the points raised
4 in the session. I'm going to read through them and ask
5 you some questions about them, Mr Bell.

6 "Redeploying staff externally.

7 "- The first staff to be redeployed were the
8 analysts working on the COVID-19 dashboard, which became
9 the single source of truth and informed the early
10 government daily briefings. This happened quickly and
11 easily and the dashboard made a real difference.

12 "- [Equality Hub] staff made a good impression on
13 other departments. Almost all of the gender team that
14 were redeployed moved on to new roles."

15 Just pausing there, was there a significant movement
16 of staff during the course of the Covid-19 outbreak?

17 **A.** There was, yes. So initially particularly from the
18 Government Equalities Office and the Race Disparity
19 Unit, because at the beginning of the pandemic there
20 were -- lots of new roles were needed almost immediately
21 around government, and so a large number of staff were
22 redeployed, particularly from those two units.

23 So Disability Unit was to some extent protected
24 during that period, but a lot of staff were redeployed,
25 including myself, for a limited period, yes, and that

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1 **Q.** In your answer to that question, you've set out how the
2 Equality Hub can reach out to other government
3 departments and the reasons why the Equality Hub would
4 do that, but it's a two-way street, isn't it? The
5 Equality Hub is a visible unit which lead government
6 departments in relation to any aspect of risk planning
7 would know about, and know how to get hold of you.

8 Do you also agree, Mr Bell, that there is a level of
9 responsibility on those within other government
10 departments to reach out to the Equality Hub and to seek
11 guidance and assistance in areas where that is
12 appreciated to be a need?

13 **A.** Yes, I would agree with that, and it's worth saying that
14 there is quite a lot of expertise now in departments in
15 conducting equality impact assessments, and quite a lot
16 of experience in doing them, so we wouldn't
17 automatically expect that people would consult us when
18 conducting this work, but obviously, you know, they do
19 from time to time and we're happy to help where we can.

20 **Q.** Thank you.

21 Let's then look at the summary of Equality Hub
22 Covid-19 lessons learned session, and this report is at
23 INQ000101263. Thank you.

24 We can see from the document that this is the report
25 of the session that took place on 18 November -- of

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1 was because of a view by senior people in government
2 that there were some new priorities, it was a national
3 emergency and people needed to move quickly.

4 **Q.** Yes.

5 Just moving down to the penultimate bullet point in
6 this paragraph:

7 "- Issues around access to IT ... meant that some
8 people experienced delays in getting up to speed in
9 other departments."

10 And:

11 "- It was felt that Cabinet Office over-egged the
12 redeployment process and redeployed too many people
13 overall. Some people were told they were going on
14 emergency redeployment but then had little or nothing to
15 do after they had moved."

16 Whilst appreciating that we're now straying, really,
17 into Module 2 issues, I want to ask you where this level
18 of redeployment left the Equality Hub: was the work of
19 the hub effectively put on hold from the moment that
20 Covid hit and the redeployment process began to take
21 effect?

22 **A.** I think the impact was actually very limited, despite
23 what's said here, because Race Disparity Unit and
24 Disability Unit were both declared -- I forget exactly
25 what the phrase was, but kind of critical business units

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1 in Cabinet Office terms, so the general notion was if
2 you're a critical business unit you weren't expected to
3 redeploy staff anywhere else because what you were doing
4 was a critical function.

5 So RDU and DU were both designated as critical
6 functions, I -- from memory I think in about June of
7 that year, I think when it became obvious that
8 disability and ethnicity were going to become -- were
9 going to be really important issues in the pandemic. So
10 I think -- I think when we're talking about redeployment
11 of people elsewhere, that really happened in the first
12 couple of months of the pandemic and very little after
13 that, except in the case of Government Equalities
14 Office, where I think a number of people were redeployed
15 later in the year, and that probably did have an impact
16 on that unit.

17 **Q.** Can you give the Inquiry an idea of the size of the
18 three units and also whether or not there has been
19 a reduction in staff since the Equality Hub has been
20 created?

21 **A.** Right, so, in round terms, Disability Unit is about
22 20 staff, Race Disparity Unit is about 20 staff,
23 Government Equalities Office is rather bigger and is
24 about 130. So that's about 170 staff overall. And it
25 remained pretty much at that level until current year

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1 "- There was too big a focus on presenteeism in the
2 early days of the pandemic regardless of the risks.
3 This meant a number of key people all became infected at
4 the same time.

5 "Conversely, this approach excluded the No. 10
6 disability SpAd from key decisions. As a result,
7 mistakes were made - eg not having a BSL interpreter at
8 the daily briefings.

9 "- It was felt that equalities interests weren't
10 properly represented in early meetings."

11 And:

12 "- There were mixed views on working with the CO
13 Covid-19 Taskforce."

14 **LADY HALLETT:** I'm sorry, Ms Blackwell, I'm not following
15 why this isn't just Module 2.

16 **MS BLACKWELL:** Well, I just wanted to finally bring this all
17 together and to see whether, in terms of going forwards
18 with the Equality Hub, what were the lessons learned
19 from the very early days of Covid. I appreciate that
20 our timescale finishes in January, but ...

21 In your position as director, Mr Bell, were there
22 lessons to be learned in terms of the time at which
23 Covid hit and the timescale running up to January of
24 2020?

25 **A.** Well, so we published in December 2021 some

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1 when, because of wider changes in the Cabinet Office, we
2 have had to make some staffing reductions of around
3 about 30, but that's certainly something that's only
4 happened in the past few months.

5 **Q.** So putting the Government Equalities Office to one side,
6 given what you've said about the redeployment of staff
7 within that unit, and bearing in mind that the sum total
8 of staff in the other two units is about 40, how many
9 staff do you say were redeployed in the beginning months
10 of the Covid-19 pandemic?

11 **A.** Right, so I'd have to check the numbers, so this is from
12 memory, but in the case of Disability Unit I think it
13 was literally one or two.

14 **Q.** Right.

15 **A.** So hardly any. In the case of Race Disparity Unit
16 I think it was probably three or four, including me.
17 So, as I say, I was redeployed, but most of the team
18 stayed in place.

19 **Q.** So there were significant numbers still running those
20 units and carrying on the business as usual?

21 **A.** Yes.

22 **Q.** Thank you.

23 May we just move down this document, please, and go
24 to the final paragraph:

25 "Experience of working with the centre

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1 recommendations about dealing with equalities issues
2 arising from the pandemic, so if I just sort of briefly
3 summarise what we said there, and how that relates to
4 some of the issues you have been --

5 **Q.** Yes, please.

6 **A.** -- talking about.

7 So I think the key things that we said in terms of
8 future approaches to pandemics was, it was essential to
9 have really effective communications with different
10 groups which were tailored to them and actually cut
11 through to who you wanted to communicate with. So that
12 was one point.

13 I think the second was that maintaining trust with
14 all groups is really important, and -- sorry,
15 maintaining it or building it where it does not exist,
16 because effective communication, effective action with,
17 particularly, disadvantaged groups strongly depends on
18 trust, so I think that's the second point.

19 I think the third one is about the absolutely
20 critical importance of high quality data about,
21 you know, particularly, because we're talking about
22 a pandemic, mortality, but also a number of other
23 impacts on people, so that the government was in a place
24 to act swiftly with issues as they were emerging.

25 So I think those issues around trust, communication

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1 and really good quality data, particularly about
 2 disadvantaged groups, I think those are the main things
 3 that we said, and there's quite a lot of detail in the
 4 recommendations about how we thought it needed to be
 5 taken forward.

6 **Q.** Yes. In terms of communications we can see that the
 7 bullet point 5 in this particular paragraph of
 8 experience relates to communication from the taskforce,
 9 so communications between the departments themselves.
 10 Was that in itself a recommendation, improvement in
 11 communication between the groups within government, or
 12 do you mean communication outwith government and between
 13 the Equality Hub and those that are its subject matter?

14 **A.** I think what we were thinking of primarily was
 15 communication with the public about public health
 16 matters, and about the pandemic and vaccines and Covid.
 17 So that's primarily what we were thinking about.
 18 Though, I mean, communication with government in the
 19 early stages of the pandemic in particular could also
 20 have been better, as you probably heard from others.

21 **Q.** Yes, all right.
 22 In terms of the recommendations that have been made
 23 and the time that has elapsed since those
 24 recommendations have been set out by the Equality Hub
 25 and today's date, what progress has been made in terms

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1 **Q.** A position that you have held since 2015, and you have
 2 previously been overall -- I'm so sorry, been -- acted
 3 as joint CEO between July and September of 2021 but
 4 in fact have worked at the commission since 2014; is
 5 that right?

6 **A.** Yes.

7 **Q.** You have overall responsibility for strategy and policy
 8 at the EHRC and you report directly to the chief
 9 executive officer?

10 **A.** That's right.

11 **Q.** You have been kind enough to make a witness statement in
 12 the course of the preparation for the Inquiry hearings.
 13 We can see it on screen now. Please can you confirm,
 14 Ms Field, that the statement is true to the best of your
 15 knowledge and belief?

16 **A.** I can confirm that, yes.

17 **Q.** Thank you very much.
 18 Thank you for the assistance that you've given, we
 19 can see that the statement was signed on 5 May, and
 20 thank you for coming to give evidence today.
 21 I want to begin, please, by inviting you to explain
 22 to the Inquiry what the Equality and Human Rights
 23 Commission is and what it does.

24 **A.** Yes, the Equality and Human Rights Commission is
 25 a statutory non-departmental public body, so it operates

23

1 of the actions that were raised?

2 **A.** I can't give you a really clear view about that at the
 3 moment I'm afraid. I mean, as I say, we made a number
 4 of recommendations back in 2021 about this but our
 5 direct involvement with Covid and pandemic planning is,
 6 you know, obviously less than it was at the time, so
 7 I can't give you a really clear view about that today.

8 **MS BLACKWELL:** All right.
 9 Unless my Lady has any questions, that completes my
 10 examination of Mr Bell, and there are no questions from
 11 any of the core participants.

12 **LADY HALLETT:** Thank you very much for your help, Mr Bell.

13 **THE WITNESS:** My Lady.
 14 **(The witness withdrew)**

15 **MS BLACKWELL:** My Lady, may I call Melanie Field, please.
 16 **MS MELANIE FIELD (affirmed)**
 17 **Questions from COUNSEL TO THE INQUIRY**

18 **MS BLACKWELL:** Is your full name Melanie Field?

19 **A.** It is, yes.

20 **Q.** Is it Miss Field?

21 **A.** Ms.

22 **Q.** Ms Field, thank you.
 23 You are the chief strategy and policy officer of the
 24 Equality and Human Rights Commission?

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

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1 at arm's length from government. It was established by
 2 the Equality Act 2006 and set up in 2007. It replaced
 3 predecessor equality commissions, the Commission for
 4 Racial Equality, Equal Opportunities Commission and
 5 Disability Rights Commission, and it has responsibility
 6 for protecting and promoting equality and human rights,
 7 including enforcing the Equality Act 2010.

8 **Q.** Is one of its roles to promote understanding and
 9 engagement with equality and human rights issues?

10 **A.** Yes, it is, yeah.

11 **Q.** Is it accountable to Parliament through the Minister for
 12 Women and Equalities and the Women and Equalities
 13 Committee?

14 **A.** Yes, it is.

15 **Q.** And is funding provided by the Government Equalities
 16 Office?

17 **A.** It is, yes.

18 **Q.** Thank you.
 19 You tell us at paragraph 9 in your witness statement
 20 that the commission adopts a "three nations approach".
 21 What do you mean by that?

22 **A.** So our statutory remit covers England, Scotland and
 23 Wales. In relation to Scotland, our human rights remit
 24 extends only to matters reserved to the UK Parliament;
 25 the Scottish Human Rights Commission has responsibility

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1 for devolved matters. But obviously working across
 2 three nations we're working in the context of three
 3 different governments of three different political
 4 colours, and different social and economic conditions in
 5 those nations. So we try to take a corporate approach,
 6 but also one that is responsive to the circumstances in
 7 the different nations in which we work.

8 **Q.** In terms of pandemic planning and emergency
 9 preparedness, and the timescale with which this module
 10 is interested, was there any contact from any of the
 11 governments to the commission to provide its assistance
 12 in terms of pandemic planning and emergency
 13 preparedness?

14 **A.** I'm not aware of any, and a search of our systems has
 15 not revealed any such contact.

16 **Q.** It's Britain's main equality organisation, is it not?

17 **A.** Yes.

18 **Q.** Given what has been aired during the course of this
 19 Inquiry so far, and what you now know about the manner
 20 in which preparedness planning went forwards in various
 21 nations, are you surprised that there was no contact,
 22 apparently no contact, over the course of time for the
 23 commission to provide its assistance?

24 **A.** I am -- yes, I am surprised.

25 **Q.** What level of assistance is the commission able to give

25

1 **A.** Yes, well, I mean, a key part of the commission's role
 2 is supporting duty holders under the legislation that we
 3 regulate to comply with that -- their obligations well,
 4 and a key part of that would be the public sector
 5 equality duty which applies to all public bodies.
 6 That's at section 149 of the Equality Act 2010. And
 7 that's the mechanism, really the legislative driver for
 8 public bodies to consider equality issues when
 9 performing their functions.

10 **Q.** Yes.

11 **A.** So that's the mechanism through which I think we could
 12 have engaged in terms of providing support about how to
 13 comply with that duty well.

14 **Q.** One of the ways in which that duty is complied with is
 15 in the creation or carrying out of an equality impact
 16 assessment, isn't it?

17 **A.** There's no requirement to carry out an equality impact
 18 assessment. The duty requires the duty holder to have
 19 due regard to a number of matters, the elimination of
 20 discrimination, the advancement of equality of
 21 opportunity and the fostering of good relations when
 22 carrying out their functions. There are specific duties
 23 to publish equality objectives and to publish
 24 information about -- so I'm referring here to the duties
 25 that apply to the United Kingdom Government, the

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1 in terms of pandemic planning and preparedness, in the
 2 knowledge that it's been suggested to my Lady that there
 3 should be a high level of consideration of those who are
 4 likely to be affected the most by a pandemic hitting?

5 **A.** I mean, I think it's fair to say that the issue was not
 6 on the commission's radar either. So it was not
 7 something that we were actively looking at or looking at
 8 engaging in, and in fact during the period in question,
 9 before the pandemic, our strategic plan, which sets out
 10 our strategic priorities, did not include a focus on
 11 health and social care, because we had taken the view
 12 that the issues in that sector that needed to be
 13 resolved were ones that our powers were not best shaped
 14 to address, in that they were around kind of funding
 15 issues predominantly.

16 Sorry, can you take me back to the core of your
 17 question?

18 **Q.** Yes, of course. I was asking whether or not you were
 19 surprised -- or, given what you know now --

20 **A.** Yes.

21 **Q.** -- about what's been aired during the course of the
 22 Inquiry, whether or not there is significant assistance
 23 that the commission can give and perhaps should have
 24 been asked to give in the terms of identifying those who
 25 are most likely to be affected by a pandemic hitting?

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1 English-specific duties -- and to publish information
 2 demonstrating how the public body has complied with the
 3 duty. But an equality impact assessment I would say is
 4 a good practice mechanism for evidencing that due
 5 consideration has been given to these matters.

6 **Q.** So there's no duty to actually carry out the assessment,
 7 but it is good practice in complying with the duty to
 8 have due regard?

9 **A.** So there's no duty to publish a document --

10 **Q.** Publish the document.

11 **A.** -- but there is a duty to have the consideration, so the
 12 process of assessing is what is in the duty.

13 **Q.** What makes an effective equality impact assessment?

14 **A.** Well, I would say what constitutes good compliance with
 15 the duty is an appreciation of what the purpose of the
 16 function is that's being carried out, and
 17 a consideration of the evidence of how the performance
 18 of that duty might impact differently on people with
 19 different protected characteristics under the
 20 Equality Act -- there are nine protected characteristics
 21 under the Equality Act -- for example, race, sex,
 22 disability.

23 So an engagement with: what's the purpose -- what's
 24 the purpose you're seeking to achieve? How might what
 25 you're proposing to do impact differently or be

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1 experienced differently by different groups? Then, are
 2 there mitigations that you need to put in place, first
 3 of all to make sure that what you're doing doesn't
 4 adversely impact particular groups, which might be
 5 unlawful discrimination; and, secondly, are there
 6 opportunities to alleviate inequalities in performing
 7 that function?

8 **Q.** So the results of that assessment and the publication of
 9 that data, it seems, could help in two regards: firstly
 10 in relation to preparedness for those who are most
 11 likely to be affected by a pandemic, but also in
 12 relation to resilience, so improving the plight of those
 13 with protected characteristics; is that right?

14 **A.** Exactly so. I mean, I think on reviewing the evidence
 15 that was sent to me as part of this process, it seemed
 16 to me that there was an inadequate consideration both of
 17 the existing health and other inequalities that might
 18 mean that people going into an emergency situation would
 19 not be on a level footing, and secondly that they might
 20 need different responses in order to come out of --
 21 you know, have equal outcomes.

22 **Q.** Yes. So going forwards, what involvement and impact can
 23 the commission have in assisting in terms of pandemic
 24 preparedness and also resilience?

25 **A.** Well, the commission itself does already provide quite
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1 including ensuring systems can quickly and effectively
 2 identify those who are clinically vulnerable through
 3 further investment in high quality linked data."

4 Do you agree with that remark?

5 **A.** I do agree with that. One of the key ways of
 6 understanding that there is a problem is to have data on
 7 the problem. If you don't have the data, then you won't
 8 know what's happening. But I think in the health and
 9 social care space there isn't consistency of approach to
 10 data collection or comprehensive data collection around
 11 people's protected characteristics. So we would always
 12 advocate for collecting comprehensive data that is
 13 disaggregated so that you can analyse the different
 14 situations of different population groups.

15 I mean, one of the things that came out of the
 16 pandemic, I think, quite early on was the inability to
 17 evidence indications that there were disproportionate
 18 deaths among certain ethnic minority communities because
 19 of the inability to link data on ethnicity to death
 20 certification. So there's something about, you know,
 21 collecting that data but also being able to join that
 22 data up between different systems so that you can get
 23 a proper picture of what's going on, and that's
 24 important both for predicting what might happen but
 25 also, in real time, monitoring what is happening and
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1 a lot of guidance for public bodies about how to comply
 2 with the duty well, and I referred to some of those in
 3 my witness statement.

4 So we do give pointers to public bodies, but we also
 5 occasionally work with public bodies. So we might offer
 6 to look at an equality impact assessment and comment on
 7 it. We might be able to draw on our own stakeholder
 8 engagement and evidence about the inequalities that
 9 exist, and feed those -- that thinking into the
 10 assessment process.

11 We also conduct our own analysis of inequalities in
 12 Britain, so we publish a statutory report at least every
 13 five years which sets out some of the issues that
 14 I think perhaps could have been or should have been
 15 considered in the planning process.

16 We are also able to assist public bodies with
 17 putting them in touch with representative groups of
 18 different communities who might also be able to feed
 19 into thinking.

20 **Q.** Dr Halima Begum, who is chief executive officer of the
 21 Runnymede Trust, has provided a witness statement to
 22 the Inquiry in which she states that:
 23 "The United Kingdom governments must ensure the
 24 country is better prepared to manage a future pandemic
 25 in a way that considers the impact on inequalities,
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1 then being able to respond to it.

2 **Q.** Thank you.

3 I'd now like to turn to the lessons learned for the
 4 future and what you say about this in your witness
 5 statement, beginning at paragraph 24. You say that, as
 6 an organisation, you recommend that:
 7 "... the government [going forward] should routinely
 8 seek views on the likely different impacts of proposals
 9 on different groups, where pressure of time allows, and
 10 ensure that impacts are monitored and steps are taken to
 11 mitigate any adverse impacts on particular groups."

12 Now, is that something that should be, in your view,
 13 embedded into the government's planning process?

14 **A.** Yeah, I mean, I think that the lesson for everyone is
 15 that in a crisis that's not the best time to try and get
 16 everything right.

17 So, I mean, I was struck, looking at the impact
 18 assessment of the 2011 pandemic preparedness strategy,
 19 that there appeared to have been -- well, there's no
 20 note of any engagement with any groups representing
 21 ethnic minorities, or, indeed, any reference to existing
 22 information about health inequalities, for example
 23 Professor Marmot's review, or any engagement with the
 24 Government Equalities Office or ourselves. I think what
 25 we have all learned is that you need to have those
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- 1 systems and mechanisms in place and you need to have
2 relationships and understanding of those communities
3 before you -- before you're trying to respond in
4 an emergency situation, so that you have those
5 relationships then that you can draw on.
- 6 **Q.** Indeed Professor Kevin Fenton, who has given evidence to
7 the Inquiry, has told my Lady about the importance of
8 co-production, so not just obtaining the data and the
9 information, but the government actively seeking the
10 assistance of groups and units in order to prepare the
11 necessary documentation together, if you like.
- 12 **A.** Yeah, I think obviously if you're going to communicate
13 effectively or prepare effective responses for different
14 communities, then those need to be informed by the needs
15 of those communities.
- 16 I mean, the other thing that I would say is that
17 that is important -- I mean, another thing that came out
18 of reviewing the documentation was that there seemed to
19 be an expectation that these issues would be sort of
20 picked up as the pandemic played out at local level, and
21 that it wasn't really possible to predict or make
22 assessments at the national level. But of course we
23 know that there are inequalities that play out
24 nationally.
- 25 **Q.** Yes.

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- 1 future.
- 2 **Q.** Finally, I just want to ask you, Ms Field, about the
3 human rights lens that you identify within the course of
4 your witness statement.
- 5 **A.** Yeah.
- 6 **Q.** You identify that there is a gap in routine
7 consideration of policy decisions being seen through
8 a human rights lens. What do you mean by that, and how
9 might that affect pandemic policies and pandemic
10 planning?
- 11 **A.** Well, I mean, in the same way as the public sector
12 equality duty requires consideration of inequalities and
13 equality issues in the performance of public functions,
14 the Human Rights Act makes it unlawful for public bodies
15 to act incompatibly with the rights set out in the
16 European Convention on Human Rights, and there are also
17 other international human rights treaties that the
18 UK has signed up to, and those -- those treaties contain
19 rights that are highly relevant to an emergency
20 situation. So, you know, the right to life, the right
21 to respect for private and family life, the right to
22 association, the right to education, and there is
23 a requirement that those rights are enjoyed without
24 discrimination. So the state has a responsibility to
25 make sure that people are not kind of disadvantaged in

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- 1 **A.** I think it is -- it's also important to remember the
2 public sector equality duty is not delegable. So
3 wherever you are in the system, you need to comply with
4 it, as it relates to the functions that you are
5 performing as a public body.
- 6 **Q.** In terms of the practicalities of obtaining data and
7 seeking an effective consultation, at paragraph 28 in
8 your witness statement you talk about the
9 Welsh Government during the pandemic -- so I'm straying
10 beyond the timescale of Module 1 for a moment, but just
11 to use this as an example -- using online platforms to
12 enable ministers and officials to seek the views of and
13 learn directly from the experiences of groups with
14 particular protected characteristics.
- 15 Now, that is an example of a process that can be
16 used outside of a pandemic, you know, hitting, isn't it?
17 That platform process, that connection between ministers
18 and those with protected characteristics, can be used at
19 any time?
- 20 **A.** Indeed, and of course during the pandemic, as a result
21 of the pandemic, we've all learnt to do that kind of
22 online engagement much better, so there is
23 an opportunity here to build on that and ensure that
24 that becomes sort of part and parcel of how public
25 bodies make policy in a much more collaborative way in

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- 1 their enjoyment of those rights.
- 2 The human rights framework provides a sort of legal
3 and, in a way, ethical framework for considering some of
4 these difficult decisions about how these rights are
5 balanced. So how do you strike the right balance
6 between the right to private and family life, you know,
7 for example, for a person in a care home to have contact
8 with their family against the right to life? How do you
9 balance the rights of individuals against the kind of
10 broader public good?
- 11 So that framework, you know, obviously, as the
12 Equality and Human Rights Commission, I would say should
13 be absolutely guiding both the planning and the response
14 to any emergency situation.
- 15 **Q.** Going forwards, as guidance and policy is updated and
16 the experience of Covid-19 is taken into account, the
17 Human Rights Act and the protections that that provides
18 to people should underpin the guidance and policies,
19 and, as you've just explained, there is a balancing
20 exercise that needs to be undertaken in order to be able
21 to have proper consideration and arrive at the right
22 place?
- 23 **A.** That's right, yeah.
- 24 **MS BLACKWELL:** All right, thank you very much.
25 My Lady, unless you have any questions, that

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1 completes Ms Field's evidence.

2 **LADY HALLETT:** Thank you very much indeed for your help,
3 Ms Field.

4 **THE WITNESS:** Thank you.

5 **(The witness withdrew)**

6 **LADY HALLETT:** I've been encouraged to take an early break.

7 **MS BLACKWELL:** Right.

8 **LADY HALLETT:** Nods. So I shall return at 11.10.

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

10 **(10.54 am)**

11 **(A short break)**

12 **(11.10 am)**

13 **MR KEITH:** My Lady, the next witness is Nigel Edwards of the
14 Nuffield Trust.

15 **MR NIGEL EDWARDS (affirmed)**

16 **Questions from LEAD COUNSEL TO THE INQUIRY**

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

19 **A.** My name is Nigel Charles Michael Edwards.

20 **Q.** Mr Edwards, whilst you give evidence, could you please
21 remember to speak up and to speak as slowly as you are
22 capable of doing. Thank you.

23 Thank you very much for providing a statement, which
24 you have, it's INQ000148416, and you have provided
25 a signature and a declaration of truth at the conclusion

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1 **A.** We are a charity. We have an endowment, which is the
2 bequest of the late William Morris.

3 **Q.** Does it follow that you are, therefore, registered with
4 the Charity Commission?

5 **A.** We are.

6 **Q.** I'm not going to go through the charitable objects one
7 by one, but in essence does the Nuffield Trust carry out
8 a number of important functions? You make available
9 an evidence base, material, detailed information, that
10 allows you and others to better understand the care
11 structures in the United Kingdom, you provide expert
12 commentary, analysis and scrutiny, and do you also bring
13 together, for seminars, symposia and so on, policymakers
14 and decision-makers in order to try to identify better
15 ways forward and solutions for the problems that you
16 identify?

17 **A.** That's a very good summary of what we do.

18 **Q.** Now, in the years before January 2020, was pandemic
19 planning or preparedness for pandemics something that
20 the trust looked at specifically?

21 **A.** We didn't look at this area specifically, for two main
22 reasons. One is that we did not have the internal
23 expertise or knowledge to really do that effectively,
24 and secondly, from a number of sources it did appear
25 that the UK's general level of preparedness was

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1 of that.

2 Mr Edwards, your statement will be published and
3 the Inquiry has read and considered it, and it will be
4 the subject of further consideration in due course.

5 I want, therefore, to ask you some questions in
6 a very broad sense about the state of resilience of
7 the NHS and the social care sector in the
8 United Kingdom, but primarily England, because that's
9 the focus of the Nuffield Trust, but not, whilst you do
10 so, to delve into the detail operationally or otherwise
11 of our NHS and social care structures, because they're
12 for later modules.

13 In essence, I want you to focus, please, on the
14 extent to which the Nuffield Trust believes that those
15 structures were capable and envisaged to be capable of
16 responding to the severe demands of a pandemic.

17 What does the Nuffield Trust do?

18 **A.** We are a charitable foundation and we do research into
19 health policy and healthcare delivery, largely with
20 a focus on the UK, and we do that by using our own
21 researchers, and working with published data.

22 **Q.** Are you the chief executive of the trust?

23 **A.** I am. I have been the chief executive for about nine
24 and a half years.

25 **Q.** Is the trust a charity?

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1 satisfactory.

2 **Q.** Is infectious disease, being a form of health emergency,
3 something in fact that the Nuffield Trust historically
4 has looked at?

5 **A.** Not specifically.

6 **Q.** But presumably you would and you did nevertheless
7 continuously look at the state of resilience of the
8 system, that is to say the extent to which the systems
9 would be able to deal with the sort of shock that
10 a health emergency or a pandemic might bring about?

11 **A.** Yes, indeed. One of our main areas of focus over the
12 years has been the ability of the NHS to deal with
13 winter, which is a period where the NHS has historically
14 come under a great deal of pressure, and indeed is
15 something of a bellwether about the overall resilience
16 and capability of the system, and this has been a focus
17 of our research and -- a significant focus of our
18 research and commentary over the time that I have been
19 at the trust.

20 **Q.** Does it form an important part of the trust's functions
21 to raise concerns where you discover there are problems
22 or you discover there are systemic flaws in the system?
23 So in relation to, for example, the ability of the NHS
24 to cope with a severe winter, do you raise your concerns
25 the government and with policymakers and so on?

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- 1 **A.** Yes, we both raise concerns but also monitor the
2 situation and try and make predictions about the future
3 response and understand some of the underlying reasons
4 why the NHS has historically struggled with dealing with
5 even a relatively routine winter.
- 6 **Q.** Although the trust didn't look specifically at
7 preparedness or pandemic planning, did you after 2020
8 carry out some pieces of work which did happen to look
9 at lessons which could be drawn from the pandemic in the
10 particular context of infection prevention and building
11 design in terms of the NHS and the social care
12 structure?
- 13 **A.** Yes, indeed we did. We undertook two pieces of work,
14 one funded by the Department of Health's New Hospital
15 Programme, and one that we funded ourselves internally,
16 the latter looking at the response of small hospitals,
17 the former looking at what we should learn from the way
18 that hospitals were designed and operated to make them
19 more resilient in future, particularly as new hospitals
20 are being constructed.
- 21 **Q.** Maintaining the focus on planning or lack of planning or
22 preparedness or lack of preparedness, what did you find
23 was the position in relation to the existence of
24 pre-existing plans, pre-pandemic plans, designed, on the
25 hospital front, to deal with the possibility of

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- 1 way that hospitals in the -- in many parts of the UK
2 have been designed and built over the years, which is to
3 really strip out any kind of redundancy, to compress the
4 spaces that are available, to save money where that is
5 possible by reducing to the lowest tolerance that sits
6 within the guidance.
- 7 **Q.** That would appear to be more of an operational aspect of
8 the state of affairs in the NHS. Can you say whether or
9 not you reached a view as to whether or not there had
10 been an adequate or proper degree of planning, guidance
11 and policy documents, drawn up to cater for that
12 possibility?
- 13 **A.** I think, on the basis of what we saw, we can conclude
14 that those plans were not adequate, and that partly
15 reflects the nature of the treatment regime that was
16 then required.
- 17 **Q.** All right.
- 18 Turning to social care and the social care sector,
19 following the pandemic, did you -- and do you continue
20 to -- carry out a study jointly with the London School
21 of Economics, I think funded by the National Institute
22 for Health and Care Research, as part of which you've
23 looked at how well prepared the social care sector was
24 for a pandemic?
- 25 **A.** Yes, indeed.

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- 1 a sustained pandemic?
- 2 **A.** So the hospitals that we spoke to, and this was
3 a sample, I should emphasise, had plans in place for
4 dealing with influenza but not, we found, for dealing
5 with a long-term sustained pandemic.
- 6 **Q.** Without going into the operational aspects of the
7 hospital estate, and again focusing just on the degree
8 of pre-planning that there was, was there a particular
9 area, the supply of oxygen, in fact, in relation to
10 which there appeared to be a marked absence of planning?
- 11 **A.** The requirement for high flow oxygen as a method for
12 treating Covid-19 certainly came as a surprise, both
13 clinically and also to state departments, who discovered
14 that, in a number of cases, both the size of the
15 pipework to supply oxygen and the machinery that's used
16 to condense oxygen to keep the supply going were
17 inadequate for the scale of the task that was -- that
18 they were required to respond to.
- 19 They responded very well, but they had to make very
20 major engineering and structural changes to be able to
21 accommodate that.
- 22 **Q.** Does the fact that those changes had to be made of
23 itself indicate that there had been an absence of
24 planning for that eventuality?
- 25 **A.** I think it probably indicates a broader issue about the

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- 1 **Q.** In relation to three or four factors or three or four
2 features of that study, firstly, the Inquiry has heard
3 a considerable amount of evidence about the existence of
4 what are called standards, assessments or tests, if you
5 like, to validate the performance of the various bodies
6 in the government structures. Is there a difference or
7 did you find there to be a difference in the
8 availability or existence of standards for the NHS to
9 operate against as opposed to the social care sector?
- 10 **A.** The NHS typically has a much clearer set of standards
11 defined than the social care sector.
- 12 I think it's fair to say that we haven't done
13 a detailed examination of the standards, but the general
14 principle of what you are saying is correct.
- 15 **Q.** You are aware, and of course the Nuffield Trust is aware
16 of the fact that there were over the years a number of
17 exercises carried out in the United Kingdom, dealing
18 with a wide range of possible eventualities and
19 different possibilities which might eventuate. Were you
20 able to get an understanding of the degree to which the
21 outcomes of the various exercises were implemented in
22 the social care sector?
- 23 **A.** It's not been an easy trail to follow. So-called
24 Exercise Alice, which looked at the challenges
25 associated with the MERS, Middle East respiratory

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1 disease, only covered health. The later Exercise Cygnus
 2 did look at social care. Our researchers did not
 3 find -- were not able to find a great deal of evidence
 4 that the lessons from that were incorporated into
 5 social care, and the -- in relation to the previous
 6 question that you asked, you know, that -- this general
 7 lower level of requirement standards in social care
 8 continued after that, there did not seem to be
 9 a significant change in advice given to the sector.

10 **Q.** It is obvious, and the evidence plainly establishes,
 11 that such preparedness as there was was focused on the
 12 possibility of an influenza pandemic as opposed to
 13 a different type of catastrophic pathogenic outbreak.
 14 To what extent did your researchers see the consequences
 15 of that focus as they looked at the general state of
 16 health of the social care sector? Did they see evidence
 17 that non-influenza outbreak had been planned for to any
 18 degree at all?

19 **A.** No. Most of the focus had been on planning for
 20 an influenza-type outbreak, and the significance of that
 21 was that a number of the proposals for how to deal with
 22 that did not take into account the airborne nature of
 23 transmission for Covid-19.

24 **Q.** Did some of the employees and the managers in the
 25 social care sector to whom your researchers spoke

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1 is also -- the information on this is also patchy or
 2 poor.

3 **Q.** Is that because the majority of the providers of
 4 social care are local providers, instructed or paid by
 5 local authorities to provide care for their purposes,
 6 and therefore there are a very large number of
 7 individual fragmented providers?

8 **A.** That is correct, although the Care Quality Commission
 9 would have a register of all registered social care
 10 providers, but that's a regulatory function rather than
 11 a managerial one.

12 **Q.** Now turning to resilience, which forms the majority of
 13 your statement. In the context of looking at the state
 14 of health of a health system or a social care system,
 15 why does resilience matter when it comes to examining
 16 the potential impact of a health emergency or
 17 a pandemic? Why can't it just be assumed that a system
 18 of care will suck up whatever a health emergency
 19 presents it with?

20 **A.** One of the reasons for that is that some of the nature
 21 of health emergencies means that there is a very large
 22 surge in demand, many percentage points greater than the
 23 baseline level, and many health systems but the UK in
 24 particular has traditionally run with very low margins
 25 of spare capacity, which means that having a plan for

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1 express any view on the extent to which, both pre and
 2 post pandemic, the United Kingdom had availed itself
 3 sufficiently of learning or knowledge or experience from
 4 other countries who had had to deal with pandemic
 5 outbreaks in earlier times?

6 **A.** We couldn't find direct evidence for that.

7 **Q.** All right.

8 The Member of Parliament Matt Hancock gave evidence
 9 to this Inquiry about the difficulties encountered by
 10 the Department of Health and Social Care during the
 11 early days of the pandemic in understanding the sheer
 12 number of social care providers, as well as the number
 13 of persons receiving care in the social care sector, as
 14 well as, I should say, the number of persons who
 15 required care but were not receiving care in the
 16 social care sector.

17 Is there, in the NHS, the means to identify
 18 centrally the numbers of persons receiving healthcare?

19 **A.** At a broad level, yes.

20 **Q.** Is there a comparable mechanism in the social care
 21 sector? Do they have comparable mechanisms for
 22 understanding how many people are being treated and how
 23 many people are receiving care?

24 **A.** No, and in fact the overall oversight of the sector in
 25 terms of even who is employed and who is providing care

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1 how to deal with a sudden surge or emergency is very
 2 important, but it also of course limits the scope of
 3 that plan because the level of spare capacity in the
 4 system is relatively low.

5 **Q.** Do different considerations apply to whether or not
 6 a system is capable of recovering from a shock as
 7 opposed to dealing with the initial shock of a pandemic?

8 **A.** Our research internationally suggests that the ability
 9 to recover from a shock is very closely related to the
 10 overall level of capacity and pre-existing resilience in
 11 the system, so those countries which had higher levels
 12 of beds and staffing, more hospitals, better provided
 13 home care services, have recovered significantly better
 14 than those, like the UK, that do not.

15 **Q.** Was the Nuffield Trust -- or is it able to reach a view
 16 as to general levels of resilience, firstly in the NHS
 17 and secondly in the social care sector, over the years
 18 preceding the pandemic? Is there a chart or a line or
 19 a broad degree of progress that you can identify?

20 **A.** If we start with bed capacity and the demand associated
 21 with that, the number of beds in the NHS has remained
 22 relatively static during the period leading up to the
 23 pandemic. The NHS has a very low number of beds
 24 per capita compared with other high income countries.
 25 It tends to run them at a much higher rate of occupancy,

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1 which of course means that its ability to absorb shocks
2 or increases in demand is much lower. And although the
3 number of beds has remained static, the population has
4 both grown and aged over this period. So while demand
5 has been going up by 2% a year, the beds have remained
6 static, and the number of nurses have gone up by 0.2%
7 over this period, which means that the system -- the
8 hospital system is highly constrained.

9 **Q.** So that's beds and nurses. What about the state of
10 resilience in terms of the workforce generally in the
11 NHS over, for example, five years preceding the
12 pandemic?

13 **A.** So the workforce has been growing, but the level of --
14 so too has the number of vacancies, and there have been
15 shifts in the way that people work for the NHS, more
16 people working on temporary contracts and through the
17 use of bank and agency-type staff, which, again, does
18 affect the ability of the NHS to provide services that
19 respond to these growing levels of demand.

20 In community services we have a much less clear view
21 of what the capacity of the system is. There does not
22 appear to be a very reliable way of quantifying that,
23 but we do know that there has not been a growth in
24 community services to compensate for, again, this growth
25 in the age of the population and its high level of need,

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1 **Q.** So you've touched upon, now, general workforce levels,
2 general bed capacity. This is all in the NHS and
3 non-social care. Again, without going into the detail
4 and certainly not the operational side, what was the
5 state of resilience in January 2020 of the capital
6 infrastructure of the NHS, that is to say the buildings,
7 the capital assets, the equipment, the hospitals, the
8 wards?

9 **A.** As part of the approach to trying to keep NHS funding,
10 at least keeping up a little bit with changes in costs,
11 the capital budget had been reduced and turned to
12 revenue, and one of the consequences of -- so it's
13 an accounting shift, but the implication of it is that
14 money that should have been spent on new equipment, on
15 repairing -- on repairs and maintenance, was shifted to
16 keeping everyday operations going, and as a consequence
17 the backlog maintenance bill of the NHS has grown very
18 substantially over this period, which is another
19 indicator of a problem because it means that
20 a significant amount of the estate is really not fit for
21 purpose.

22 **Q.** So in other words, and forgive me for oversimplifying
23 it, there is a certain amount of money that goes into
24 the NHS pot, money that might have been used to improve
25 the infrastructure was used instead for its current

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1 and as a consequence -- I mentioned earlier winter,
2 which I think is quite a good indicator of the
3 resilience of the system. So, for example, in 2018,
4 NHS England instructed hospitals to cancel all of their
5 planned work to make space for emergencies in January of
6 that year.

7 **Q.** What are community services? You referred twice to
8 community services --

9 **A.** Yes.

10 **Q.** -- by contrast to hospital services?

11 **A.** That is a much more complicated question than it might
12 at first appear, but it would include some types of
13 community hospitals, so hospitals which don't --

14 **Q.** Slow down, please.

15 **A.** Sorry, I do apologise.

16 **Q.** It's quite all right.

17 **A.** Hospitals which don't manage emergency care --

18 **Q.** Right.

19 **A.** -- maybe used for rehabilitation or for aftercare
20 following a hospital visit.

21 Nurses and other clinical staff who provide care for
22 people in their own homes, support patients with
23 long-term chronic -- with chronic conditions, manage
24 their care and provide rehabilitation and aftercare in
25 a home care setting.

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1 account, that is to say for its trading, for keeping the
2 system ticking over?

3 **A.** That's correct.

4 **Q.** And that means that we've fallen behind in terms of the
5 maintenance of our infrastructure and our capital
6 expenditure?

7 **A.** That is correct.

8 **Q.** All right.

9 That's the NHS. Could you give us, by reference to,
10 firstly, places, then the general workforce numbers, and
11 then, again, the capital infrastructure, the analogous
12 position for the care home sector?

13 **A.** It's not so easy to do this for social care. We can
14 talk generally about what had happened to funding over
15 this period.

16 **Q.** Yes?

17 **A.** So funding comes from councils, as you mentioned, and
18 many of them had a significant reduction in their -- the
19 grants that they were receiving from central government,
20 so they had -- the spending in 2019 in real terms was
21 actually less than it was -- it was only just at 2010/11
22 levels, but the demand for social care and the need for
23 it had significantly increased over that period, with
24 the consequence that many local authorities were
25 reducing the -- what is called the eligibility criteria,

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1 so how much care -- how much do you need to demonstrate
2 a need for care to be able to be entitled to receive it
3 from local authorities. So we've seen a constriction in
4 the number of people offered care and the level of care
5 that was available.

6 In the nursing home care sector, the consequence of
7 that squeeze was that many nursing homes were having
8 financial difficulties. Those with a strong self-paying
9 component, so -- were using that to subsidise the local
10 authority residents who they were often housing at
11 a loss. So there was --

12 **Q.** Can you just pause there?

13 **A.** Yeah.

14 **Q.** By that do you mean that, in order to balance their
15 books, because obviously care has to be paid for and
16 money needs to be paid to care home providers to provide
17 the service, persons who pay privately get charged more
18 to make up the deficit because the councils are paying
19 relatively little to the care home providers to provide
20 the service for their local authority care home
21 residents? Is that the nub of it?

22 **A.** That's absolutely correct. And one of the consequences
23 of the financial squeeze is -- although this is harder
24 to quantify, is that this sector was also reporting that
25 its investment in physical infrastructure, technology

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1 to get access to data for the purposes of legitimate and
2 important research that he was conducting.

3 Is the NHS's ability to collate and provide data
4 relatively good in the opinion of the Nuffield Trust?

5 **A.** Broadly. I mentioned a concern about the data on
6 community, these community services, which are
7 an important component of care, but for hospital
8 services the availability of data is pretty good.

9 **Q.** Does the Nuffield Trust have a view as to the extent to
10 which concerns about data protection and privacy have
11 prevented the proper utilisation and dissemination of
12 data?

13 **A.** The problem of privacy are more relevant to the use of
14 data, for example, to identify people at risk or to --
15 and sometimes to do planning. Most local authorities
16 have found ways to work with other agencies to do that,
17 but there are some bureaucratic hurdles which the
18 current legal framework can put in the way. But from
19 the point of view of administrative data about pure
20 numbers, there's no particular reason why data
21 protection or protection of privacy should affect the
22 ability of the system to understand the broad -- the
23 broad trends and movements. It's only at the point
24 where you are trying to maybe look at a population and
25 say "Who do we think is most at risk, and where should

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1 and other improvements had been severely limited over
2 this period.

3 **LADY HALLETT:** Can I just check, you started off by talking
4 about nursing homes; are you using nursing homes and
5 care homes interchangeably?

6 **A.** I am, yes.

7 **MR KEITH:** There are different types of --

8 **A.** Yes.

9 **Q.** -- social care homes, are there not?

10 **A.** Yeah, they have --

11 **Q.** What are the broad groups?

12 **A.** They have two. There are those that provide an element
13 of nursing care and which some of the care is
14 provided -- is paid for by the NHS, and the hotel
15 component either by the individual or by local
16 authorities, and then there are care homes which do not
17 have a nursing -- a healthcare component and are more,
18 you know, sometimes called residential homes.

19 **Q.** That's very clear, thank you.

20 Can we now look at data. So, as I said, Mr Hancock
21 referred to the very real difficulties that the
22 Department of Health and Social Care had had in trying
23 to get on top of the numbers in the social care sector,
24 and my Lady has received evidence from
25 Professor Woolhouse, who spoke of difficulties in trying

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1 we intervene?" that the need to have some form of
2 semi -- what's called pseudonymised data, which had --
3 might relate to personal details. But from the point of
4 view of planning, long-term forecasting, understanding
5 capacity, there was no -- there is no, as far as I'm
6 aware, no particular data protection or other
7 constraint.

8 **Q.** So just to pause there for a moment, there's no problem
9 in gaining access to pre-existing data, what has
10 happened to whom and where and what services they've
11 been provided with, and what services they may need on
12 a historical basis. What is much more difficult is
13 looking to the future prospectively and saying: who in
14 number 13 or 14 or 15, the close in a particular area,
15 is going to require a special need or a special service
16 or is going to require being looked after on account of
17 a pre-existing vulnerability or need? Is that the
18 issue?

19 **A.** That can be the issue. I think in our evidence we gave
20 an example from West Berkshire where that evidence --
21 where they had very successfully managed to bring data
22 from different sources to do precisely that sort of very
23 detailed forecasting.

24 But from -- just to --

25 **Q.** So just to pause there.

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1 A. Yeah.

2 Q. For the purposes of preparedness and planning, it's
3 forecasting that matters, it's the ability to be able to
4 plan for all eventualities and to make plans to make
5 sure that individual members of the population receive
6 whatever services they're going to need. That system of
7 forecasting, is that in a good state?

8 A. I think we should just -- perhaps I will clarify, if
9 I may, a point here.

10 I am making a -- we can make a distinction between
11 sort of broad strategic planning to ensure that you've
12 got a viable system which is resilient and that you --
13 is using resources effectively, and that allows you to
14 think about the sort of overall shape of the system,
15 does not require that level of detail about the
16 individual. The --

17 Q. But specific planning identification of individual needs
18 does?

19 A. Yes. Yeah.

20 Q. To what extent, in your experience, does the NHS provide
21 for that level of data?

22 A. The NHS has, with some issues about community services,
23 generally got fairly good data to allow that sort of
24 planning and capacity planning. However, the fragmented
25 nature of the social care market, the fact that there

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1 supply chains and the ability to access medicines and
2 supplies, that's for later consideration, but in terms
3 of the resilience of the sector, the social care sector,
4 how significant was the impact on the workforce of the
5 pre-pandemic commencement of the exit process?

6 A. There was a substantial drop in migrant -- so it's worth
7 saying that the social care workforce, particularly in
8 some parts of the country, particularly the south of
9 England, has been highly dependent on migrant workers.
10 A significant number of those had been coming from
11 the EU, and there was a distinct drop off in that from
12 2016, for the two or three years following 2016, which
13 started to be made up from -- with migration from non-EU
14 countries, but there was a hiatus between the drop-off
15 from the EU and the recommence -- the ability of the
16 system to change the rules, to introduce new approaches
17 to issuing visas. And there was also a problem which --
18 at this point social care was not on the shortage
19 workforce list of the Migration Advisory Committee.

20 Q. All right, we don't need to go into the detail of it.
21 It seems obvious, though, Mr Edwards, that the
22 government, as might be expected, did start to take
23 steps immediately to try to increase recruitment from
24 other parts of the world in order to make up that
25 looming deficit?

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1 are different purchasers (there's local authorities and
2 there are individuals), the problems that local
3 authorities have experienced due to spending cuts that
4 they have been subject to, and in fact the fragmented
5 nature of the social care market means that the data to
6 be able to do that is much less readily available, and
7 I think at the level of the Department of Health has
8 been broadly poorly understood in recent years.

9 Q. In your statement you address the impact of leaving the
10 European Union, and I absolutely stress you make no
11 political points about the merits or otherwise of
12 leaving the European Union, but do you identify that,
13 even whilst the terms of the departure were being
14 negotiated, so pre-pandemic, the fact of the exit of the
15 United Kingdom from the European Union began to have
16 an impact on the resilience of the health and social
17 care systems? That's a yes or a no.

18 A. That's a yes.

19 Q. Did you do so and did you identify three areas in which
20 that impact began to become apparent: workforce,
21 especially in relation to social care; the resilience of
22 supply chains; and the ability to access medicines and
23 supplies?

24 A. That's correct.

25 Q. We're not concerned in Module 1 with the resilience of

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1 A. In health, but there was, I believe -- I would have to
2 maybe come back to you on the exact timing of this --
3 but I think there was a hiatus between understanding the
4 implications for the workforce in that particular sector
5 and then changes in the rules to allow for people to be
6 admitted from other non-EU countries.

7 Q. All right. Well, a hiatus may be forgiven, perhaps, but
8 they took steps to try to ameliorate the problem as they
9 saw it?

10 A. Yes.

11 Q. But to what extent -- and we're now, again -- we're
12 still concerned, of course, with pre-pandemic state of
13 affairs, so the state of preparedness and what sort of
14 state of resilience the sector was in. By the time of
15 the pandemic in January 2020, had that anticipated
16 deficit been made up or were we in a position in which
17 there was still a shortfall in terms of the numbers in
18 the workforce at the moment of the impact of the
19 pandemic?

20 A. There was still a shortfall in the social care
21 workforce. I don't know to what -- it's probably of
22 only academic interest -- extent that reflects the
23 issues around funding, the impacts of Brexit and other
24 factors, but the fact is that, in common with the health
25 sector, the social care sector went into the pandemic

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1 with a significant number of vacancies and problems with
 2 both recruiting and retaining its workforce.
 3 **Q.** Finally, a discrete and separate topic, pre-existing
 4 vulnerabilities of different groups.
 5 You've given evidence, Mr Edwards, about how
 6 post pandemic the Nuffield Trust carried out research
 7 work in relation to the NHS and social care sectors,
 8 with a view on what sort of state they were in at the
 9 time of the pandemic and on the degree of planning
 10 retrospectively that you were able to ascertain.
 11 To what extent did you find that there had been
 12 pre-existing planning for the needs of those persons who
 13 have particular non-clinical vulnerabilities? So that
 14 is to say persons who have vulnerabilities on account of
 15 social or ethnic considerations as opposed to purely
 16 clinical vulnerability. Did you see much by way of
 17 planning for their needs in the context of a planned
 18 health emergency?
 19 **A.** No, I don't think that came up in our research at all.
 20 **Q.** All right. Does that mean you didn't look for it or you
 21 didn't see evidence of it?
 22 **A.** I don't think we found evidence of it.
 23 **MR KEITH:** All right.
 24 Mr Edwards, thank you very much. Those are all the
 25 questions that I have for you.

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1 **A.** That is correct.
 2 **Q.** You have also served in various roles with the World
 3 Health Organisation. You co-chaired a scientific
 4 advisory group, you chaired the board of the Health
 5 Metrics Network and you've sat on a number of advisory
 6 boards for its research strategy division and for its
 7 European region division.
 8 For the particular interest of this Inquiry, you've
 9 written a book called *The COVID-19 Catastrophe: What's*
 10 *Gone Wrong and* -- even more relevantly for this
 11 module -- *How to Stop it Happening Again*.
 12 **A.** Correct.
 13 **Q.** *The Lancet* has a number of different parts, does it not?
 14 It has a number of journals within it; is that correct?
 15 **A.** Yes, we have 24 journals and we have offices in multiple
 16 countries around the world.
 17 **Q.** Do each of those journals deal with particular parts of
 18 the medical world but including infectious diseases and
 19 global health?
 20 **A.** That's right. The weekly *Lancet* -- it's our
 21 200th anniversary this year -- covers all aspects of
 22 medicine, public health and global health, and then we
 23 have speciality journals that are, as you say, focused
 24 on particular diseases such as infectious disease,
 25 oncology, diabetes and so on.

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1 There are no applications under Rule 10.
 2 **LADY HALLETT:** Thank you very much for your help,
 3 Mr Edwards.
 4 **THE WITNESS:** Thank you.
 5 **(The witness withdrew)**
 6 **MR KEITH:** My Lady, the next witness is Dr Richard Horton,
 7 please.
 8 **DR RICHARD HORTON (affirmed)**
 9 **Questions from LEAD COUNSEL TO THE INQUIRY**
 10 **MR KEITH:** Could you give the Inquiry your full name,
 11 please.
 12 **A.** My full name is Richard Charles Horton.
 13 **Q.** Dr Horton, thank you for attending this morning and for
 14 the provision of your witness statement dated
 15 27 April 2023, INQ000148421, which you have signed and
 16 appended a statement of truth on the last page.
 17 **A.** Correct.
 18 **Q.** Dr Horton, you are the editor-in-chief of *The Lancet*,
 19 an very well known UK-based medical journal, you're an
 20 honorary professor at the London School of Hygiene and
 21 Tropical Medicine and also of University College London
 22 and the University of Oslo, you worked for many years at
 23 the London Royal Free Hospital before joining *The Lancet*
 24 in 1990, and you became the editor-in-chief in 1995. Is
 25 that all correct?

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1 **Q.** Whilst you give evidence, Dr Horton -- I didn't warn
 2 you, it's my fault -- could you please try to go as
 3 slow --
 4 **A.** I apologise.
 5 **Q.** -- as you are physically capable.
 6 **A.** I apologise.
 7 **Q.** That way we won't -- either of us -- speed up.
 8 Evidence has been given in this Inquiry, Dr Horton,
 9 about the Global Health Security Index in which, as is
 10 well known, and is now well established in the evidence,
 11 the United Kingdom did rather well.
 12 Evidence has been received in particular from
 13 Professor Woolhouse, whom you'll know, and also the
 14 academic Dr Kirchhelle, about some of the learnings or
 15 some of the lessons that might be drawn from the obvious
 16 feature that, whilst the United Kingdom was rated very
 17 highly in the GHSI index, when it came to actual
 18 performance we may arguably have been thought to have
 19 done rather less well.
 20 Could you just set out, please, your views as to why
 21 you think the indicative performance in that index was
 22 not translated into actual performance?
 23 **A.** Certainly. Just before answering your question, I would
 24 just like to pay my respects and acknowledge members of
 25 bereaved families who are attending today and offer, on

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1 behalf of my colleagues at *The Lancet*, my condolences
2 for the loss and suffering that you have endured during
3 the pandemic.

4 In response to your question --

5 **Q.** And go slowly.

6 **A.** And go slowly -- we have tried in the past several
7 decades, as a medical community, to predict resilience.
8 The Global Health Security Index with Johns Hopkins
9 University is one such exercise. The World Health
10 Organisation has its own initiative. We've also tried
11 to make correlations based on the strength of national
12 health systems. What became clear during this pandemic
13 is that none of those measures were effective in
14 predicting response.

15 In some ways in retrospect that is not surprising.
16 If you take the one you mentioned, the Global Health
17 Security Index, it's an excellent document in setting
18 out the technical capacities of a public health system
19 in the face of a pandemic: six broad categories,
20 37 indicators, almost 200 separate questions
21 interrogating the competence of a pandemic preparedness
22 and response system; but what it omits is the human
23 dimension.

24 **Q.** Pause there. By that, do you mean the realities of the
25 impact of a pathogenic outbreak on members of the

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1 adequately document the capacities such as levels of
2 immunisation, laboratory capacities, supply chains,
3 infection control mechanisms; all that is very well
4 documented in these indices. It is the: how do we frame
5 the pandemic? What was the threat? We may come on to
6 this. The focus has been on influenza, but for
7 two decades we've known that that was not necessarily
8 the major or certainly the only threat that we faced.

9 **Q.** Was it well known that there had been, of course,
10 an epidemic and then arguably a pandemic relating to
11 SARS and to MERS and that the Far East in particular had
12 responded, one might think, quite well in terms of
13 putting into place structures and procedures for dealing
14 with those emerging epidemics?

15 **A.** Yes. Until 2002, we thought that coronavirus -- by "we"
16 I mean the medical community -- thought that
17 coronaviruses were a relatively benign category of
18 virus, and we were truly astonished in 2002 when
19 SARS CoV-1 emerged.

20 I brought along this report. It is a workshop
21 summary from the Institute of Medicine, from the
22 United States, 350 pages' worth of analysis --

23 **Q.** Dated?

24 **A.** 2004 -- which reviews our experience from the first SARS
25 outbreak, and it documents our astonishment that --

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1 population, or do you mean the response of the
2 particular health system in the country under
3 examination?

4 **A.** How our political leaders, our health leaders frame the
5 threat, how we assess the threat, and how we respond to
6 the threat. Those dimensions cannot be easily captured
7 or quantified in a measure such as the health security
8 index.

9 **Q.** Is that because, as Dr Kirchhelle might suggest, those
10 indices are too technologically based and fail to
11 reflect adequately the reality of how any human system
12 will respond in the face of a crisis?

13 **A.** Precisely; they're necessary but they are insufficient.
14 It is only when you are tested by a pandemic that you
15 really see whether your system operates effectively.

16 **Q.** I think there is a well known boxer who said, "Everyone
17 has a plan until they get punched in the mouth". These
18 indices examine plans for countries, they examine
19 systems and anticipated eventualities. Do they, in your
20 opinion, fail to take into account the actual reality of
21 the baseline health systems in each country, or how the
22 governors and the response systems will actually respond
23 in the face of a crisis?

24 **A.** The second part, they fail to take account of the way
25 human beings respond in the face of a crisis. They do

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1 **Q.** Just pause there, when you say "our experience", do you
2 mean the Western world or America --

3 **A.** Global experience.

4 **Q.** Globally?

5 **A.** This is a global report, but commissioned by the US
6 Institute of Medicine.

7 It documents our astonishment about the changed
8 pathogenicity of coronaviruses, so that they're now
9 targeting humans, and it warns the world community that
10 it needs to understand these, this category of viruses,
11 develop better diagnostics, better treatments, vaccines,
12 and really put coronaviruses on the map as a serious
13 human threat.

14 Now, that was in 2004. We have MERS in 2012 and
15 ongoing, and, with hindsight, we clearly did not elevate
16 the threat -- despite being warned clearly about the
17 threat, did not elevate that threat into our National
18 Risk Register.

19 **Q.** Do you have a view, as the learned editor of *The Lancet*,
20 as to why, notwithstanding the degree of knowledge in
21 the public, scientific and academic worlds, that
22 knowledge wasn't translated into governmental planning?
23 And by governmental, I don't just mean the
24 United Kingdom, but generally it would seem across the
25 western world.

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1 **A.** It's very hard to understand why, and I think -- I mean,
2 I had this book on my shelf for 20 years, and yet we
3 were publishing papers that were talking almost only
4 about influenza as a threat. So I think there was
5 a general groupthink in the medical and public health
6 community that really focused on influenza as the
7 threat.

8 However, if you were working in China or
9 an Asia-Pacific country, I think there was a different
10 perception. I think this was a Western groupthink, and
11 certainly colleagues I have in China were very well
12 aware that coronaviruses were a major threat.

13 **Q.** Did the combination of an arguable lack of focus on
14 non-influenza threats, as well as the high ranking in
15 the GHSI and other indices, engender, do you think,
16 a complacency on the part of the West?

17 **A.** I think we were complacent, for several reasons. First,
18 I think that we were overconfident in our National
19 Health Service and public health service to cope with
20 a pandemic. We're very proud of our NHS, but the
21 reality is, as -- we had a commission published in 2021
22 with the London School of Economics -- some of the
23 chronic weaknesses in the NHS left us very vulnerable,
24 and I think we underestimated those weaknesses.

25 I think we were mistrustful of evidence coming from
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1 to the pandemic.

2 The Exercise Cygnus, for example, clearly documented
3 areas of weakness around surge capacity, triage
4 management, regional and local planning, social care,
5 and even schools. All areas that, of course,
6 subsequently became major concerns during Covid-19.

7 That simulation took place in 2016. It seems that
8 we did not take note of those vulnerabilities and act on
9 those. There's not much point in doing the simulation
10 if you're not acting on it. I can't explain why we
11 didn't, but the simulation was critical in identifying
12 those vulnerabilities.

13 **Q.** The degree to which it was implemented is a matter for
14 my Lady, but may we take it from what you've said -- and
15 it's obvious from your last answer -- that exercises are
16 always essential, they are a vital component in the
17 system of preparedness?

18 **A.** Vital because they're testing the resilience of your
19 system, and resilience is the word that overshadows all
20 of our discussion.

21 **Q.** Going back to the international indices, Dr Horton, to
22 what extent did the United Kingdom's rankings in those
23 indices take account of the reality that, as you would
24 say, when the Covid pandemic struck, the United Kingdom
25 in particular was in fact struck by two epidemics? You
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1 China. I think that was a -- you know, there was
2 a degree of Sinophobia in the international order, which
3 meant that we didn't take signals from China as
4 seriously as we should, and -- and this might be
5 arguable -- but I think at the time, in January 2020, we
6 had a sense of our national sovereignty that might have
7 made us feel stronger as a nation to weather a shock,
8 which was clearly misplaced.

9 **Q.** I'm not going to ask you any more questions on that
10 topic, Dr Horton.

11 Your statement makes obvious and sensible reference
12 to the importance of simulations and exercises, and
13 the Inquiry has heard a great deal of evidence about the
14 extent to which there were exercises and the extent to
15 which lessons and recommendations from those exercises
16 were implemented. But can you express a view as to the
17 general importance of simulations and exercises in
18 readying a state, and particularly the United Kingdom,
19 in preparing it for whatever eventualities may ensue?
20 How important, in the general scheme of things, is the
21 exercise and simulation process?

22 **A.** The simulations are crucial for identifying possible
23 weaknesses, and indeed it was the failure to respond to
24 the signals from those simulations that I believe
25 contributed to the UK's early misadventures in response
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1 describe it as a syndemic. Firstly, what do you mean by
2 a syndemic and, secondly, to what extent did those
3 indices reflect that reality, as you see it?

4 **A.** The concept of a syndemic was first written about by
5 an American anthropologist called Merrill Singer in the
6 1990s, and it's important because it's connecting the
7 biological with the social: two biological epidemics
8 interacting to make each worse. It's not just the
9 co-existence, it's the fact that they each make the
10 other worse.

11 **Q.** What are the two biological --

12 **A.** Well, in this particular case it is the virus and
13 chronic diseases within our population, obesity, heart
14 disease, renal disease, cancer and so forth.

15 The intersection of those two epidemics overlaid on
16 patterns of social inequality meant that we had this
17 very, very toxic, potent mix of risk profile which --
18 and it's important, the notion of a syndemic, because it
19 affects your management and your prevention.

20 Management because you're not only dealing with
21 a virus, you also have to deal with a pattern of disease
22 in your society that makes certain groups of people
23 highly vulnerable. And not only the disease but the
24 patterns of inequality: certain people who are in more
25 deprived communities will be at greater risk than
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1 others.

2 And it's important for prevention, because you won't
3 have true resilience from a future pandemic shock if
4 you've only focused on the virus. You have to think
5 about the overall health of the population and you have
6 to think about reducing inequalities.

7 So in the future, pandemic prevention will partly be
8 about identifying and responding to a viral threat, but
9 it will also and equally be important to think about the
10 overall health of the population and patterns of
11 inequality.

12 **Q.** If I may attempt to summarise it yet further, is it
13 therefore the duty of government not just to take
14 account of those social disparities, the
15 vulnerabilities, the inequalities, because
16 an intervening viral pandemic will hit them harder, but
17 they must plan for that, prepare for it, and mitigate
18 the risk and the reality that such sectors of society
19 will be hardest hit as a result of a virus which draws
20 no distinction in terms of victims but of course hits
21 those who are vulnerable the hardest?
22 **A.** Absolutely. A pandemic preparedness and response plan
23 needs to think about the pandemic as a syndemic; and if
24 we don't, we will not be truly resilient to a future
25 threat. It's absolutely -- it's such a fundamental

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1 vulnerable here, because we have -- we do have
2 an excellent national health system which is able to
3 address people who present with particular diseases, but
4 what we have not got is an effective public health
5 system that is able to focus on health promotion and
6 health -- and disease prevention, and it's that
7 disabling of the public health system that left us
8 particularly vulnerable to Covid-19.

9 **Q.** In the latter half of your statement, you set out some
10 separate discrete points of learning or thoughts that
11 you've had following, of course, the --

12 **LADY HALLETT:** Sorry, are you moving to a different?

13 **MR KEITH:** Yes.

14 **LADY HALLETT:** Could I just ask, Dr Horton.

15 **A.** Yes.

16 **LADY HALLETT:** When you say the "disabling of the public
17 health system", in summary can you say what you meant by
18 that?

19 **A.** The chronic underfunding of public health. And also
20 the -- we have a very centralised public health system
21 in the UK -- in England, perhaps I should focus on here,
22 in contrast to some other countries which have a much
23 more decentralised public health system.

24 So, for example, in Germany in the early part of the
25 pandemic they were able to -- because they have

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1 point, I think, in the misunderstanding of what Covid-19
2 has been about and what we need to do to prevent its
3 effects in the future, similar effects in the future.

4 **Q.** There is obviously a close relationship between state of
5 resilience, therefore, and proper planning?

6 **A.** Correct.

7 **Q.** But in regard to both, vulnerability and inequality has
8 to be first and foremost because they are the ones who
9 are most likely to be affected by a future health
10 emergency or a pathogenic outbreak?

11 **A.** That's right. This was not an equal opportunity virus.

12 This was a virus that struck different groups of people
13 at different levels of risk, and the way we -- I mean,
14 these are other dimensions of public policy, but in the
15 specific realm of pandemic prevention we should be
16 giving greater attention to those who are living with
17 chronic disease and to those who are living in more
18 deprived communities if we're thinking about pandemic
19 prevention, yes.

20 **Q.** You would argue that that must go beyond making
21 appropriate clinical arrangements for dealing with those
22 persons who are infected by a virus, but who suffer fro
23 co-morbidities, to addressing the comorbidities
24 themselves?

25 **A.** Yes, and this is where I think we were particularly

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1 a decentralised public health laboratory system, they
2 were able to get early data on the distribution of the
3 virus across the country, which enabled them to plan and
4 respond to the pandemic with greater detail and faster
5 than we could. We didn't have a test and trace system
6 at all across the country.

7 So I think it's that lack of investment in public
8 health, both in terms of health protection and health
9 promotion, that left us vulnerable.

10 **LADY HALLETT:** Thank you.

11 **MR KEITH:** Picking up on some of the points that you make
12 towards the conclusion of your statement, you say in
13 paragraph 12, we needn't bring it up on the screen, but
14 it's in paragraph 12, that:

15 "COVID-19 underlined the value and importance of
16 genomic surveillance systems and these should be
17 prioritised in strengthening our national capacities for
18 operational readiness."

19 Dr Horton, it is, I think, obvious that once
20 academics and medics in China informed ProMED, the
21 international surveillance body, and informed the
22 regional office of the World Health Organisation in the
23 first days of January and the last couple of days of
24 December 2019, that that knowledge of the coming
25 epidemic, then only an epidemic, was well known.

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1 Why does there need to be further attention given or
2 greater attention given to enhancing our genomic
3 surveillance systems, if -- the reality of the last
4 pandemic showed that actually knowledge of the coming
5 wave was well distributed and well known, why do we need
6 more surveillance?

7 **A.** Well, I would argue more by accident than design, in
8 terms of those early days. Remember, the initial
9 response by local government officials in Wuhan was to
10 suppress information, not to report information. The
11 initial signal, you are right, came through ProMED, but
12 it did not come through official channels of the Chinese
13 government to WHO.

14 I have spoken to the person who was leading the WHO
15 office in China. He had no direct contact from Chinese
16 authorities in those early days about the outbreak in
17 Wuhan. So the channels didn't work.

18 **Q.** They worked belatedly?

19 **A.** Well, they worked by accident. Not even belatedly.
20 He -- the WHO officials had to -- they saw the ProMED
21 posting and then they were the ones who went to the
22 Chinese authorities and said, "Hey, what's going on?"
23 So the information flow was in the opposite direction.

24 So we desperately need an awareness and a system,
25 a global system to -- genomic surveillance certainly,

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1 One Health -- the concept of One Health is something of
2 a Cinderella in global policymaking, we're only
3 beginning to realise its importance.

4 And then, you know, there has been a lot of
5 discussion about the origins of Covid, and I'll only say
6 that --

7 **Q.** Let's not go there, Dr Horton.

8 **A.** Let's not go -- well, it's only relevant to this point,
9 to your question, and that is: of the biosafety level 4
10 laboratories in the world that might be dealing with
11 potentially dangerous pathogens, there is no
12 international oversight of those laboratories. It is in
13 our interests to make sure that we are an energetic and
14 muscular proponent of stronger international regulation
15 of biosafety level 4 laboratories, for national health
16 security in the UK. I stop there.

17 **Q.** This Tribunal has considerable powers, Dr Horton;
18 I'm afraid the regulation of the international order of
19 controlled detection, surveillance and border closures
20 is probably beyond its remit.

21 All the things you've mentioned are all, therefore,
22 concerned, aren't they, with the emanation of threat as
23 opposed to the United Kingdom's domestic response to the
24 threat once it presents itself; is that a fair summary?

25 **A.** It is. I would argue, though, that we do have

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1 but also to detect pneumonias of unexplained origin.
2 And it's relevant to the UK -- because one could say:
3 well, this is all about China, what's that got to do
4 with the UK? The reality is that the UK's national
5 health security depends upon global health security. We
6 are not safe as a population unless the rest of the
7 world is safe. So that puts a responsibility on us to
8 engage with the rest of the world to make sure that the
9 rest of the world is safe.

10 I mean, over half of countries today do not have the
11 necessary capacities as set out in the International
12 Health Regulations to prevent or respond effectively to
13 a pandemic. 55% of countries. That means that if there
14 is a spillover of a virus, whether it's from an animal
15 to a human or it's from a research-related laboratory
16 leak, the fact is that in over half the countries of the
17 world that spillover could easily escalate into
18 an epidemic and then a pandemic. So we have an interest
19 in making sure that those countries are able to respond
20 effectively.

21 If we take spillovers, which is the most likely
22 source of a future pandemic virus, we need to take a One
23 Health approach to pandemic prevention. That means
24 thinking about how human health interacts with animal
25 health and the environment, and at the moment

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1 a responsibility to engage globally in the interests of
2 the UK population. That's really, in summary, my point.
3 I want us to be a strong, energetic advocate in the
4 international community in ways that I think we've been
5 less so in recent years.

6 **Q.** Well, if I may say so on behalf of my Lady, your call
7 has been heard.

8 **A.** Okay.

9 **Q.** What can be done about it is perhaps another matter.

10 **A.** Okay.

11 **Q.** You then turn to the question of whether or not the
12 United Kingdom has sufficient research structures or
13 mechanisms for collating and identifying pathogenicity
14 and transmissibility, that is to say the building blocks
15 of particular pathogens.

16 The evidence so far and the evidence yet to come,
17 and therefore we mustn't pre-judge it, would suggest,
18 because there has been evidence about how quickly the
19 United Kingdom was able to produce a diagnostic testing
20 device and to find suitable effective antivirals, and
21 of course it's a matter -- it's well known that it
22 punched well above its weight in terms of vaccine
23 discovery and supply.

24 **A.** Absolutely.

25 **Q.** Does that not all rather indicate that the scientific

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1 and research base in relation to pathogens and the risks
2 of future diseases is very well established?

3 **A.** I would say that's one of our -- has been one of our
4 great strengths in terms of pandemic preparedness: the
5 quality and the robustness of the science base,
6 certainly.

7 However, in relation, if we just rewind back to your
8 very opening question about why did the UK perhaps not
9 perform as well as predicted by these health security
10 indices, it's not just the science base, it's the
11 scientists and the scientific advice that we then give
12 to government, and there was, I would submit, clear
13 failures in the quality of the scientific advice that we
14 gave to government.

15 **Q.** Do you mean post January 2020 in terms of the response
16 or the pre-existing position in terms of the risk
17 assessment process?

18 **A.** No, I'm talking about those early weeks in January 2020.

19 **Q.** All right. We're not going to go there because that's
20 a matter for Module 2.

21 **A.** Okay.

22 **Q.** But what about the risk assessment process? In your
23 statement you say elsewhere that there is, as with
24 many -- as with all governments, perhaps, and all types
25 of administration, that there's a danger that, in the

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1 **A.** Yes.

2 **LADY HALLETT:** That's what I thought we were doing, but just
3 from the way you introduced it --

4 **A.** Sorry.

5 **LADY HALLETT:** -- I thought you were going into response.

6 **A.** I was just going to say that the way the German system
7 operated was that the government invested responsibility
8 in the Robert Koch Institute and the president of the
9 Robert Koch Institute, who then assembled a team around
10 him to give advice.

11 Our system is more decentralised and I think that
12 that fragmentation means that, in terms of assessing the
13 risk, we don't do as well at being decisive at a moment
14 of peril.

15 **MR KEITH:** But from what you've said earlier you would say,
16 I think, that that imperfection in the system is of
17 equal importance in terms of pre-emergency drawing up --
18 identification, drawing up and response to risk as it is
19 when the emergency strikes and you have to respond?

20 **A.** Well, clearly that's so, because I would say that we've
21 had 20 years of documented evidence about the growing
22 danger of coronaviruses, and yet that evidence made no
23 headway into UK planning for a pandemic.

24 **Q.** Another important and significant feature of your
25 statement is at paragraph 18, where you say this:

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1 field of identifying and judging risk, each part of the
2 system may have a tendency to assume that somebody else
3 in the system is going to be the final arbiter of the
4 nature of that risk and draw the appropriate lesson and
5 raise the appropriate warning, and therefore everyone
6 looks to each other and nothing gets done.

7 **A.** Yes.

8 **Q.** Is that the nub of it?

9 **A.** It is. We have -- and I'm not making any comments about
10 individuals, but in terms of the offices, we have
11 a Chief Scientific Adviser, a Chief Medical Officer,
12 NERVTAG, SAGE, which is -- SAGE is a -- is not really
13 a committee because different people cycle in, they
14 cycle off. This is a very, very good system designed to
15 pass the buck to another group, and in a crisis
16 situation I think one might consider that a more command
17 and control approach might work better.

18 In Germany, for example -- again I choose Germany as
19 my comparator because they did very well in the early
20 phase of --

21 **LADY HALLETT:** Are we on to response?

22 **MR KEITH:** I think Dr Horton is drawing comparison with the
23 German scientific advisory committees for the purposes
24 of expressing a view on the efficacy of our risk
25 assessment procedures.

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1 "... the [United Kingdom] Government must make
2 strengthening trust one of its principal instruments for
3 pandemic prevention."

4 Doctor, trust is obviously a vital part of response,
5 which is why we're not going to look at it in detail
6 now, the need on the part of the population to have
7 trust in its government so that when the government
8 tells it how to respond and how to protect itself it
9 will do so.

10 Why is trust relevant, though, to pandemic
11 prevention?

12 **A.** So I think this is new understanding that's come during
13 the pandemic, so I -- I appreciate we're in Module 1
14 here, so tell me if I'm straying out of bounds, but what
15 we have learnt during this pandemic is that trust in
16 government, interpersonal trust, are two variables that
17 are crucial in their influence of infection mortality
18 rates. We didn't have that understanding before the
19 pandemic in quite the way we do now.

20 I think that's another contributor to why the Global
21 Health Security Index has not been a good measure,
22 because it doesn't measure trust, it measures technical
23 capacities. But these more nuanced dimensions of the
24 way the public interacts with itself and with
25 government, these are decisive factors which shape the

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1 outcome to a pandemic.
 2 **Q.** So are you in essence saying, if I've understood you
 3 correctly, when a pandemic or a pathogenic outbreak
 4 strikes, mortality rates and the ability of a population
 5 to respond and to survive depends to some extent on the
 6 trust it has in its government so that it will do as
 7 it's told in order to protect itself, but that that
 8 trust can't be born in a day, it must be nurtured,
 9 prepared for, planned for and encouraged so that when
 10 the pandemic strikes it's in place?

11 **A.** That's absolutely right. It needs -- trust needs to be
 12 an essential element of pandemic prevention,
 13 preparedness and response, and that goes from -- all the
 14 way from believing the government in terms of whether
 15 a lockdown is implemented to vaccine uptake and the
 16 safety of vaccines which have very rapidly been
 17 developed.

18 If the trust is not in place, it doesn't matter how
 19 good your preparedness and response plan is, it isn't
 20 going to work.

21 **Q.** But it is a necessary part, therefore, of preparedness?

22 **A.** Absolutely central.

23 **Q.** Right.

24 My Lady, those are all the questions that I have for
 25 Dr Horton. Thank you, Dr Horton.

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1 the US Institute of Medicine from 2004, that's been with
 2 you for almost 20 years, documenting the growing danger
 3 of a coronavirus.

4 Was the scientific information and learning from
 5 SARS, which could have informed our planning scenarios,
 6 was it well recognised in other scientific literature,
 7 other than that journal from the US Institute of
 8 Medicine, in that period, the run-up to January 2020?
 9 And was it something that was accessible to those who
 10 give scientific advice?

11 **A.** Oh, unquestionably the SARS outbreak in 2002/03 spurred
 12 on a huge interest and research activity into
 13 coronaviruses, because suddenly we were aware that these
 14 were not a benign group of viruses circulating in our
 15 communities, causing mild respiratory illnesses, coughs
 16 and runny noses; actually they could cause multisystem
 17 disease, tipping people into intensive care with high
 18 fatality rates. This was utterly new 20 years ago.

19 That shock led to a surge of new research into
 20 coronaviruses, and it only redoubled when MERS in 2012
 21 came on the scene.

22 So, yes, in the literature, which was entirely
 23 accessible, both in the general medical literature and
 24 the specialist literature, there's an enormous
 25 discussion about the dangers of SARS CoV and MERS -- and

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1 **THE WITNESS:** Thank you.

2 **MR KEITH:** There are two topics, my Lady, on which you have
 3 provisionally granted permission and ten minutes of
 4 questioning from Covid Bereaved Families for Justice UK.

5 **LADY HALLETT:** Ms Munroe.

6 Questions from MS MUNROE KC

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

8 Good afternoon, Dr Horton.

9 **A.** Hello.

10 **Q.** My name is Allison Munroe and I ask questions on behalf
 11 of the Covid Bereaved Families for Justice UK and, as
 12 has been said, there are two discrete topics that I'd
 13 like to ask you about.

14 The first, in fact, has been touched upon already.
 15 It's about the focus on influenza rather than other
 16 pathogens, including a coronavirus.

17 In your paragraph 5 of your statement, you
 18 considered that point in particular, and you referred to
 19 SARS as having provided "fair warning about the dangers
 20 of non-influenza epidemics", and then you go on to
 21 express a view that:

22 "The threat of a newly emerging coronavirus should
 23 have been more conspicuous in the risk estimations and
 24 the pandemic planning scenarios."

25 Now, Dr Horton, you've referred to that report from

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1 zoonotic infections in general, infections that jump
 2 from animals to humans. We recognised and have
 3 recognised for many decades that the biggest threat as
 4 a species we face from disease, infectious disease,
 5 comes from the jumping of a virus from an animal to
 6 a human. We knew that, and we knew that it wasn't just
 7 influenza. It's a whole range of different viruses,
 8 from coronaviruses to Ebola, and others.

9 So this has been a central debate in the global
 10 health community over 20 years about those threats and
 11 what we do about them.

12 **Q.** Thank you very much, Dr Horton.

13 Still on the topic of focusing on influenza
 14 pandemics, again this was touched upon earlier in your
 15 evidence, this concept of Western groupthink.

16 Do you know of any Western countries or countries in
 17 the Global North that implemented any learning from SARS
 18 and indeed MERS in respect of training and surge
 19 capacity, for example?

20 **A.** No, I think we -- I can't identify any country that
 21 actually implemented a plan with a coronavirus as
 22 a significant potential threat. That was -- I think
 23 there was a Western focus on influenza, which was not
 24 matched by countries that had been on the sharp end of
 25 SARS-CoV-2 in the early 2000s.

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1 Q. Thank you.

2 Moving on, then, to the second discrete topic,
3 professional education for healthcare workers.
4 Professor Heymann, of course, back in the first week of
5 the Inquiry gave evidence, and in his report he
6 describes a number of measures that were adopted by
7 a number of countries in East Asia in the wake of SARS.

8 My Lady, we don't need to bring it up, but for
9 reference its INQ000195846, at paragraph 64, page 15.

10 Just reading a little part of that paragraph, he
11 says this:

12 "Many countries in Asia (eg Singapore, Japan,
13 Republic of Korea ... Taiwan and Hong Kong ...) had
14 strengthened preparedness after the SARS outbreaks
15 in 2003. Preparedness activities in these countries
16 included cross-government pandemic containment,
17 simulation exercises; teaching and practising outbreak
18 containment skills with healthcare workers through the
19 implementation of formal training and hospital surge
20 capacity exercises; strengthening infection control
21 measures at health facilities including the construction
22 of state of the art patient isolation facilities at
23 hospitals; and strengthening disease detection
24 networks."

25 So those are the areas that he sort of looked at in

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1 in Asia one would see people wearing masks, for example,
2 routinely in the streets, busy streets, in shops, on
3 metros.

4 So this became embedded in the public culture.

5 A precautionary approach to the potential danger of
6 a pandemic, which governments were able to ...

7 Now, to answer your main question, put simply,
8 threats to UK health and health security are going to
9 come from outside the UK, which means that our doctors,
10 our nurses, our health workers do need to be aware and
11 apprised of those threats and in readiness to respond to
12 those threats.

13 I think that our health workers did an absolutely
14 brilliant job during this pandemic. I don't take
15 anything away from their response. However, it was done
16 as an emergency, in something of a panic, and I was
17 receiving messages during those early months and the
18 system was close to meltdown, because we were not ready,
19 and our health workers had not been adequately trained
20 and prepared for the dangers of a pandemic, how to
21 redeploy staff to focus on people in critical illness,
22 how to build surge capacity in intensive care in
23 a moment. Those plans had to be implemented instantly
24 and there was very little planning for that.

25 So I think this educational revolution is to

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1 terms of training and education, and in your statement
2 at paragraph 19 you say this:

3 "A revolution in nursing and medical education is
4 a necessary part of preparing for the next pandemic."

5 So my question, Dr Horton, honing in on that, the
6 learning and practising aspect of education, in your
7 view should such training -- as well as perhaps other
8 aspects of the training that Dr Heymann has mentioned --
9 be provided to healthcare workers in the UK as part of
10 that revolution in education that you describe in your
11 paragraph 19?

12 A. So let me try and offer two parts -- two answers.

13 First, may I add to Professor Heymann's list the
14 preparing of the public for a potential pandemic. So
15 what all of those countries did, have done, very
16 effectively is they have prepared the public -- this
17 goes to the point on trust -- they have prepared the
18 public for a potential future pandemic. So if and when
19 one comes, issues around physical distancing,
20 quarantine, mask wearing, travel advisories, the public
21 is aware of these issues, they don't suddenly get
22 dropped on them with surprise. They know in advance
23 that these are potential interventions the government
24 might take.

25 Indeed prior to the pandemic if one travelled widely

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1 relocate the UK in a global community and a community --
2 a global community at risk. It needs us to have a far
3 more expansive view of what constitutes national health
4 and a national health service.

5 **MS MUNROE:** Thank you very much, Dr Horton.

6 Thank you, my Lady, those are my questions.

7 **LADY HALLETT:** A very good line to finish on.

8 Thank you, Ms Munroe.

9 **MR KEITH:** My Lady, that concludes the evidence of Dr Horton
10 and the evidence for this morning.

11 **LADY HALLETT:** Thank you very much indeed for your help,
12 Dr Horton, your thoughtfulness.

13 **THE WITNESS:** Thank you. Thank you very much.

14 **LADY HALLETT:** I shall return at 1.45.

15 (12.42 pm)

(The short adjournment)

16 (1.45 pm)

(The short adjournment)

17 (1.45 pm)

21 **MS BLACKWELL:** My Lady, good afternoon. May I call the
22 Secretary of State for Levelling Up, Housing and
23 Communities, the Right Honourable Michael Gove.

MR MICHAEL GOVE (sworn)

Questions from COUNSEL TO THE INQUIRY

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1 **MS BLACKWELL:** Secretary of State, thank you for the
2 assistance that you have so far given to the Inquiry.
3 You have provided a witness statement which is at
4 INQ000185354, and if we go to page 13, please --
5 thank you -- do we see that it's signed on 9 May of this
6 year, and it's true to the best of your knowledge and
7 belief?

8 **A.** It is.

9 **Q.** Thank you very much.

10 Thank you for coming to give evidence before
11 the Inquiry today. May I invite you, please, to speak
12 slowly and into the microphones so that the stenographer
13 can hear you for the transcript.

14 By way of introduction, and for the purposes of this
15 module, your ministerial background makes you
16 particularly qualified to assist the Inquiry. My Lady
17 has heard much about the lead government department
18 models, and you have been minister of multiple
19 policy-heavy departments, some of which have been lead
20 government departments. You were Secretary of State for
21 Education from May 2010 to July 2014, Lord Chancellor
22 and Secretary of State for Justice from May 2015 to
23 July 2016, and Secretary of State for the Environment,
24 Food and Rural Affairs from June 2017 to July 2019.

25 We have also examined the role of the Cabinet Office
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1 heard as being pros and cons of that state of
2 preparation, so far as it affected pandemic preparation
3 and resilience.

4 I make it clear that we're not here to debate the
5 political issue of whether or not the EU exit was right
6 or wrong, but one of the positive aspects about which
7 the Inquiry has heard is the creation of the XO and XS
8 committees, two committees at the heart of the EU exit
9 work, the Exit Operations Cabinet subcommittee and the
10 Exit Strategy committee.

11 Secretary of State, you chaired the XO Cabinet
12 subcommittee. Tell us about it please, and how it sat
13 with the XS committee.

14 **A.** Thank you.

15 The XO committee was established shortly after
16 Boris Johnson became Prime Minister. There was
17 a widespread feeling, and one that I shared, that there
18 had been insufficient focus and urgency in our
19 preparation for EU exit overall, and specifically for
20 a no-deal exit.

21 The decision to adopt this particular committee
22 structure, the advice that the Prime Minister received
23 came originally from Dominic Cummings. Dominic was, as
24 I think is well known to this Inquiry, a principal
25 adviser to the Prime Minister at the time.
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1 and the Civil Contingencies Secretariat, and ministerial
2 roles there, which hold the resilience brief, and you
3 have been Chancellor of the Duchy of Lancaster from
4 July 2019 to September 2021, and Minister for the
5 Cabinet Office from February 2020 to September of 2021.

6 We have also examined the role of the regional and
7 local tier of government across the United Kingdom, but
8 particularly the role of local resilience fora and the
9 role of RED within the DLUHC department, and you have
10 been Secretary of State for Levelling up, Housing and
11 Communities, firstly from September of 2021 until July
12 of 2022, and then again from October of 2022 until the
13 present date.

14 Finally, we have looked at the extent of
15 co-operation and engagement between the United Kingdom
16 and the devolved administrations, and you have been
17 Minister for Intergovernmental Relations from September
18 of 2021 to July of 2022, and again from October of 2022
19 until the present day.

20 I hope that that is all accurate.

21 **A.** To the best of my knowledge, yes.

22 **Q.** Thank you.

23 I'd like to begin, please, by asking you some
24 questions about the preparation for a no-deal EU exit,
25 and I want to take you through what the Inquiry has
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1 XO was established to operate on a rhythm which
2 meant that we met daily on weekdays, and sometimes at
3 weekends, in order to superintend the activity of
4 individual government departments, and also our partners
5 in local government in the private sector and beyond, in
6 order to make sure that contingency planning for all
7 available risks associated with a no-deal Brexit could
8 be bottomed out. XO met under my chairmanship, it had
9 a cast of government ministers -- one of the good things
10 about it is there was continuity in that each government
11 minister from each department with a responsibility for
12 Brexit planning was a regular attendee, not always the
13 case with other Cabinet committees.

14 **Q.** Yes.

15 **A.** Also around the table in the Cabinet Office Briefing
16 Room on terms of equality ministers sat with officials
17 and indeed individuals from government agencies and
18 local government, to horizon scan, plan, and decide in
19 real time what the steps were that were required to
20 enhance preparedness.

21 **Q.** Before I ask you to explain how that sat with the Exit
22 Strategy committee, I'd just like to take you through
23 the ten benefits that you have set out in your witness
24 statement in terms of the composition of the committee,
25 how it met, when it met, and how that assisted in the
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1 achievements that it needed to reach.
 2 So you cite the following: first, that there was, as
 3 you have said, regular attendance of; second, nominated
 4 lead ministers, rather than what you describe as
 5 a rotating cast list in some other committees; third,
 6 that there was strong No. 10 backing for the committee
 7 to ensure that decisions were enacted rapidly; and,
 8 fourth, that the attendance at committee was
 9 prioritised; fifth, that, as you have made reference to,
 10 it was a committee where officials and ministers worked
 11 together and sat together around the table; and, sixth,
 12 that it was a dedicated and extremely able secretariat
 13 that supported the committee; seventh, that decisions
 14 were written up in real time and circulated rapidly;
 15 and, eighth, there was a daily rhythm, to which you've
 16 made reference, which ensured that issues could
 17 continually be worked through; eight(sic), that the
 18 meetings focused on taking decisions rather than
 19 open-ended discussions; ninth, that the meetings took
 20 place at the COBR facility; which, tenth, helped to lend
 21 a greater gravity, as you describe it, to the
 22 discussions.
 23 What do you mean, Secretary of State, when you said
 24 in your witness statement that it avoided the problem of
 25 the rotating cast list that happened in some other

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1 departments can sometimes be jealous of their own turf
 2 and priorities. In order to have heads knocked together
 3 there needs to be a knowledge that the centre. No. 10,
 4 and those working alongside the Prime Minister, want to
 5 see progress made.
 6 **Q.** Was that achieved by the interconnection between the two
 7 committees, XO and XS?
 8 **A.** Yes, and also by the attendance regularly at XO meetings
 9 of individuals from the No. 10 team who were known to
 10 have the ear of the Prime Minister, and, in addition,
 11 the secondment to the XO committee of some of the very
 12 best civil servants within the Cabinet Office.
 13 Within the Civil Service, people will know that even
 14 though someone may be not perhaps the most senior in the
 15 hierarchy, they're someone who commands respect for
 16 their ability to achieve change and to co-ordinate
 17 action. So the fact that we had civil servants like
 18 Jess Glover, Pamela Dow and others working on the
 19 XO committee was a clear sign that some of the crème de
 20 la crème in the Cabinet Office were committed to this
 21 project.
 22 **Q.** Insofar as the XS committee was concerned, was that
 23 routinely chaired by the Prime Minister?
 24 **A.** Yes.
 25 **Q.** All right.

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1 committees?
 2 **A.** There are many Cabinet committees that meet, and
 3 interministerial groups set up by successive
 4 Prime Ministers, to address issues that involve a number
 5 of departments. Sometimes, too often in fact, it is the
 6 case that the relevant Secretary of State will delegate
 7 attendance to a junior minister and sometimes it will
 8 not be the same junior minister. I'm not referring to
 9 the natural churn of resignation and promotion, but even
 10 within a ministerial team you will find that minister A
 11 attends in January, minister B in February, and
 12 minister C in March, and that weakens accountability and
 13 responsiveness.
 14 **Q.** One of the other strengths of the XO committee was the
 15 strong No. 10 backing that you say it had. Is there
 16 a suggestion that it is hard to prioritise work within
 17 government unless there is a consistent pushing from the
 18 centre?
 19 **A.** Yes. Government is asked and expected to do so much; in
 20 order to ensure that effective action is taken there
 21 needs to be prioritisation. Strong secretaries of state
 22 can drive through change in their own departments, ably
 23 supported by excellent civil servants and junior
 24 ministers. But there are many issues which involve
 25 different departments working together; individual

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1 Now, as part of the documents which you have
 2 exhibited to your statement, we have been able to
 3 consider the report from the Cabinet secretariat on XO
 4 lessons learned, a review that took place in December
 5 of 2019.
 6 I don't propose, Secretary of State, to take you
 7 through it in detail, but would it be a fair summary to
 8 say that, given the perceived productivity and success
 9 of the XO/XS model, there was a desire to see if its
 10 governance structure might be applicable to non-Brexit
 11 issues or whether successful elements of its governance
 12 structure could be applied to other more normal time
 13 committee structures?
 14 **A.** I think that's fair, and I think it is also the case
 15 that the Institute for Government, which acts as
 16 a critical friend to successive administrations, also
 17 reflected that while not every aspect of Brexit
 18 preparedness was perfect, nevertheless the committee
 19 structure and the operation of XO brought benefits.
 20 **Q.** Thank you.
 21 Were there doubts, though, as to how far it might be
 22 capable of application, because of the need to maintain
 23 pace and focus and engagement?
 24 **A.** Yes. One of the challenges that Whitehall and ministers
 25 faced is because there was a deadline -- of course the

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1 deadline was extended, but because there was a deadline
 2 we knew that, with a ticking clock at our back, we
 3 needed to proceed at pace. That meant that the normal
 4 tempo of papers being produced within Whitehall was
 5 accelerated, and I think it is fair to say that outside
 6 crisis situations or big projects in which the
 7 Prime Minister has invested an enormous amount of
 8 interest, that the rhythm that XO maintained, the daily
 9 battle rhythm, would be difficult to sustain. But I do
 10 believe that it was helpful for all of government to be
 11 operating at that pace, because we made government more
 12 match fit overall for the terrible events that this
 13 Inquiry has been set up to look at.

14 **Q.** Yes, and I think the Institute of Government comment
 15 piece that you also appended to your witness statement
 16 suggests in similar terms that it is a model that is
 17 worth replicating in certain circumstances, but that the
 18 pace would not always be sustainable, as you've
 19 explained.

20 You also tell us in your witness statement that, in
 21 your opinion, one of the central lessons of the
 22 pandemic, in terms of preparedness, is that whole-system
 23 resilience issues should be planned for better, that the
 24 initial structures were simply not adequate for a civil
 25 contingency of that scale and nature, and that the

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1 and, of course, animal disease. I had observed that
 2 LRFs, local resilience forums -- fora, had not performed
 3 as they should at the time of the Grenfell fire. I was
 4 concerned that they would not be able to cope as they
 5 should in the event of severe flooding, and I asked
 6 a retired military planner, General Tim Cross, to look
 7 at the readiness of local resilience fora in the event
 8 of floods.

9 The report that he prepared for my department, while
 10 it highlighted much good work, reinforced the fact that
 11 there was a -- there were a series of weaknesses in the
 12 transmission mechanism from the local to the central,
 13 and from the individual government department to the
 14 centre.

15 In addition, when I was preparing within the
 16 Department for the Environment for the effects of
 17 a no-deal exit, and they would have been significant on
 18 food supplies and on other questions, I was struck by
 19 the fact that the centre did not seem to have the
 20 galvanic energy required in order to make sure that each
 21 government department was doing as it should.

22 This relates ultimately to a dysfunction in the
 23 design of the Cabinet Office, which we may turn to.

24 **Q.** Right, thank you.

25 Moving back, though, to the issue about which I was

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1 pandemic required a truly cross-government whole-system
 2 response with delivery structures on an integrated and
 3 co-ordinated basis.

4 Now, there is a suggestion in the Institute of
 5 Government article that the XO/XS model was at least
 6 partly borne out of your frustrations with the ability
 7 of the United Kingdom Government to handle preparing for
 8 a whole-system risk of this nature.

9 So my question to you is this: given that the whole
 10 risk systems have been on the NSRA and NRA for many
 11 years, what does it say about the United Kingdom
 12 Government that these kind of issues, with
 13 cross-government working and the need for whole-system
 14 structures for whole-system risks, was not recognised at
 15 an earlier stage?

16 **A.** I think there would be those who would argue that
 17 significant progress had been made following on from the
 18 establishment of the National Security Council and the
 19 updating of the National Security Risk Assessment and
 20 its public manifestation, the National Risk Register.

21 But you can always -- one can always learn and improve.

22 I was struck when I was at the Department for
 23 Environment by two things which relate to your question.
 24 The first is that the department for the environment is
 25 the lead government department when it comes to floods

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1 asking you, and setting out really the reason why I have
 2 focused on the XO/XS model, it's right, isn't it, that
 3 that model was adapted for the Covid-O and Covid-S
 4 model, which in fact replaced COBR? And when
 5 the Inquiry comes to deal with Module 2, it will no
 6 doubt examine the efficiency of those committees. But
 7 that was the decision that was taken, I think, at that
 8 time, that the model that had been created and worked so
 9 well during the preparations for an EU exit was the
 10 basis for what happened during the outbreak of Covid in
 11 government. So in that sense it was a positive outcome
 12 of the EU exit preparations.

13 But the Inquiry has also heard evidence from
 14 witnesses within the United Kingdom Government and also
 15 the devolved administrations about the adverse impact
 16 that the necessary planning for a no-deal EU exit had on
 17 other resilience activities and pandemic preparedness,
 18 and in particular heard from Katharine Hammond, who was
 19 the director of the CCS whilst you were the CDL.

20 Do you accept that, as a result of the necessity for
 21 workforce capacity to move over and deal with matters
 22 that were important in terms of the preparation for
 23 a no-deal EU exit, that that had a detrimental effect on
 24 the preparation for pandemic planning?

25 **A.** No.

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1 **Q.** Why not?

2 **A.** Because I haven't yet seen any activity that has been
3 identified that would have enabled us to significantly
4 better deal with the Covid-19 pandemic that did not
5 occur as a direct result of EU exit.

6 **Q.** Well, are you aware of Exercise Cygnus and the
7 recommendations that came out of that, and the fact that
8 the Pandemic Flu Readiness Board was created, was stood
9 up in order to take forward the recommendations that
10 came out of that exercise, but that that board could not
11 meet and the work that it was expecting to do could not
12 be carried out because of workforce capacity issues?

13 **A.** I have. My understanding is that the work of that team
14 was shared with the then Chancellor of the Duchy of
15 Lancaster, David Lidington, in January of 2019. Various
16 workstreams were requested to be carried forward. That
17 was agreed, and then the PFRB met again in November
18 of 2019 to review process. And I think in Katharine's
19 evidence, she mentions that a significant proportion of
20 that which was required, including stocking the
21 appropriate antivirals to deal with a pandemic flu,
22 carried on. But as the Inquiry has heard, ultimately
23 the pandemic that occurred was not a flu pandemic, it
24 was one for which we were unprepared because few Western
25 nations, if any Western nations, had anticipated the

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1 whole question of school closure, and we may touch on
2 that.

3 But on the third point, CCS's own readiness, I also
4 think that Katharine is being modest there, in that CCS
5 and the Cabinet Office overall did flex rapidly once it
6 was clear what the scale of the pandemic was.

7 **Q.** Well, we've looked at two documents dealing with
8 staffing resources. There's a lessons learned report
9 from the Cabinet Office regarding
10 Operation Yellowhammer --

11 Which we see at INQ000100183, please, and could we
12 go, please, first of all to paragraph 5 of page 5.

13 Look at 5(b), which tells us that:

14 "Staff resourcing was and remains a concern for
15 January 2020 for the majority of Departments, DAs, IGs
16 and the central secretariat, including CCS."

17 Could we now go to page 14, please, and look at
18 paragraph 28(a), which deals with the balancing of
19 business as usual and Yellowhammer work. Thank you. In
20 fact, can we go to paragraph (d), please, instead.

21 Thank you.

22 "Balancing [business as usual] and [Yellowhammer]
23 work ..."

24 Pausing there, there were two periods of time
25 dealing with Yellowhammer, weren't there, and this is

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1 particular type of pandemic that Covid-19 was.

2 **Q.** The Inquiry has also heard that certain aspects of the
3 preparations within government for a pandemic influenza,
4 and indeed the 2011 guidance which was in the process of
5 being updated, were capable of assisting in relation to
6 the pandemic that hit, the pandemic of a coronavirus.
7 So wouldn't you accept that the stalling of the work on
8 the updating of the guidance and the Pandemic Flu
9 Readiness Board undoubtedly had an effect on the
10 country's preparedness for the pandemic which hit?

11 **A.** I don't think that can be proven. In Katharine's own
12 evidence, she alludes, I think, to three areas where she
13 feels that CCS, as the central co-ordinating
14 secretariat, could have done better, in the specific
15 area of the pandemic. She talks about emergency
16 funding, she talks about the work of the Department for
17 Education, and then she talks about CCS's own readiness
18 to adapt its structures to a pandemic response.

19 I actually think, and I have an enormous regard for
20 Katharine, that on the first, emergency funding, the
21 speed with which HMT initiated the furlough programme
22 and the Covid business intervention loan scheme shows
23 that the Treasury was agile, and I can't imagine that it
24 could have been much more so.

25 I do think she has a fair point when it comes to the

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1 the second such period.

2 "... a number of people divided their time between
3 ongoing BAU work and YH work in the months and weeks
4 leading up to the IOC."

5 IOC being? What does IOC mean in this context?

6 **A.** I'm not entirely sure.

7 **Q.** All right. We'll find that out.

8 **LADY HALLETT:** It proves my point that acronyms don't always
9 assist communication.

10 **MS BLACKWELL:** Quite, my Lady.

11 **A.** Indeed.

12 **Q.** "This was deemed necessary prior to the arrival of the
13 Fast Streamers, but it did result in significant
14 overloading of staff, and caused line managers problems
15 in scheduling work to deadlines."

16 It is obvious, is it not, that if an additional
17 important workstream that is to be prioritised over
18 business as usual work takes the workforce away from its
19 business as usual, that is necessarily going to cause
20 overloading of staff and problems in terms of focusing
21 on the work which they were originally doing? Isn't
22 that a logical conclusion of giving more work to the
23 same number of people?

24 **A.** I'd say three things. The first thing is that the Civil
25 Service grew and expanded in readiness for EU exit, and

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1 the number of people that we recruited overall, both in
2 the Cabinet Office and in other departments, grew to
3 take on this additional load.

4 The second thing is, as I mentioned earlier, the
5 nature, the pace and the intensity of the work
6 undoubtedly placed pressure on individuals in the
7 system, but it also ensured a greater degree of match
8 fitness for what none of us anticipated but what was to
9 come the year after.

10 The third thing is, as I say, it is difficult to
11 identify what was anticipated, what could have been
12 planned, and what was not carried forward that might
13 have put us in a better position.

14 Katharine identified three areas in her evidence.
15 I've mentioned the areas where I agree and disagree.
16 But the fact that a committee did not meet does not mean
17 that if it had that that meeting in and of itself would
18 have meant that we were significantly better prepared.
19 And indeed I would argue that the skills acquired, honed
20 and refined during EU exit preparation helped us, not
21 only to have an organisational system that was better in
22 dealing with a crisis, but having a cadre of people who
23 had been through an intense process that enhanced their
24 ability to respond.

25 **Q.** In terms of workforce capacity, of course it cannot be
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1 orienting its work towards the particular type of
2 pandemic that Covid was to become.

3 **Q.** All right.

4 The Inquiry has heard evidence that there is likely
5 to be an increase in concurrent and cascading risks due
6 to the ever more complex world in which we live, and you
7 have set out in your witness statement why you do not
8 think it appropriate for there to be a "standing
9 capacity ready to co-ordinate fully an emergency
10 situation or a dedicated team of officials on hand to
11 create the scale of intervention which lockdown [or
12 something akin to lockdown] ultimately required".

13 But what you suggest in the witness statement is
14 that it's reasonable to expect the centre of government
15 to have tried and tested plans in place, by way of
16 an alternative to a standing capacity.

17 You have mentioned Sir Oliver Letwin. He gave
18 evidence to my Lady on the issue of the creation of
19 a national resilience institute, which he suggested to
20 my Lady was certainly worth considering.

21 What do you think about that suggestion, and would
22 the creation of a resilience institute, bringing with it
23 its new architecture, a chair, a board, the work which
24 it could be doing full-time, does that go any way to
25 fitting the bill in terms of what we need going forwards

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1 proved that the fact that a committee didn't meet means
2 that we were not as well prepared for the pandemic as we
3 might have been, but doesn't it stand to reason that
4 a significant overloading of staff, as is set out in
5 this paragraph here, is a reflection of the fact that
6 there was too much work for the workforce in the civil
7 service at the moment whose focus was bent away from
8 what they should have been doing, preparedness for
9 a pandemic, towards EU exit?

10 **A.** No, I don't agree with that, because I think that the
11 preparation for EU exit in and of itself was some of the
12 best preparation that could have been undergone for any
13 future crisis.

14 One of the points that has, I think, been well made
15 by Oliver Letwin and by others, is that it is training,
16 it is the acquisition of general skills in crisis
17 management, that is among the most useful ways of
18 ensuring that we have pandemic preparedness. And
19 of course it is possible that had a particular meeting
20 or had a particular workstream been taken forward then
21 we might have identified something that could have
22 strengthened our ability to weather the pandemic, but
23 nowhere have I seen, I think outside, you know, one or
24 two scholarly articles from Johns Hopkins and elsewhere,
25 anyone who was suggesting that government should be

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1 for the additional challenges that lie ahead?

2 **A.** I think, as is so often the case with Oliver, that it is
3 a very good idea. And I think it is necessary but not
4 sufficient.

5 **Q.** Why not?

6 **A.** Because more, I think, requires to be done.

7 So, in some of the work reviewing the fitness and
8 appropriateness of our structures, including Oliver's
9 own evidence, I think there is much that is good,
10 I think that the notion that there should be a lead
11 minister at Cabinet level with responsibility for
12 resilience -- I don't think it should be a minister just
13 for resilience -- I can expand on that if required --
14 but I think that that is appropriate. I think that
15 elevating the role of the deputy National Security
16 Adviser, who is responsible for dealing with threats and
17 hazards and resilience, is important as well. I think
18 that strengthening the role of the Civil Contingencies
19 Secretariat, the Resilience Directorate, is important.
20 But there is one more thing, which is that my own view
21 is that the relevant minister responsible for resilience
22 should be the lead minister in the Cabinet Office,
23 whether they are called Chancellor of the Duchy of
24 Lancaster or whatever.

25 **Q.** Yes.

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1 **A.** They would have other responsibilities. But one of the
 2 problems within the Cabinet Office is that whoever is
 3 the lead minister there does not have full oversight
 4 over the whole of the Cabinet Office in the way that
 5 a secretary of state does over their department. The
 6 National Security Secretariat was an area that was to
 7 an extent shielded from my view during a lot of my time
 8 when I was nominally in charge of the Cabinet Office,
 9 and I think that this is an overhang from the way in
 10 which the Cabinet Office was originally set up, to serve
 11 the Cabinet Secretary rather than to be a department
 12 with a lead minister wholly responsible for its
 13 operation.

14 **Q.** Do you also agree with the evidence that the Inquiry has
 15 heard not only from Sir Oliver Letwin but also from
 16 others, including Sir Chris Whitty, that ministers
 17 working within resilience need to have appropriate
 18 training?

19 **A.** Yes.

20 **Q.** Right.

21 There is a balance to be struck, is there not,
 22 between the challenge that ministers bring to the
 23 scientists who are advising government departments, in
 24 not being scientifically qualified -- and the importance
 25 of that challenge as far as this Inquiry has heard is in

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1 **Q.** There needs, doesn't there, to be a level of
 2 understanding, though, within ministers --

3 **A.** Yes.

4 **Q.** -- as to what questions to ask? The way in which
 5 Sir Chris Whitty explained that conundrum to the Inquiry
 6 was to say that in every emergency he has ever seen
 7 there is a desperate need to get scientists in the room,
 8 but "Between emergencies you have to kind of elbow your
 9 way in", is how he explained it.

10 So does there need to be a standing capacity for the
 11 provision of scientific advice and a need, perhaps
 12 through exercising or through other organised workshops
 13 for ministers, to have and to keep having, in other
 14 words so that that doesn't get stale, a level of
 15 understanding as to what sort of pathogens and pandemic
 16 situations or other scientific matters of risk are
 17 coming down the line?

18 **A.** Yes. It would be a very rare person who had a level of
 19 knowledge which would mean that they would be
 20 omniscient in every emerging crisis. It would be
 21 rare to have someone who would simultaneously understand
 22 terrorist threats, cyber threats, pandemic threats and
 23 the threats to critical national infrastructure.
 24 I think the only person I can think of who comes close
 25 to that is Oliver Letwin, and as I think David Cameron

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1 order to alleviate the possibility of groupthink within
 2 the scientific advice that's being given.
 3 What level of training do you think ministers should
 4 have in order to get the balance right?

5 **A.** I think ministers definitely would benefit from
 6 training, and I think there are several aspects to it.
 7 The first is learning from those ministers who
 8 either have experience or ex-ministers who have
 9 experience in handling crises. I think also undertaking
 10 exercises -- again, I think Sir Oliver's recommendation
 11 of a much more regular tempo of exercise, involving
 12 military planners, so that it is close to the sorts of
 13 simulations that the armed forces undertake, is
 14 absolutely right, and it's having something as close to
 15 an emergency as possible that will enable ministers to
 16 learn better.

17 But your other point is absolutely spot-on.
 18 Sir Oliver is right, politicians, as he said, are
 19 amateurs. When we are engaging with professionals and
 20 experts, what we bring is not deep subject expertise,
 21 but what we bring is the capacity to ask the daft liddle
 22 question, and sometimes it is only when someone asks
 23 that question that we find out that the Emperor has no
 24 clothes or the pandemic preparedness plan has a huge
 25 hole in the middle.

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1 said, you can't clone Oliver, if only you had
 2 a government composed of Olivers, it would be a better
 3 world. But your basic point is absolutely right that
 4 ministers, particularly if they have departmental
 5 responsibilities, do need to acquaint themselves with
 6 some of the scientific issues, and most recently one
 7 science issue, a science risk and opportunity, the
 8 growth of artificial intelligence, has been discussed
 9 around the Cabinet table with the Government's Chief
 10 Scientific Adviser, and ministers brought to that
 11 conversation a base level of knowledge enhanced by what
 12 Dame Angela was able to tell us.

13 **Q.** Finally on this point you raise in your witness
 14 statement the need for consistent challenge, for what
 15 you describe as red teaming?

16 **A.** Yes.

17 **Q.** That's something which should always be present in any
 18 of the groups, be it scientific or governmental or
 19 a combination of both, that meet in relation to pandemic
 20 planning going forwards and also a nod to resilience?

21 **A.** Yes, I do think that, and I think -- there is a danger
 22 in groupthink. There is also a danger, and again
 23 Oliver Letwin brought this out, that people within
 24 a civil service hierarchy or within a political culture
 25 will not wish to seem awkward. They will not wish to be

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1 the person questioning their superior in front of
2 another. So having people who are charged explicitly
3 with being awkward and thinking of what may be wrong in
4 a particular case is useful, and I have found that in
5 some of the departments in which I have worked, having
6 a team within the department to do that is useful. So
7 within DLUHC at the moment we have a unit, a policy
8 unit, that is there both to complement but also to
9 challenge the policy propositions that are put forward
10 by others.

11 **Q.** The Inquiry has heard that there are very few risks
12 which don't require the involvement of more than one
13 government department, especially, as I've already made
14 mention of, the fact as we go forwards in time there are
15 more concurrent and cascading risks that are likely to
16 occur.

17 Taking that into account, is the lead government
18 department system flawed?

19 **A.** It has its flaws. There are obvious areas where the
20 expertise and the personnel within the lead government
21 department will be well equipped to deal with
22 a particular situation.

23 I mentioned flooding earlier. DEFRA, its
24 relationship with LRFs, and the Environment Agency, and
25 the expertise that it has, means it is the natural lead

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1 has just published there's an acknowledgement that the
2 lead government department model broadly works, which
3 I think is right, as I hope I have explained, but that
4 there needs to be a strengthening of the centre, and
5 I hope that one of the things that the Inquiry will be
6 able to help this government and future governments with
7 is a better understanding of how that strengthened
8 centre might operate.

9 **Q.** On a slightly different topic, but connected, I think,
10 is the division of roles between various government
11 departments in terms of preparedness and resilience.

12 **A.** Mm.

13 **Q.** We know that the Department for Levelling Up, Housing
14 and Communities has within it the Resilience and
15 Recovery Directorate, which was formerly known as the
16 Resilience and Emergencies Division, and the connection
17 that has with local government, which we'll come on to
18 speak about in a moment.

19 But the Inquiry also knows and understands that the
20 CCS sits within the Cabinet Office, and indeed connected
21 is the Department for Digital, Culture, Media and Sport,
22 which has within it the Civil Society and Youth system,
23 which touches upon the voluntary sector.

24 If all of these different groups and bodies are
25 necessarily part of planning and resilience, should they

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1 government department. Sometimes the nature and scale
2 of a flood will mean that there needs to be a MACA
3 request, a request to the military to help the civil
4 power, and you will need an Armed Forces minister or the
5 Secretary of State for Defence there. Sometimes there
6 will be local government or health ramifications. But
7 essentially DEFRA is the logical lead government
8 department there.

9 But as Covid-19 showed, DHSC, even though it had,
10 I think, a very good secretary of state and an excellent
11 ministerial and official team, simply could not
12 co-ordinate the scale of activity across government
13 required.

14 Similarly, while it is obviously the Home Office
15 that has the expertise in dealing with terrorism, if,
16 God forbid, there were to be another terrorist incident
17 on UK soil, I don't believe that the Home Office on its
18 own would necessarily be able to play the role that
19 an enhanced team in the Cabinet Office could provide.

20 **Q.** So is there one system which works for the situation
21 that might be created by all risks, or does the lead
22 government department system have within it a suitable
23 level of flex in order to be able to adapt to the
24 situation?

25 **A.** I think in the Resilience Framework that the government

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1 all sit within the same government department?

2 **A.** Yes.

3 **Q.** Right, and how would that be achieved?

4 **A.** By what is known as a machinery of government change.
5 It is the case that from time to time areas which are
6 the responsibility of one government department move to
7 another, so it might be the case that the handling of or
8 policy on privacy and freedom of information might move
9 from the Ministry of Justice to the Cabinet Office,
10 depending. My view is that RED should move from DLUHC
11 to the Cabinet Office. And RED developed, as
12 the Inquiry has heard, following the abolition of
13 government offices of the regions --

14 **Q.** Yes.

15 **A.** -- with the personnel there moving to DLUHC, not all
16 physically in the same building, several of them
17 dispersed across the country, but the liaison function
18 between local government, local resilience fora and the
19 centre was subsumed within that directorate.

20 My view is, while the people leading it are
21 excellent and the people working in it are very good,
22 that it is logical for that to go into the
23 Cabinet Office.

24 Again, I reflected, and I hope that this isn't
25 outside the scope of Module 1, early in the onset of the

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1 pandemic, when I was briefed by CCS on what my
2 responsibilities might be as the lead Cabinet Office
3 minister at the time, CCS placed a special emphasis on
4 dealing with excess deaths because that was an area that
5 other government departments didn't deal with, but they
6 did. But there was less emphasis in that conversation
7 on the need for the type of co-ordination which
8 I believe only a central department like the
9 Cabinet Office can lead.

10 **Q.** Are there plans within government to effect that change?

11 **A.** Discussions are ongoing.

12 **Q.** All right.

13 Moving on, then, to talk about local government and
14 the connection, as you've set out, between the local
15 resilience fora and the government associations going up
16 to central government. You will know that the Inquiry
17 has heard from Catherine Frances, and she told my Lady
18 that, in her experience, there was or has been no
19 detraction from the relationship between local
20 government and central government with the abolition of
21 the regional level.

22 As you've explained, to a certain extent some of
23 those tasks that were carried out by the regional level
24 have moved up to the central level, although they're
25 still being maintained.

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1 DEFRA that there were some local resilience fora which
2 are excellent, and others not so much, and the whole
3 question about how we improve and strengthen the hand of
4 local leaders to respond is, I think, a vital one.

5 **Q.** Catherine Frances described to my Lady that one of the
6 purposes of RED is to act as a critical friend --

7 **A.** Yes.

8 **Q.** -- to the local resilience fora and the Local Government
9 Association. The Inquiry heard yesterday from
10 Mark Lloyd, who is the chief executive of the Local
11 Government Association, who explained to the Inquiry
12 that in his view -- which is gleaned from the members of
13 his organisation who are local authorities -- there is
14 a problem with information cascading down from central
15 government to the local level. By way of an example, or
16 examples, he told my Lady that it took the launch of
17 judicial review proceedings for the Exercise Cygnus
18 your Ladyship to be published --

19 **A.** Yes.

20 **Q.** -- despite the fact that six years earlier, when the
21 exercise had taken place, local resilience fora had been
22 involved in the exercise. And as concerning, one might
23 think, the entire existence of Exercise Alice and its
24 report was only discovered by the Local Government
25 Association during its preparations for this Inquiry.

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1 Given that there is such a plethora of types of
2 local authority in terms of their size, complexity --
3 I think it was described as a patchwork quilt of
4 different types of organisation -- is there an argument
5 for reinstating the regional level of governance or of
6 the presence of a regional level of connection?

7 **A.** I'm not sure, is the honest answer. Even though the
8 resilience team within DLUHC, and formerly of course
9 within MHCLG, operates to the Secretary of State within
10 that government department, many of the people who work
11 in it are based regionally, and there are five regional
12 hubs, and the people who work there as government
13 liaison officers and resilience advisers are out in the
14 field. So there is a regional structure, as it were,
15 within the department.

16 So should one recreate the government office of the
17 region structure? I personally don't think so, because
18 I think, though it is obviously arguable, that what we
19 should be seeking to do is to empower local leaders
20 rather than -- obviously there needs to be liaison, but
21 empower them rather than have someone watching over them
22 as a Big Brother.

23 But, as your question clearly implies, there is
24 a variation in quality and resource and structural power
25 within local government, and I observed in my time at

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1 Do those examples show that there perhaps is
2 a difficulty in central government acting with secrecy
3 and not as the critical friend that has been described?

4 **A.** Yes, is the short answer.

5 I'll expand a little. I have found in government
6 that DLUHC or its predecessor department, MHCLG, is
7 a good friend of local government, but not every arm of
8 government -- and I think this is true across
9 administrations, Conservative, coalition and Labour --
10 has been as open, trusting and collaborative with local
11 government as it should be. I think that that is part
12 of politics.

13 But change has come, and in the Resilience Framework
14 that Oliver Dowden has published, it is clear that we
15 will share information more effectively, that we will
16 use platforms like ResilienceDirect in order to ensure
17 that the whole resilience community, as it were, is
18 involved in these conversations.

19 I would add two other things briefly. The first is
20 that the people who lead local resilience fora will tend
21 to be uniformed officers, principally from the police or
22 the fire and rescue service, and sometimes elected
23 councillors and officials within local government will
24 feel that even at a local level there isn't always the
25 sharing of information that there should be, never mind

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1 between local and national.

2 **Q.** Yes.

3 **A.** A wider sharing of information is in everyone's
4 interests.

5 Then the second thing is, in terms of the role of
6 critical friend, I think again, as the Inquiry has
7 heard, improving the quality of training matters. We
8 have an Emergency Planning College which the
9 Cabinet Office maintains just outside York. I think
10 more, significantly more, could be done to improve the
11 work that it does and to share best practice.

12 Again, the Government Skills and Curriculum Unit
13 within the Cabinet Office, which was established by one
14 of the great officials I mentioned earlier, Pamela Dow,
15 and is now being led by another brilliant official,
16 Sapana Agrawal(?).

17 **Q.** In addition to which, does there need to be reflection
18 given to whether or not the practical manner in which
19 information is provided to local authorities and local
20 resilience fora, and I'm thinking in particular in terms
21 of the National Risk Assessment information --

22 **A.** Yes.

23 **Q.** -- cascading down so that that can be taken into account
24 in the local risk assessment, there needs to be
25 an assurance, surely, within central government that

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1 **Q.** -- or another body?

2 **A.** I think both. Again, when I was at DEFRA, I mentioned
3 I commissioned General Tim Cross to look at the level of
4 preparedness across local resilience fora for flooding,
5 and that work was useful in both stress testing, how
6 well prepared LRFs were, and making recommendations, and
7 one of the recommendations that Tim made, and again is
8 there in your question, is peer challenge and
9 peer review helps, that the democratically elected
10 leader who will be accountable -- and he or she will
11 often be the face and voice of a community at a time of
12 crisis -- should be involved.

13 Also there will be a level of expertise, whether at
14 an emergency planning college or equivalent or within
15 the Cabinet Office and RED, that can really test plans
16 and preparedness to make sure that they -- I was about
17 to say "conform", but at least match expectations.

18 **Q.** Yes. So a combination of both?

19 **A.** Yes.

20 **LADY HALLETT:** Mr Gove -- sorry to interrupt -- you said
21 a little while ago that in your experience some local
22 resilience fora were excellent and I quote you, some
23 "not so much".

24 **A.** Yes, my Lady.

25 **LADY HALLETT:** What kind of weaknesses did you identify in

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1 that practically is working, and that everybody who

2 needs to --

3 **A.** Yes.

4 **Q.** -- have access to the resilience hub is able to do so?

5 **A.** Absolutely, and I think that that is there in the
6 Resilience Framework that has been published, that the
7 NRA/NRSA work must be shared with those who will
8 potentially be at the frontline of response.

9 **Q.** What do you say about the evidence that my Lady heard
10 yesterday from Mr Lloyd about the level of assurance in
11 terms of pandemic preparedness and resilience of what is
12 going on at a local level? Because we know that the
13 central government doesn't have an assurance role in
14 terms of the plans that are drafted locally.

15 One option which Mr Lloyd presented to the Inquiry
16 yesterday was that there needed to be a procedure
17 developed during which local resilience fora could check
18 each other's plans, some sort of inline assurance given,
19 but that also he said democratic leaders -- locally,
20 democratic leaders should be involved in providing
21 a level of assurance.

22 Would that work, in your view, or should
23 consideration be given to some sort of central assurance
24 during and involving the RED process --

25 **A.** Yes.

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1 the local resilience fora where they were not so much
2 excellent?

3 **A.** The most conspicuous example was in the aftermath of the
4 Grenfell fire. I rejoined government just a few days
5 before the fire occurred. I used to live very close to
6 where the fire occurred and in the days afterwards
7 I spent some time just walking around the scene, and my
8 department is now responsible, obviously, for the
9 aftermath. And it struck me then that essentially, and
10 no individual is to blame, that that individual London
11 borough was simply not up to dealing with that tragedy.

12 Secondly, when I was at DEFRA I also had
13 responsibility -- or the department had responsibility
14 for some of the clean-up work after the Salisbury
15 Novichok poisoning. The local government figures in
16 Wiltshire, leader of the council and others, were
17 excellent, but some of the other people involved in
18 emergency work there a little less so, and I sensed that
19 sometimes we needed to, as we did at Grenfell, step in,
20 in order to help to shore up a structure that wasn't as
21 robust as it needed to be. In an ideal world every LRF
22 would be as strong as the best.

23 **LADY HALLETT:** Thank you very much.

24 **A.** Thank you, my Lady.

25 **MS BLACKWELL:** Community engagement.

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1 The Inquiry has heard from John Swinney, the deputy
2 First Minister from the Scottish Government, that
3 resilience has to be everybody's business, a sentiment
4 echoed by Gillian Russell, the former director of Safer
5 Communities in Scottish Government, and also
6 Professor Alexander, who told my Lady in his evidence
7 that at one level risks are essentially owned by all of
8 us, rather than by governments alone, and that we are
9 all responsible for our own safety.

10 Is it imperative that in preparing for a pandemic
11 and attempting to ensure that the community is as
12 resilient as possible, that there is significant
13 community engagement?

14 **A.** Yes, and even before. I think there are obviously
15 elements of preparedness for certain threats and hazards
16 that can't be shared with everyone, particularly with
17 threats. It would be obviously foolish to share with
18 states and non-state actors who might wish us harm how
19 we would respond in the event of a cyber attack or so
20 on. However, a broader conversation about the impact
21 that certain threats and hazards can have and how we can
22 build resilience within society, I think, is a good
23 thing.

24 As we saw in our media and in families and
25 workplaces, during and after the pandemic there has been
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1 involves competing priorities. It's not always possible
2 to satisfy every organisation, however noble its aims
3 and means, it's not always possible to provide them with
4 the list of policy changes or resource allocation for
5 which they press, but it is important to have as many
6 people as possible involved in conversations about risk
7 so that we can hear from voices which, as your question
8 implies, have sometimes been marginalised and overlooked
9 and who represent groups that were, of course, hit
10 particularly hard by Covid-19.

11 **Q.** It's important, isn't it, for those who, as you
12 acknowledge, might be the most affected --

13 **A.** Yes.

14 **Q.** -- by a pandemic for the government to understand the
15 ways in which that might happen and therefore might be
16 avoided, and it isn't difficult for the government to
17 reach out to -- particularly to those who represent
18 a great deal of people who are vulnerable both in terms
19 of general levels of vulnerability and health
20 inequalities?

21 **A.** Absolutely, but I think it is important when we have
22 these conversations that while groups that advocate for
23 those who are living with vulnerabilities should be
24 heard and should be respected, that we also make sure
25 that the conversation is not exclusively one in which
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1 a lively and informed conversation about the merits and
2 demerits of lockdown. I think that while government
3 can't mandate, it can help to lead and facilitate
4 conversations about how we, as a country, can be more
5 resilient in the face of certain threats and dangers,
6 whether those are as a result of climate change or as
7 the result of some of the threats to which I've alluded.

8 So I think having that conversation and also more
9 broadly reflecting on how civil society can remain
10 strong is part of a broader programme of resilience.

11 **Q.** The Inquiry has received witness statements from those
12 in positions of authority representing the
13 British Red Cross, the Campaigns and Justice at
14 Inclusion London, and also Disability Rights UK, which
15 is a leading pan-disability charity, whose evidence
16 reflects many organisations in a similar situation, and
17 that is that, in terms of pandemic preparedness, they
18 were not engaged with at all, at any level, by
19 government. Does that need to change?

20 **A.** I think it is important with preparedness for all sorts
21 of threats and hazards, including pandemics, that the
22 widest possible conversation takes place. But sometimes
23 it will be the case that government will disappoint
24 a particular group. As the Inquiry has heard from
25 David Cameron, George Osborne and others, politics
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1 pressure groups take the lead, but wider society has its
2 voices heard.

3 A brief point: we discovered during the pandemic,
4 medical experts would have known beforehand, that one of
5 the greatest vulnerabilities, one of the likeliest
6 comorbidities, was for those people who were living with
7 obesity, and I think that a broader conversation about
8 public health and the diet that we have and the
9 pressures that that creates is one which no single
10 group, I think, has a monopoly of wisdom on.

11 **Q.** Are you able to assist the Inquiry by telling my Lady
12 what plans are afoot in terms of a greater level of
13 co-operation with and consultation with these sorts of
14 groups?

15 **A.** In my view, government has to ensure, and this Inquiry
16 helps, that we are in conversation with those in local
17 government who are elected leaders from a variety of
18 parties and traditions, and that we are also in
19 conversation with groups that represent the marginalised
20 and those who are vulnerable. And in my own department,
21 the levelling up component involves me and my ministers
22 and officials spending as much time as possible hearing
23 from those people who are economically more vulnerable
24 and socio-economically more disadvantaged, and when it
25 comes in particular to one of my other areas of
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1 responsibility, housing, what has struck me, not just
 2 because of the pandemic but because of other factors, is
 3 that many of those who suffered most in the pandemic
 4 were living in overcrowded housing conditions or poor
 5 housing conditions, and the quality of housing
 6 particularly but not exclusively in the socially rented
 7 sector, has been an issue that has been underplayed.
 8 And we've made it our mission to ensure that the voices
 9 of tenants, particularly in the socially rented sector,
 10 are amplified when it comes to policymaking.

11 **Q.** Are you confident that the ties between those
 12 organisations, representing as they do the most
 13 vulnerable and those with health inequalities, are tight
 14 enough or could more be done?

15 **A.** More can always be done. I do not wish to make it seem
 16 trite, but I think health inequalities are some of the
 17 most striking inequalities within our society. But our
 18 society has a number of levels or layers of inequality.
 19 Again, in my work on levelling up, it's striking that
 20 while there is an enormous amount to celebrate about our
 21 country, that regional inequality, geographical
 22 inequality, is quite marked, and health inequalities are
 23 also geographically very striking, and the point has
 24 been well made that the difference in life expectancy
 25 between Kensington and Chelsea and Blackpool or even

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1 **A.** Oh, completely, but one of the reasons why ministers
 2 were told that there was a risk in lockdown and that
 3 toleration of lockdown would be limited was because of
 4 the behavioural science consensus with which we were
 5 presented. That's not to say that the people who were
 6 presenting were anything other than entirely rigorous
 7 and thoughtful in the way in which they assessed the
 8 evidence and presented it to us, but it's simply the
 9 case that the behavioural science assumptions turned out
 10 to be less, what's the word, accurate about the
 11 durability and the willingness of the public to accept
 12 restrictions on liberty.

13 Of course none of us would want to impose these
 14 restrictions, but it was an example, as it were, of
 15 a scientific consensus, framed on the basis of what was
 16 known, then changing over time as new evidence and new
 17 facts force the existing theory to adapt.

18 When -- you know, it became a cliché during the
 19 pandemic when people said we needed to "follow the
 20 science", what some sometimes forgot is that science
 21 itself changes and evolves as models improve because new
 22 evidence arrives.

23 **Q.** Does that suggest that the advice that was being
 24 provided to the government then on behavioural science
 25 and behavioural reactions to the imposition of rules and

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1 Glasgow is something that no country can contemplate
 2 with equanimity.

3 **Q.** You tell us in your witness statement that as the
 4 pandemic took hold and you became involved in meetings
 5 specific to the government response, that it appeared
 6 that the assumption had been that behaviours such as
 7 lockdown would not be viable for more than a brief
 8 period?

9 **A.** Yes.

10 **Q.** You will know that the Inquiry has heard from
 11 Matt Hancock, who talked about flawed assumptions being
 12 in place which affected the way in which planning went
 13 forwards.

14 This week we heard from Dr Kirchhelle, who suggested
 15 to my Lady that it was imperative going forwards for
 16 behavioural science and social science to form
 17 an important place in any planning of how we are going
 18 to be able to fight the next pandemic coming down the
 19 line, and the importance of appreciating the effect of
 20 how that pandemic is not only going to affect different
 21 people in different ways, but what society is likely to
 22 do by way of reaction to rules being imposed and matters
 23 of that nature.

24 Do you agree that behavioural science and social
 25 science has an important place in planning?

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1 regulations, that that was out of date?

2 **A.** Well, I think it was the best available evidence at the
 3 time. So, again, all of us have to recognise that when
 4 it comes to behavioural science it is different from, as
 5 it were, physics, chemistry and mathematics, where there
 6 can be a greater degree of precision in the expectation
 7 of what is going to happen if you -- you know, if you
 8 introduce one element into water or if you apply
 9 a certain degree of force to mass then certain things
 10 are likely to follow. Behavioural science, by its very
 11 nature, is based on observation but it is also the case
 12 that human beings in our infinite, what's the word,
 13 unpredictability will sometimes react to new crises in
 14 ways that people cannot predict accurately.

15 So behavioural science, like economics, is informed
 16 by past evidence and is shaped by expertise, but it
 17 cannot predict with certainty in the way that the hard
 18 physical sciences can.

19 So it became out of date, as we saw how people
 20 changed, but I would not want to criticise the people
 21 who put forward that evidence because they were acting
 22 in good faith, that was the best available evidence, it
 23 was just that new facts meant that we saw that it wasn't
 24 as accurate a predictor as we might have hoped.

25 **Q.** Is there a need, do you think, for there to be a greater

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1 challenge to behavioural science before the advice gets
 2 to ministers? In other words, if there was a wider pool
 3 of scientists from whom that advice was sought, there
 4 might be challenge inside the system which would bring
 5 about perhaps a more accurate depiction of what the
 6 reality is.

7 **A.** I think that is fair, but I think it is also politicians
 8 who are sometimes at fault. Because we ask our advisers
 9 for the facts, and, as I've mentioned, sometimes it
 10 is -- what we're really asking for is a prediction, and
 11 expert advisers can offer their best advice, we seek
 12 certainty but it's often elusive, and it would be better
 13 if politicians and decision-makers were to say, "Tell me
 14 about the debate, what is the lead option within the
 15 academic community here, but what also are the
 16 alternatives?"

17 So most people think that a lockdown would be very
 18 difficult, but are there some who argue that the
 19 tolerance for it would be greater? Similarly, most
 20 people assume that this virus emerged in the wet market,
 21 but some suggest it might be a lab leak. Where is the
 22 evidence? We need to have a certain degree of tolerance
 23 for the fact that we can't have certainty.

24 **MS BLACKWELL:** My Lady, I'm about to go on to a new topic.
 25 Is that a convenient moment to break?

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1 for the workforce capacity, and infrastructure of
 2 social care, and the fact that the lack of attention or
 3 the diversion of attention away from those
 4 recommendations, particularly in relation to adult
 5 social care, were a direct result of staff having to
 6 concentrate on preparations for a no-deal EU exit.

7 Do you accept that example as being a concrete
 8 example of a detrimental effect in terms of adult social
 9 care?

10 **A.** I'm not sure that I do, because I don't know what it is
 11 that would have been different in the approach that was
 12 taken toward adult social care that could have been
 13 anticipated beforehand. But of course the way in which
 14 the discharge of patients from NHS beds into adult
 15 social care was handled is an object of regret and
 16 concern, and in particular also the spread of Covid-19
 17 because of the use of agency staff who sometimes worked
 18 in more than one care home was a factor as well. So
 19 I think it is open to reflection.

20 **Q.** Thank you very much.

21 You are currently Minister for Intergovernmental
 22 Relations. What does that mean?

23 **A.** It means that I act on behalf of the Prime Minister in
 24 liaison with the devolved administrations. The
 25 Prime Minister, Boris Johnson when he took office,

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1 **LADY HALLETT:** Mr Gove, we take a break for the benefit of
 2 the stenographer, but we'll make sure that you leave
 3 this afternoon, we'll finish your evidence today.

4 **THE WITNESS:** Thank you very much, my Lady.

5 **LADY HALLETT:** Back at 3.10.

6 **(2.57 pm)**

7 **(A short break)**

8 **(3.10 pm)**

9 **LADY HALLETT:** Ms Blackwell.

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

11 Mr Gove, I'm asked to revisit one of the questions
 12 and answers that took place in the earlier session
 13 before the break, and it related to the evidence that
 14 you gave that, in your view, there was no proof that the
 15 workforce within government being focused or refocused
 16 on planning for the possibility of a no-deal EU exit had
 17 a detrimental effect on pandemic planning.

18 I have been asked on behalf of Scottish Covid
 19 Bereaved to draw to your attention one aspect of the
 20 result of the workforce being diverted that was covered
 21 by Mann and Alexander, Bruce Mann and David Alexander,
 22 in their expert report, in which they considered the
 23 recommendations and actions that had arisen out of
 24 Exercises Alice and Cygnus, including the adaptation of
 25 plans for and the revisiting of plans for social care,

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1 wanted to emphasise the importance of the Union and, as
 2 well as being Prime Minister and Minister for the Civil
 3 Service, was also Minister for the Union.

4 **Q.** Yes.

5 **A.** He wanted to have a minister working alongside him when
 6 he was liaising with the Scottish Government, the
 7 Welsh Government and the Northern Ireland Executive, to
 8 take up some of the day-to-day liaison work, and that
 9 devolved on to my shoulders.

10 **Q.** What does that liaison work consist of?

11 **A.** There are two aspects to it. One is there was
 12 an overhaul of structures, influenced very much by
 13 Andrew Dunlop's excellent report, which put on a firmer
 14 footing the nature of the co-operation conversations
 15 that we have.

16 The second is making sure that when the
 17 First Ministers and deputy First Ministers and other
 18 ministers --

19 **(Interruption)**

20 **MS BLACKWELL:** I think that's my voice, unfortunately.

21 **A.** I'm so sorry, terrible moment.

22 The -- so it involved making sure that when they
 23 needed to talk to the UK Government, if the
 24 Prime Minister was otherwise engaged that I would always
 25 be there, and particularly during Covid I had regular

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1 calls with -- Zoom calls with representatives from the
 2 devolved administrations.
 3 **Q.** John Swinney, deputy First Minister from the
 4 Scottish Government, has told the Inquiry that at one
 5 point in the run-up to Covid, and as the four nations
 6 were attempting to do their best to work together, that
 7 the relationship between the administrations,
 8 particularly in terms of Whitehall and Scotland, were
 9 pretty poor. Is that something that you recognise?
 10 **A.** I think it operates on two levels. So quite a lot of
 11 the time -- the majority of the time, in fact -- there
 12 was effective co-operation, and I think in the witness
 13 statement from the former First Minister she was pretty
 14 clear that, even though she has a radically different
 15 view of what the future of Scotland should be within the
 16 United Kingdom and a radically different view from the
 17 UK Government about Brexit, nevertheless on a day-to-day
 18 basis there was effective co-operation, and that was my
 19 experience.

20 However, the Scottish Government and those leading
 21 it have -- because of that divergent political view that
 22 I mentioned, they sometimes have an incentive to
 23 accentuate the negative in the relationship, because the
 24 overall political aim of the SNP is to present the
 25 United Kingdom as a dysfunctional state. But to their

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1 possible together, and I believe that although there
 2 have been ups and downs in the relationship that it is
 3 important to see and talk to colleagues in the devolved
 4 administrations as often as possible.

5 **Q.** In the situation that is currently persisting in
 6 Northern Ireland, the breakdown of the power-sharing
 7 agreement and the lack of ministerial oversight, how do
 8 you keep contact with Northern Ireland? Is there
 9 somebody in the absence of a minister there with whom
 10 you will share your concerns and reflections?
 11 **A.** Yes. So, in the absence of the Executive, it will be
 12 the Northern Ireland Civil Service, and the respective
 13 leads in the Northern Ireland Civil Service government
 14 departments with whom we will interact. Jane Brady, who
 15 leads the Northern Ireland Civil Service at the moment,
 16 for example came along to the recent
 17 British-Irish Council meeting at which the
 18 First Minister of Scotland, the First Minister of Wales,
 19 the Taoiseach, the Tánaiste, the UK Government and
 20 others were represented, and she did very effective job
 21 in making sure that Northern Ireland's interests were
 22 represented. But ultimately it's regrettable that we
 23 don't have ministers there.

24 Additionally, there is a bigger role to play for the
 25 Northern Ireland Office in the absence of an Executive,

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1 credit, Scottish Government ministers and
 2 Scottish Government officials on a day-to-day basis
 3 operate in a collaborative way.

4 **Q.** How often do you, in your role as intergovernmental
 5 minister, meet with relevant representatives from the
 6 other four nations and does that happen altogether or
 7 individually or both?

8 **A.** Both. The government publishes a quarterly report on
 9 the meetings that take place between the United Kingdom
 10 Government and ministers in the devolved
 11 administrations. There are some government departments
 12 that meet more frequently, like DEFRA, because of
 13 certain shared interests, others that meet less often,
 14 and sometimes the frequency intensifies. During
 15 Covid-19 it was very regular.

16 **Q.** Yes. Do you see your role as minister being beneficial
 17 to the sharing of plans for pandemics and for other
 18 national risks going forwards between the four nations?

19 **A.** Yes, for everything. Again, it can sometimes be the
 20 case that there will be some ministers at UK Government
 21 level who will express irritation that the Scottish
 22 Government or the Welsh Government might, after
 23 a particular meeting, place a political slant on it.
 24 I accept that, and it can be an irritation, but
 25 ultimately we all benefit from working as closely as

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1 not direct rule, of course, but certainly a bigger role
 2 to play in making sure that the liaison between UK
 3 Government and NICS is effective.

4 **Q.** Finally I would like to touch upon the United Kingdom
 5 Resilience Framework.

6 **LADY HALLETT:** Sorry, just before you do, could I ask
 7 a question following on --

8 **MS BLACKWELL:** Yes, of course, my Lady.

9 **LADY HALLETT:** I don't know if you heard the evidence,
 10 Mr Gove, but Michelle O'Neill talked about how, when she
 11 had worked at the Northern Irish equivalent of DEFRA,
 12 they had had a Fortress Ireland policy with the
 13 Republic of Ireland, and she was talking about how the
 14 same kind of thing ought to apply in the course of
 15 a pandemic because it's one epidemiological unit. I can
 16 never say that word.

17 So, question: to what extent, as far as
 18 intergovernment relations are concerned, you're involved
 19 with liaising with the devolved administrations but
 20 would it be the Foreign Office who would be involved
 21 with liaising with the Republic of Ireland?

22 **A.** It's a very good point, my Lady, because during the
 23 course of Covid-19 I would also have conversations with
 24 Simon Coveney and others in the Irish Government, and,
 25 for precisely the reasons that you mention, because the

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1 island of Ireland is a single epidemiological area,
2 there were questions about people who might arrive in
3 the Republic of Ireland, because they had a slightly
4 different approach towards flights and ferries, who
5 could then obviously, using the Common Travel Area, go
6 to Northern Ireland and then into the rest of the UK.

7 So we needed to have those conversations.

8 The conversations were generally led by the
9 Foreign Office and by our ambassador in Dublin.

10 It was also the case that there are very good
11 relations between our Cabinet Secretary, whoever he or
12 she is, and their equivalent in the Irish Government.

13 So it operates on several layers, but the FCDO is the
14 lead department.

15 **LADY HALLETT:** Thank you.

16 **MS BLACKWELL:** I was turning to ask you about the United
17 Kingdom Resilience Framework and to seek your views on
18 this: Bruce Mann and Professor David Alexander have told
19 the Inquiry that they don't think that, in its present
20 form as currently drafted, it fulfils the function of
21 a UK-wide resilience strategy.

22 The Inquiry has also heard that the
23 Scottish Government has published a hub and spokes model
24 of guidance, and that in Northern Ireland a civil
25 contingencies framework now replaces and consolidates

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1 You have provisionally provided permission for
2 ten minutes of questioning from Covid Bereaved Families
3 for Justice. May that be done, please? I think it's
4 Mr Weatherby.

5 **LADY HALLETT:** Mr Weatherby.

6 **Questions from MR WEATHERBY KC**

7 **MR WEATHERBY:** Mr Gove, I ask questions on behalf of Covid
8 Bereaved Families for Justice UK, which represents the
9 interests of many families from across the UK, and I've
10 got permission just on a discrete area, so not many
11 questions from me, you'll be pleased to hear, but
12 relating to the interplay between no-deal planning and
13 its effect on the response to Covid.

14 So I think your position is that there were
15 advantages that were gained from the no-deal planning
16 which -- they were unintended, but there were unintended
17 advantages which assisted with the response to the
18 pandemic as it happened.

19 So, for example, I think it's your position that the
20 standing up of a whole-system emergency structure was
21 something of a rehearsal which gave people experience;
22 is that fair?

23 **A.** Yes, it is fair.

24 **Q.** Now, would you also agree, though, that the planning for
25 no-deal identified a number of systemic weaknesses which

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1 a series of former protocols.

2 Will the government reflect upon the evidence that
3 the Inquiry has heard and look again at the way in which
4 the Resilience Framework is currently drafted and seek
5 to improve the current state, if indeed those
6 reflections suggest that improvement can be made?

7 **A.** Absolutely, and I think in my own evidence I reflected
8 on that. It's important that the devolved
9 responsibilities of the devolved administrations are
10 respected, and we can learn from, and I'm sure
11 the Inquiry has and will learn from, good practice in
12 each of the different parts of the United Kingdom.

13 But sometimes it is the case that the UK Government
14 needs to think UK-wide, and one of the reasons why
15 Public Health England was reformed and the UKHA was set
16 up was because, quite properly, some pandemic
17 preparedness and indeed some public health advice should
18 always be the province of devolved administrations, but
19 sometimes you do need, particularly in a polycrisis,
20 a UK-wide response that will involve consultation with
21 the devolved administrations but where sometimes you
22 need to take decisions at speed and the UK Government
23 flex there is critical.

24 **MS BLACKWELL:** Thank you.

25 My Lady, that concludes the questions that I have.

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1 were as likely to arise in the event that the UK was
2 affected by another type of civil emergency, and
3 obviously we're looking at pandemics here, but which
4 hadn't been previously identified in that sense; would
5 you agree with that proposition?

6 **A.** Yes, I think that preparation for any significant
7 challenge of that kind will stress test systems and will
8 expose some weaknesses within those systems. Government
9 is a project of continuous improvement, so it is
10 undoubtedly the case that some areas for improvement
11 will have been identified.

12 **Q.** Yes, they're pretty big areas, some of them. I just
13 want to advert to a couple of them. Did you hear
14 Mr Hancock's evidence?

15 **A.** I heard some of it and read all of it.

16 **Q.** Okay, that's helpful. I don't need to put it on screen,
17 then, but I'll just read to you a short passage from
18 Mr Hancock.

19 For the record, Day 10, page 64.

20 He said this:

21 "... the work done for a no-deal Brexit on supply
22 chains for medicines was the difference between running
23 out of medicines in the peak of the pandemic and not
24 running out. We came extremely close, within hours, of
25 running out of medicines for intensive care during the

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1 pandemic, it wasn't widely reported at the time, and
2 I think the only reason that we didn't run out is
3 because of the work that Steve Oldfield and his team
4 did, which they did during 2019, in preparation for
5 a no-deal Brexit, but became extremely useful in saving
6 lives during the pandemic.

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

16 Do you agree with that, first of all?

17 **A.** I don't disagree with it. It certainly chimes with my
18 recollection, yes.

19 **Q.** Yes, so a major unintended advantage coming from the
20 no-deal preparation; but the corollary of that is that
21 it highlights that before that the pandemic planning
22 hadn't identified this key problem?

23 **A.** Yes, I think that both the preparation for
24 a no-deal Brexit and the pandemic itself reinforced the
25 fact that, not just with medicines but with many other

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1 **A.** Yeah.

2 **Q.** And the lack of knowledge of food supply chains was
3 something that was identified with DEFRA around 2018 as
4 part of the no-deal preparations. So again, something
5 which may well have turned out to be highly pertinent in
6 a pandemic situation, again something that hadn't been
7 spotted before the happenchance of the no-deal situation
8 arising?

9 **A.** I think that is a perfectly legitimate conclusion.
10 I take one step back, which is that overall -- and this
11 is a critical question of resilience -- overall one of
12 the lessons of the pandemic is that if you are reliant
13 on just-in-time supply chains --

14 **Q.** Yes.

15 **A.** -- and if you're reliant on a very integrated network of
16 suppliers, some of whom if they come under stress might
17 fall over --

18 **Q.** Yes.

19 **A.** -- that has an impact on resilience, and there's
20 a trade-off between the efficiency that globalisation
21 has brought and the resilience of what might either be
22 called reshoring or friend-shoring.

23 **Q.** That raises the issue, doesn't it, that there may well
24 be clear economic advantages of last minute supply
25 chains, but in terms of planning for potentially

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1 medical goods and items of medical equipment, that the
2 nature of our supply chains in a globalised world -- and
3 I know it's something of a cliché -- was such that we
4 were -- they were fragile, and we reliant on -- as other
5 countries were -- the just-in-time delivery --

6 **Q.** Yes.

7 **A.** -- of commodities from some countries and actors that,
8 at a moment of crisis, would not necessarily be reliable
9 for us.

10 **Q.** Yes. So without the happenchance of another near miss
11 civil emergency, the no-deal Brexit arising, then we
12 would have gone into the pandemic in a very vulnerable
13 position with respect to vital drugs and, as you follow
14 on, other medical devices?

15 **A.** Yes, and I think that -- I hope it's not taking things
16 too far, but obviously one of the issues of concern
17 during the pandemic was the availability of PPE --

18 **Q.** I'm coming on to that, if I may.

19 **A.** Okay. Please, please.

20 **Q.** Sorry to cut across you there.

21 **A.** No, not at all.

22 **Q.** But, before I do, you mentioned earlier in your evidence
23 food supply.

24 **A.** Yes.

25 **Q.** And of course you were at DEFRA.

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1 catastrophic events, we had the nearest of misses,
2 according to Mr Hancock, in terms of medicines, and so
3 that was headed off at the pass, if you like, by the
4 happenchance of no-deal planning.

5 In terms of food supply chains, again we'll no doubt
6 look at this later on in another module, but perhaps the
7 same position wasn't quite so acute in the response with
8 food supply chains, but it might well have been.

9 But then you raised PPE. So PPE doesn't really
10 arise with no-deal preparations, so here we have
11 a systemic problem and it's not spotted by the
12 happenchance of something else and things turn out to be
13 not so great, again because of last minute supply
14 chains?

15 **A.** Yes, I think that's true, and I think it was true for
16 most western democracies. PPE was, in many cases
17 sourced, either from countries in the Middle East or the
18 Far East, not all of whom are necessarily reliable
19 democratic partners. And it was the case, I think,
20 that, for example, in Germany doctors protested outside
21 the Bundestag because of the lack of PPE, and there was
22 a strain here.

23 So I think again, to be fair to Matt Hancock and his
24 team, as part of pandemic flu preparedness there were
25 PPE stockpiles.

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1 Q. Yes. We're going to deal with that later, but my point
2 here is in terms of supply chains --

3 A. Yeah.

4 Q. -- and the fact that fortuitously in some areas another
5 near miss problem --

6 A. Yes.

7 Q. -- led to them being averted with Covid, but in other
8 areas it didn't, because it didn't arise.

9 A. I think that's --

10 Q. That's right, isn't it?

11 A. I think that's a legitimate point, yes.

12 Q. Okay.

13 Just finally, in terms of looking back at the Brexit
14 readiness, there was a report in December 2019 from the
15 Brexit Readiness Unit of the Cabinet secretariat.
16 I think you'll be familiar with that report, so
17 I probably don't need to go to it, but I can if we need
18 to.

19 Now, just for the record, it's INQ000149081, and at
20 paragraphs 5 and 6 it highlights that there were
21 a variety of issues regarding borders and in paragraph 6
22 what were termed regional sector support. So the --

23 A. Oh yes.

24 Q. -- there were challenges of the flow of people and
25 goods, security, trade, problems related to strategy,

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1 phytosanitary checks that food required, then DEFRA was
2 in the lead.

3 Q. Yes.

4 A. When it came to intelligence-led checks on migration and
5 whether or not there were individual bad actors who
6 might pose a threat to the country, obviously the
7 Home Office --

8 Q. Yes.

9 A. -- was in the lead.

10 Q. Yes.

11 A. Again, the point that I would make is that of course
12 when you have the sort of challenge that no-deal
13 planning required, you can often find that there are
14 parts of government or parts of the operation of
15 government that can be strengthened and were, but it is
16 never the case that any government can anticipate all of
17 the --

18 Q. Yes.

19 A. -- weaknesses within its operation.

20 Q. The point being, the conclusion at paragraph 5 is that
21 "These must be resolved quickly" and here we are in
22 December of 2019, just about on the cusp of Covid
23 occurring.

24 A. Yes.

25 Q. No doubt some of these wouldn't be related to the

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1 policy, planning, contingency and operational
2 management; and reference was made to political
3 direction and accountability, and a confusion of
4 co-ordination roles and the inefficient use of data, all
5 relating to borders.

6 I stress that this was related to the Brexit
7 preparedness or the no-deal preparedness, but the issue
8 of borders is again something that needed to be planned
9 for for pandemics, so some of those issues may well have
10 overlapped with pandemics as well, and again these are
11 issues that are only arising through no-deal; is that
12 right?

13 A. Yes. I think that there would have been some people in
14 government who would have been aware of them, but --
15 again if it's helpful -- the barriers to data sharing
16 referred to I think is a reference to the fact that HMRC
17 was not able, for understandable reasons, to share
18 commercial data with other government departments
19 because of the obligation of confidentiality it has to
20 the commercial actors with whom it deals. I found that
21 frustrating, but I can understand why it's a policy
22 factor.

23 More broadly, one of the issues is there was no
24 single government department in the lead for border
25 issues, so when it came to the sanitary and

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1 pandemic, but some of these issues would overlap with
2 it, and yet here again there's a systemic failing, isn't
3 there, to recognise in planning for pandemics that there
4 are issues that need to be looked at at borders?

5 I mean, borders are an obvious point with pandemics,
6 because you may need to control the flow of people
7 through them or to screen people or to quarantine
8 people.

9 So again, a systemic weaknesses in the pandemic
10 planning; yes?

11 A. Yeah, well, I'd put it slightly differently, which is
12 that: no matter how much thought might have been given
13 to some of the lessons learned from no-deal planning,
14 there was a broader question as well -- which the
15 Health Secretary alluded to -- which is that our
16 approach towards pandemic flu planning was that, and
17 that of many other countries, was that it was almost
18 impossible to so control our borders as to prevent the
19 disease spreading, it was about the mitigation of the
20 disease once it was here.

21 Q. Yes. Okay. With respect, that's a slightly different
22 point.

23 A. Indeed.

24 Q. As it turned out, we know that the control of borders or
25 issues relating to borders were relevant.

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1 A. Oh, they absolutely were.
 2 Q. Yes --
 3 A. But I think --
 4 Q. -- so a failure?
 5 A. But I think for the Inquiry -- again, it's not for me to
 6 say, but I do think that for the Inquiry one of the
 7 interesting questions -- and again I think Matt Hancock
 8 mentioned this -- is, you know, he outlined what one
 9 might call the Hancock doctrine, which is that rather
 10 than simply dealing with the consequences of a pandemic
 11 one should seek to prevent it arriving in the first
 12 place.
 13 Q. Yes.
 14 A. And I think that that is a lively debate and I have
 15 a lot of sympathy with the position he put forward.
 16 Q. Yes. And if that's the way forward, then getting the
 17 border situation and the co-ordination of people and all
 18 the matters I've just been through --
 19 A. Completely.
 20 Q. -- is absolutely key and --
 21 A. Completely.
 22 Q. -- therefore was a systemic failure at the time?
 23 A. Well, it was -- there are live counterexamples of
 24 countries that closed their borders, New Zealand being
 25 the most prominent, and again I'm sure the Inquiry will

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1 A. I don't think there was a failure at all. I think the
 2 point that was made here was, again, there was a tension
 3 between the Treasury, which wanted to make sure that it
 4 was aware of what the differential impact on certain
 5 sectors might be of a no-deal Brexit -- certain sectors
 6 would have been more exposed, others much more
 7 resilient -- and the individual government departments
 8 that hoped that they might be able to appeal to
 9 the Treasury for support for their particular sector,
 10 whatever it might be.
 11 Q. Yes.
 12 A. But if we look at the pandemic --
 13 Q. Yes.
 14 A. -- I think one of the things that was striking is the
 15 speed with which the Treasury --
 16 Q. Okay.
 17 A. -- was able to provide support and, as George Osborne
 18 pointed out in his evidence, that was a consequence of
 19 two things: one, the relative fiscal strength that
 20 the --
 21 Q. Okay, well --
 22 A. -- government had as a result of the decisions he took.
 23 Q. All right. I think, with respect, you're moving on to
 24 what actually happened in the response --
 25 A. Sure.

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1 want to look at what the strengths and weaknesses of
 2 that approach were --
 3 Q. Yes.
 4 A. -- because again, lockdown and border closure inevitably
 5 impose economic and social costs --
 6 Q. Okay.
 7 A. -- even as they can be very powerful tools in preventing
 8 or slowing the spread of a disease.
 9 Q. Yes. So having the option was essential?
 10 A. **(Witness nods)**
 11 Q. Now, finally what was referred to in this report as
 12 regional and sector support --
 13 A. Yes.
 14 Q. -- which is aka business and economic support.
 15 A. Yes.
 16 Q. The same point arises here, doesn't it, that here were
 17 issues spotted with respect to no-deal, a whole-system
 18 civil emergency, where there was a realisation --
 19 certainly in the no-deal planning, and here in the
 20 report at just before the Covid strikes -- that with
 21 such a whole-system civil emergency there may well be
 22 a need for proper economic support, both to businesses
 23 and furlough and other stuff, and again a systemic
 24 failure to look at that at all in terms of pandemic
 25 planning. Yes?

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1 Q. -- and no doubt the Inquiry will come back to that, and
 2 no doubt it will be arguable about the position that --
 3 A. Of course.
 4 Q. -- Mr Osborne adverted to.
 5 But here what I'm focusing on is that here's
 6 an identification that there isn't -- there hasn't been
 7 the thinking put into how you stand up quickly business
 8 and economic support more generally; and it's a systemic
 9 failure, isn't it, in respect of pandemic planning that
 10 that hadn't been thought of at all?
 11 A. I'm not sure that's the case, and I think that one would
 12 have to look at what the Treasury had prepared in the
 13 event of requiring rapid economic support for certain
 14 sectors, because the Treasury as a department tends to
 15 play its cards very close --
 16 Q. Okay.
 17 A. -- to its chest.
 18 **MR WEATHERBY:** All right. No doubt we'll do that. Thank
 19 you very much.
 20 **THE WITNESS:** Thank you.
 21 **MS BLACKWELL:** My Lady, that completes Mr Gove's evidence
 22 and indeed the evidence for today.
 23 **LADY HALLETT:** Thank you very much indeed for your help,
 24 Mr Gove, and you are now free to go, really grateful to
 25 you.

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1 **THE WITNESS:** Thank you very much, my Lady, thank you.
 2 **(The witness withdrew)**
 3 **LADY HALLETT:** We shall resume at 10.30 on Monday for the
 4 final evidence and closing submissions in this module.
 5 **MS BLACKWELL:** Thank you, my Lady.
 6 **LADY HALLETT:** Thank you very much.
 7 **(3.43 pm)**
 8 **(The hearing adjourned until 10.30 am**
 9 **on Monday, 17 July 2023)**

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