

Friday, 13 October 2023

(10.00 am)

(Proceedings delayed)

(10.04 am)

LADY HALLETT: Mr Keith.

MR KEITH: Good morning, my Lady. May I please call Alex Thomas.

MR ALEX THOMAS (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY

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

A. Alex Thomas.

Q. Mr Thomas, thank you for the assistance that you have already provided to the Inquiry by way of the provision of an expert report, largely focused upon the core political and administrative decision-making which is the focus of this module.

You prepared that report in advance, of course, of Module 2. Did you, as we can see there, provide a statement at the bottom of the first page confirming it's your own work and that the facts are within your knowledge and of course acknowledging your duty to provide independent evidence?

A. Yes, I did.

Q. You are, as it happens, a programme director at

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and analysis from colleagues, but all of which I would stand by based on my own judgement and experience.

Q. The Institute for Government has already published, has it not, during the course of the pandemic, a number of articles, reports and pieces of learning in relation to aspects of the government's response?

A. Yes.

Q. From March 2020 through in fact to December 2021, have you either contributed to or published yourself a number of reports looking at the government and civil service, touching upon issues such as the government's initial response, the Prime Minister's management style, coronavirus announcements, confusion over lockdowns and the imposition of tier restrictions, governance, the relaxation of rules, and so on? So really across the wide, broad breadth of the government's response.

A. That's correct. The way we produce work at the IFG is a mix of reflective research reports, of which I've authored or been a co-author of some directly focused on the pandemic, others that touch on aspects of the pandemic, but also more short-term, reactive, what we call comment pieces, which are, you know, 800 to 1000 words responding to events as they emerged over the course of the pandemic, but also across the whole of government business.

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a non-partisan think tank called the Institute for Government?

A. I am.

Q. What is the Institute for Government, please?

A. The Institute for Government, as you say, is a non-partisan think tank founded about 15 years ago with the objective of making government more effective.

Q. You are a programme director there. Do you still do the heavy lifting, or are you in a senior management responsibility role?

A. I lead our work on the civil service and policy making. That involves leading a small team of six or seven people, of researchers. They do a lot of the heavy lifting but I do do research and analysis myself.

Q. Whilst you give evidence, Mr Thomas, could I please remind you to keep your answers as slow as you humanly can.

A. I will do my best.

Q. Is, therefore, your report the product solely of your own research, opinions, conclusions and views, or have you drawn upon work and research done by members of your IFG team?

A. The report is a collection of the most relevant research that we, as a IFG team, have done. Some of it is my own work, my team's work, but it does reflect contributions

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Q. In the interests of transparency, do you confirm that in fact you were previously a civil servant from 2003 to the end of 2019, and during that time, part of that time, from 2011 to 2019, were you a senior civil servant?

A. That's correct.

Q. In the course of your job as a senior civil servant and before that a civil servant, did you work in a number of government departments, including what was then Department for Environment, Food and Rural Affairs, the Cabinet Office, the Department of Health and Social Care, the Cabinet Office again, and ultimately I think you concluded your career in the civil service in the Department for Environment, Food and Rural Affairs?

A. That's correct.

Q. All right.

Does your report focus on the "how" of government?

That is to say how it works, how efficient it is, and its capacity, its ability to do things, as opposed to the policies that it may produce from time to time?

A. It does. The remit of the Institute for Government as a whole is more about the "how" of government than the policy "what" of government. We tend to take the government's objectives as stated and then work on

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1 the administration of them and how to make them more  
 2 effective. That's reflected in the evidence I've  
 3 provided.

4 **Q.** Do you tell the government what specifically it should  
 5 do, or do you comment on the capacity and capability of  
 6 the things that it has done?

7 **A.** We do both. So we will analyse what government has  
 8 done, while making recommendations about how to improve  
 9 the processes of government.

10 **Q.** To improve the processes of government or to take  
 11 specific decisions differently in the future?

12 **A.** I think there is inevitably something of a blurred line  
 13 between the policy objectives of government and  
 14 the processes in which they administer those policy  
 15 decisions, but our core work and my core work would be  
 16 taking the government's objectives as stated and then  
 17 how best to translate them.

18 Sometimes, take for example work on an unrelated  
 19 policy like net zero, the work of the Institute for  
 20 Government takes as an assumption that successive  
 21 governments have wanted to take action on reducing  
 22 carbon emissions in the UK. We might then make  
 23 recommendations about how best to do that.

24 **Q.** I'd like to commence the substantive part of your  
 25 evidence by examining one after the other the various

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1 I suppose, the Cabinet Office's role in responding to  
 2 the various directions which may be placed upon it by  
 3 the Prime Minister, other government departments, or  
 4 external crises?

5 **A.** I think that's correct. I suppose when I describe it  
 6 like that, I was thinking more about the internal  
 7 dynamic in the Cabinet Office, which is principally  
 8 focused on the Prime Minister, and on the political  
 9 side, and the Cabinet Secretary and head of  
 10 the civil service on the administrative civil service  
 11 side. Those are the two core nodes around which  
 12 the Cabinet Office operates, but there is, you know,  
 13 a changing -- over the course of years and decades there  
 14 has been a changing cast of characters around a national  
 15 security adviser, a permanent secretary in  
 16 the Cabinet Office, a chief operating officer or chief  
 17 executive, a minister for the Cabinet Office,  
 18 a chancellor of the Duchy of Lancaster. I won't go on,  
 19 but each of these individuals tends to have a particular  
 20 place and authority in the system to which  
 21 the Cabinet Office institutionally, I found in my time  
 22 there, will respond.

23 **Q.** So would it be fair to say that administratively and  
 24 politically the Cabinet Office is a very fluid organism,  
 25 it needs to change the direction in which it faces

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1 government entities or departments or bodies that played  
 2 the greatest role in the government's response to  
 3 the pandemic. So we're going to start, if I may, with  
 4 the Cabinet Office.

5 Could we have, please, back up on the screen from  
 6 Module 1 INQ000204014, our much beloved spaghetti-gram.

7 You will see at the top of the page, Mr Thomas,  
 8 the Prime Minister, underneath whom there is  
 9 the Cabinet, and then under that the Cabinet Office, and  
 10 the Cabinet secretariat. I needn't trouble you for  
 11 the moment with COBR, we'll be coming back to that, and  
 12 obviously SAGE as well in yellow, again to which we'll  
 13 be returning to in due course.

14 The Cabinet Office sits at the very heart of  
 15 government, does it not?

16 **A.** Yes, it does.

17 **Q.** Is it indeed a multi-headed hydra, because it has  
 18 a large number of moving parts within it, a collection  
 19 of secretariats and the like?

20 **A.** Yes, it has for a very long, perhaps forever, been  
 21 almost impossible to draw an organogram, organisation  
 22 chart of the Cabinet Office, because by its nature it is  
 23 fluid and the way I put it in my evidence is that it  
 24 responds to the power structures of the day.

25 **Q.** Could you elaborate on that? Is that a reference to,

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1 depending on who is in the seat of power within  
 2 the Cabinet Office and who outside the Cabinet Office is  
 3 making demands of it?

4 **A.** Yes. I think there are certain core functions that  
 5 continue, and have more or less organisational  
 6 stability, a secretariat function, a civil contingencies  
 7 function, to which we will no doubt return, you know,  
 8 the sort of administrative and corporate headquarters of  
 9 the civil service, if you like. But the actual way  
 10 those are manifested has tended to change with time,  
 11 which is reflected in, at times, dramatic reductions in  
 12 the number of civil servants in the Cabinet Office, and,  
 13 over recent years, dramatic increases in the numbers of  
 14 civil servants in the Cabinet Office.

15 **Q.** And may the Cabinet Office be usefully divided into two  
 16 broad parts? You've got those parts of  
 17 the Cabinet Office by way of the secretariats which  
 18 produce policy and take decisions, for example  
 19 the National Security Secretariat, which you've  
 20 mentioned, the domestic or economic secretariats,  
 21 the Civil Contingencies Secretariat, formerly part of  
 22 the CCS, but it's now been changed, and then, by  
 23 contrast, the more functional side of  
 24 the Cabinet Office, so dealing with things like  
 25 procurement, project management, human resources,

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- 1 digital resources and so on; is that a fair distinction?
- 2 **A.** That's correct, and the former grouping would tend to  
3 tilt itself towards the Prime Minister and  
4 the collective Cabinet responsibility, although  
5 principally the Prime Minister, the latter towards one  
6 of the ministers in the Cabinet Office, whoever had the  
7 responsibility for those functions.
- 8 There is a third, even more amorphous grouping of  
9 policy teams in the Cabinet Office. For example,  
10 there's a minister for veterans' affairs at the moment.  
11 They will have a support team that sits in  
12 the Cabinet Office. There is now, since 2010,  
13 a constitutional capability in the Cabinet Office. So  
14 there are core teams that are more like line  
15 departments, if you like, but happen to be located, for  
16 various reasons, in the Cabinet Office.
- 17 **Q.** In general terms, where does much of the United Kingdom  
18 Government crisis machinery sit?
- 19 **A.** The co-ordinated response sits in the Cabinet Office and  
20 in the Civil Contingencies Secretariat.
- 21 **Q.** Does it therefore follow that in a crisis, for example  
22 a viral pandemic, that the Cabinet Office plays  
23 a primary -- I deliberately say a primary -- role in  
24 responding to the crisis?
- 25 **A.** That's correct.

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- 1 jobs require quite different capabilities and skills.  
2 So there's ongoing debate about whether those roles  
3 should be merged or not.
- 4 **Q.** It may be self-evident, Mr Thomas, but because  
5 the Cabinet Secretary, Janus-faced, has to face towards  
6 the Prime Minister and the civil service, for which he  
7 or she is responsible, as well as the national security  
8 infrastructure, not only is that a difficult role to  
9 perform, but it requires a distinct ability to be able  
10 to bring together all those various disparate parts,  
11 synthesise the information that they are providing and  
12 bring it together for the Prime Minister?
- 13 **A.** That's correct. I should also add the Cabinet Secretary  
14 is also, clearly, the secretary to the Cabinet, so has  
15 a Cabinet-facing role as well.
- 16 **Q.** Indeed.
- 17 **A.** Which, you know, is important both constitutionally and  
18 practically. But yes, being at the pinnacle of all of  
19 those different aspects of civil service in the state  
20 is, you know, a vital and very difficult role.
- 21 **Q.** You have obviously been given access to -- and we'll  
22 come to this in a moment -- the WhatsApps produced by  
23 Mr Cummings and the entries into Sir Patrick Vallance's  
24 evening notes, as well as, in fact, the dairies of  
25 others and text messages from other people. At a very

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- 1 **Q.** How important in a crisis is the role of  
2 the Cabinet Secretary, the body or the person, the role  
3 or the person to whom you made reference a few moments  
4 ago?
- 5 **A.** Very important, partly because they are the principal  
6 adviser to the Prime Minister, and reflect, if you like,  
7 the sharp end of civil service advice to  
8 the Prime Minister; partly because, more often than not  
9 in recent times, they are the head of the civil service,  
10 and so the person who is ultimately responsible for  
11 mobilising civil service and administrative capacity.  
12 Partly also, with relevance to Covid, because  
13 the Cabinet Secretary was also the National Security  
14 Adviser, who has particular responsibilities around  
15 the national security response in a crisis.
- 16 **Q.** So the Cabinet Secretary, in truth, performs a number of  
17 different, perhaps not altogether consistent, roles?
- 18 **A.** I think they can be consistent. Whether the ability to  
19 do them can be held in one person, however talented, is  
20 up for debate. A personal reflection on  
21 the Cabinet Secretary is that there -- it is in one  
22 sense very important for the Cabinet Secretary and the  
23 head of the civil service to be the same person,  
24 embodying the best advice to the Prime Minister and  
25 the best administrative response of the state, but those

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- 1 high level, they show the remarkable difficulty of  
2 the job of Cabinet Secretary, and in particular the way  
3 in which the Cabinet Secretary is obliged to try to  
4 operate institutional levers of power to try to make  
5 the system work, to try to bring it all together to  
6 enable the government to best respond in a crisis.
- 7 How important is the ability to exercise those  
8 institutional levers of power?
- 9 **A.** It is very important. And like so many things in the  
10 British system, it is more amorphous and sometimes  
11 unclear exactly what authority the Cabinet Secretary  
12 has. There is a parallel between the Prime Minister's  
13 primus inter pares, first amongst equals, role with his  
14 or her Cabinet, and the Cabinet Secretary's role with  
15 his -- always has been a his -- permanent secretary  
16 colleagues and colleagues within the Cabinet Office.
- 17 One of the things I would argue that hinders  
18 the Cabinet Secretary's ability to respond in normal  
19 times as well as in crises is a lack of clarity over  
20 exactly what authority the Cabinet Secretary has over  
21 the other levers of government, all of which have their  
22 own permanent secretaries, all of whose primary  
23 responsibility is to their Secretaries of State. That  
24 is, to some extent, a function of the constitutional  
25 set-up of the United Kingdom, but also creates, I would

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1 argue, administrative weaknesses.

2 That said, in a crisis, there is a "rally round  
3 the Cabinet Secretary" effect, but as time goes on  
4 clearly policy and administrative differences and  
5 difficulties can make it hard -- you know, even harder  
6 for the Cabinet Secretary to organise and assert  
7 themselves.

8 **Q.** Does the lack of a structural clarity, that is to say  
9 a lack of any written policy or protocol or  
10 constitutional arrangement, which sets out the limits of  
11 the Cabinet Secretary's role and his or her powers, mean  
12 that an even greater premium is placed upon the personal  
13 authority of that Cabinet Secretary, whoever he or she  
14 may be?

15 **A.** Yes, because, as I say, the lack of formal powers,  
16 I don't think those can make up for personal authority  
17 and status, but I think where, you know,  
18 a Cabinet Secretary might have come in, you know, new to  
19 the job or there might be some questions over their  
20 authority -- I mean, Simon Case himself has acknowledged  
21 that there's no job description for a Cabinet Secretary,  
22 and so to that extent they will be making it up as they  
23 go along and reliant on their own status with their  
24 colleagues and -- in the civil service. And,  
25 critically, with the Prime Minister.

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1 his most senior civil servant and principal  
2 civil service adviser, that would make it very difficult  
3 for the Cabinet Secretary to do their job effectively,  
4 which would obvious have knock-on consequences for  
5 the coherence, organisation and responsiveness of  
6 the system.

7 **Q.** Who has ultimate, indeed sole responsibility for  
8 the appointment of his or her Cabinet Secretary?

9 **A.** Well, therein lies a tale. The simple answer to your  
10 question is the Prime Minister. And it's for the reason  
11 that I said, which is that any Cabinet Secretary who  
12 loses the confidence of their Prime Minister won't last  
13 very long, and ultimately it's the Prime Minister who  
14 selects a Cabinet Secretary when they're appointed.

15 Some Cabinet Secretaries have been appointed through  
16 more or less open appointment processes, so there is  
17 an aspect of kind of the usual, if elevated,  
18 civil service appointment process, involving the First  
19 Civil Service Commissioner, and so on, but it would be  
20 fair to say that's an opaque process that ultimately  
21 lands on the Prime Minister's desk.

22 **Q.** We're going to look in due course at some of the -- more  
23 specifically some of the decision-making, particularly  
24 in the first few months of the pandemic. But by way of  
25 preface, Mr Thomas, in general terms, in those first few

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1 **Q.** Just to be clear, you've referred to Simon Case. Is  
2 Mr Case the current incumbent Cabinet Secretary, was he  
3 appointed in fact Cabinet Secretary in the autumn of  
4 2020, following Mark Sedwill, now Lord Sedwill?

5 **A.** That's correct.

6 **Q.** In general terms, the material, the WhatsApp, the diary  
7 material, the text messages, show a distinct degree of  
8 dysfunction, unhappiness or loss of confidence  
9 surrounding the role of the Cabinet Secretary, in  
10 particular during the first few months of the crisis.  
11 To what extent, in your opinion, did the loss of  
12 confidence in the Cabinet Secretary have an impact upon  
13 the government's ability to respond efficiently,  
14 properly and in good time to the various specific crises  
15 and decisions that it had to make?

16 **A.** So, I mean, from the material I've seen, I agree with  
17 you that they demonstrate a loss of confidence in  
18 the Cabinet Secretary in two particular individuals.  
19 I would only say from what I've seen two, but they are  
20 two very important individuals: the Prime Minister and  
21 his most senior adviser, Dominic Cummings. So I can't  
22 speak to a wider systemic loss of confidence in the  
23 Cabinet Secretary, but I would say that if, you know, if  
24 it is correct that the Prime Minister in particular did  
25 not have confidence in the performance and abilities of

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1 months, so particularly February, March, April, May, how  
2 would you rate the structural performance of  
3 the Cabinet Office in its ability to be able to deal  
4 with the emerging and then the actual crisis?

5 **A.** So from what I've seen it appears to me to be chaotic.  
6 Some -- many -- talented individuals working extremely  
7 hard, extremely long hours, but not in a decision-making  
8 structure that was good either at responding quickly and  
9 authoritatively to rapidly developing external events or  
10 synthesising complex material that was coming in from  
11 scientists, economic advisers, other government  
12 departments. We may well, I'm sure, get on to some of  
13 the specifics, but the responsiveness and the ability to  
14 synthesise seem to me to be somewhat lacking.

15 **Q.** In your report, you make the point that it is vital that  
16 the Cabinet Office and Number 10 act in lockstep. Very  
17 evidently, that ability to work together is a reflection  
18 in part of the way in which you've described that  
19 the Cabinet Office works towards and works with various  
20 multiple parts of government, and of course  
21 the Cabinet Secretary is the appointee of  
22 the Prime Minister, and the Cabinet Secretary is  
23 the secretary to the Cabinet, so that requires Number 10  
24 and the Cabinet Office to work closely together.

25 The Prime Minister is in Number 10, his chief

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1 adviser, Mr Cummings, was in Number 10, not  
2 the Cabinet Office. To what extent in general terms did  
3 the Cabinet Office and No 10 continue to act in lockstep  
4 from March 2020 through to the early autumn, the late  
5 summer of 2020?

6 **A.** Of course it's -- you know, Number 10 is part of  
7 the Cabinet Office, so they are, in some respects,  
8 the same organisation, but as you imply there is a very  
9 distinct culture, rightly, in Number 10 that is focused  
10 around the Prime Minister, and there is a link door that  
11 you need a special pass to access and once you go  
12 through that link door the environment is very  
13 different. So that's by way of preface to agreeing with  
14 you that the two are, you know, the same but separate.

15 It does seem to me from the material I've seen, we  
16 made the point in some of our research, based on  
17 publicly available or media reporting, but also from  
18 some of the material available to the Inquiry, that  
19 because of the perceived loss of confidence by very  
20 senior people, political people in Number 10, there was  
21 a loss of confidence in the Cabinet Office that led to  
22 an unhelpful divergence which put excessive strain on  
23 individuals working in Number 10 -- Number 10 is  
24 absolutely not equipped to deal with  
25 a whole-of-government crisis in this way -- and pushed

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1 This, Mr Thomas, is a WhatsApp message from  
2 Mr Cummings to Mr Johnson, and it's attached to a letter  
3 which Mr Cummings wrote to the Inquiry. The top  
4 WhatsApp is dated 12 March. I'm not going to read it  
5 all out, it's self-evident and the theme and the tone  
6 and the manner of it is very clear.

7 In general terms, it is extremely damning of  
8 the state, the function, the ability of the  
9 Cabinet Office to operate.

10 With an appropriate nod to the intemperate language  
11 that Mr Cummings habitually appears to deploy, and to  
12 the manner of his language, does it matter -- or rather,  
13 to what extent does it matter that the chief adviser  
14 then to the Prime Minister has such views of  
15 the Cabinet Office?

16 **A.** It does matter. And of course, you know, implicit in  
17 your question is this is, you know, one person's view as  
18 expressed. It does matter, because it goes to both,  
19 I mean, obviously the content of that message goes to  
20 the authority of the Cabinet Secretary and the  
21 confidence in which the political team has in him, and  
22 precisely that point about the divergence between  
23 Number 10 and the Cabinet Office that means  
24 the principal political adviser to the Prime Minister  
25 does not have confidence in the civil contingencies

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1 out those in the Cabinet Office whose job would  
2 otherwise have been to perform the functions I said  
3 earlier about rapid response and synthesis of evidence.

4 **Q.** You say Number 10 is absolutely not equipped to deal  
5 with a whole-of-government crisis in this way; is that  
6 for two reasons: firstly, the crisis machinery rests  
7 largely in the Cabinet Office, and therefore it's not  
8 Number 10 which has to deal with crises, but also that  
9 the absolute number of staff, employees, personnel in  
10 Number 10 is not built for a whole-of-government  
11 response?

12 **A.** Yes. Number 10 has grown somewhat, I understand, in  
13 recent years, but total numbers of staff are, you know,  
14 200, 300. Most of those are support staff, operational  
15 staff. There are a handful of private secretaries.  
16 There's a small policy unit. Those functions are about,  
17 yes, giving some personal advice to the Prime Minister,  
18 but also transmitting information and advice from  
19 the rest of government to the Prime Minister, and then  
20 transmitting the Prime Minister's decisions out to  
21 the rest of government. They are not, in any means,  
22 a crisis response machine, and you can't run a crisis  
23 response from Number 10 for those reasons.

24 **Q.** Could we have, please, on the screen, INQ000048313, at  
25 page 22.

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1 architecture that is there to synthesise and advise on  
2 an emerging breaking crisis.

3 **Q.** It's important, isn't it, that you note that  
4 Mr Cummings' views are, of course, only his own views.  
5 The reference to Mark is to Mark Sedwill, the then  
6 Cabinet Secretary, but that of course is only  
7 Mr Cummings' view.

8 So your point is, isn't it, that regardless of  
9 whether or not Mr Cummings' personal view of  
10 the Cabinet Secretary was right or wrong, the very fact  
11 that the Prime Minister's chief adviser is expressing  
12 these views has of itself a damaging effect and may also  
13 be reflective of a pre-existing and extremely  
14 unfortunate structural problem at the heart of Number 10  
15 and the Cabinet Office?

16 **A.** I think that is a fair conclusion. I would make just  
17 a couple of points of context. One is I think  
18 Mr Cummings has expressed forceful views in many places,  
19 and also government is a stressful and difficult  
20 environment. It is not that unusual for someone  
21 privately to express forceful views behind somebody  
22 else's back about their performance, and for that not  
23 really to reflect their true views. So I think there is  
24 a question there about exactly the consistency and  
25 completeness of Mr Cummings' view.

20

1 Secondly, there is an incentive sometimes  
 2 culturally, a very poor incentive, to be critical about  
 3 others in front of the principal, as civil servants and  
 4 advisers might call them. So to go into a minister's  
 5 office or to send the Prime Minister a message saying,  
 6 you know, "Isn't so-and-so terrible", because that is  
 7 part of the sometimes court-like, courtier-like  
 8 environment that can operate detrimentally in senior  
 9 places in the top of government.

10 **Q.** I'm going to put that proposition back to you, please,  
 11 Mr Thomas, rephrased. So are you saying that in  
 12 the high octane and febrile atmosphere of high  
 13 government, high political government, everybody  
 14 slagging each other off is not uncommon?

15 **A.** It is more common than it should be.

16 **Q.** My Lady, these WhatsApps of course reflect other no less  
 17 important but different substantive issues, for example,  
 18 in relation to the government's response in terms of the  
 19 imposition of social restrictions and the operation of  
 20 COBR, to which we'll come back to, through other  
 21 witnesses. Included in that observation there is this  
 22 reference at the bottom of the page to the DAs. I'll  
 23 come back to you on that in due course.

24 Page 7, please, of this document.

25 This is dated 14 March, in another WhatsApp string,  
 21

1 "This is what the Warners, [that's Ben and  
 2 Marc Warner] have been screaming at me. Patrick has  
 3 been 'the policy machine is off the pace' -- but YOU [so  
 4 he is speaking to Mr Johnson there] need to tell Sedwill  
 5 this."

6 And the degree of intemperate language and  
 7 aggression, volatility, is of itself unfortunate.

8 **A.** I agree.

9 **Q.** Page 56, 57, this is an extract from a letter that  
 10 Mr Cummings wrote to the Inquiry. He has cut and pasted  
 11 an older historic, historical email dated 13 July 2020,  
 12 into his letter. He says it's:

13 "An email I sent on the problems of the No 10/CabOff  
 14 set up that is relevant to the Inquiry, 13 [July] (it  
 15 was copied to [the Prime Minister] but he never engaged  
 16 seriously)."

17 And the email, if we go over the page, please, of  
 18 13 July contains at the second paragraph on that page,  
 19 these words:

20 "Current CABOFF doesn't work for anyone -- it's high  
 21 friction, low trust, and [obviously] many good parts but  
 22 overall low performance. From [permanent secretaries]  
 23 to lower ranks, nobody I've spoken to across Whitehall  
 24 thinks it works well. And covid shone an unforgiving  
 25 light on parts including CCS ..."

23

1 group, thread. Mr Cummings says:  
 2 "Talked to Sedwill [that's Lord Sedwill, the  
 3 Cabinet Secretary] and he is still miles off pace."  
 4 Then this:  
 5 "... the problem is CabOff [Cabinet Office] and DHSC  
 6 haven't listen and absorbed what the models truly mean."  
 7 **LADY HALLETT:** Sorry, just before you go on, Mr Keith, who  
 8 sent the messages at the top, "We need to draw lessons",  
 9 who sent ...? Because there's a copied -- further down,  
 10 it's where you copy the message to respond to it. So  
 11 who send the "Talked to Sedwill and he is still miles  
 12 off pace"?

13 **MR KEITH:** Mr Thomas, are you able to say whether or not the  
 14 first white WhatsApp comes from a different origin than  
 15 the second one?

16 **A.** I mean, those two -- based on my understanding of  
 17 WhatsApp, those two look like they come from the same  
 18 person, and that person is down as -- I assume this is  
 19 Mr Cummings' mobile phone -- down as Johnson Boris, who  
 20 I assume is Boris Johnson.

21 **Q.** So "Yup. Nothing like it since at least 1918 and maybe  
 22 much longer" is a response from Mr Cummings?

23 **A.** If this is Mr Cummings' -- a screenshot from  
 24 Mr Cummings' phone, yes.

25 **Q.** Then, at the bottom of the page, Mr Cummings again:  
 22

1 Is CCS the Civil Contingencies Secretariat, the  
 2 secretariat within the Cabinet Office primarily  
 3 concerned with crisis response?

4 **A.** I assume so, yes, that would make all the sense in  
 5 the world.

6 **Q.** If Mr Cummings is to be -- if his words are to be  
 7 accepted in this regard, and if he is to be believed in  
 8 this regard, that would tend to suggest that  
 9 the dysfunctionality of the Cabinet Office was not just  
 10 a view held by him, but it was held across Whitehall.

11 **A.** It would, and that would also be consistent, you know,  
 12 in the interests of sort of full disclosure to  
 13 the Inquiry, with conversations that I and others had  
 14 around that time.

15 I find this note a much more kind of -- a less  
 16 intemperate and more convincing critique of  
 17 the machinery of government as it was operating than  
 18 some of the previous messages, which lack context, and  
 19 as I -- you know, for the reasons I've said previously.

20 **Q.** Sir Patrick Vallance's evening notes also contain  
 21 a multitude of references to chaos in Number 10, to  
 22 infighting, factionality in Number 10. He says that  
 23 according to the Cabinet Secretary himself -- this is in  
 24 November 2020, so that would be Simon Case:  
 25 "... No 10 [was] at war with itself -- a Carrie  
 24

1 faction (with Gove) & another with SPADs ..."

2 So that presumably would include Mr Cummings and

3 perhaps some others.

4 "PM caught in the middle. He has spoken to all his

5 predecessors as [Cabinet Secretary] & no one has seen

6 anything like it."

7 That diary entry is from November later in the year,

8 six months later. It would seem, again, and due caution

9 of course must be applied to the accuracy of WhatsApps,

10 which lack nuance and can be intemperate, and also diary

11 entries which may not accurately reflect the reality of

12 the position day by day and may indeed even have been

13 drafted for a different audience, but if we accept

14 the factionality and infighting was still taking place

15 in November, is that not rather incredible that the two

16 departments at the heart of the government, which were

17 obligated to respond to this crisis, Number 10 and

18 Cabinet Office, were still fighting, at least in part,

19 six months later?

20 **A.** I think many things about that period were incredible

21 and concerning. On this particular point, though, my

22 assessment would be that something slightly different

23 was going on, which was that in the early period of

24 the response to the pandemic, February, March,

25 April 2020, there was an anxious and chaotic and

25

1 the structures that were then in place, latterly

2 the dysfunctionality lay more in the personalities and

3 their working relationships and indeed the people who

4 were in government?

5 **A.** Clearly in a complicated and, you know, extraordinary

6 situation, that is something of a simplification, but

7 it's a simplification I would be happy to endorse.

8 **Q.** I'm very pleased to hear you say that.

9 COBR. If we go back, please, to the chart at

10 INQ0002041014, page 4, a certain amount of evidence,

11 quite a lot of evidence, was received in Module 1,

12 Mr Thomas, on COBR and its position in the government

13 structure and on its functions, but we'll remind

14 ourselves of where it is. We can see it's the yellow

15 box towards the top of this page, the Cabinet Office

16 Briefing Rooms, hence COBR. And there have been plenty

17 of references to COBRA with an A, was that because once

18 upon a time one of those Cabinet Office briefing rooms

19 was called room A, so it became COBRA?

20 **A.** It is partly that. I think it is probably more because

21 of the resonance of the acronym that it sustains.

22 **Q.** It is COBR that is the machinery for dealing with crises

23 in the first instance. Is it a ministerial

24 decision-making body, or is it a body that brings

25 together ministers, officials, public servants and

27

1 sometimes divided situation between the Cabinet Office

2 and Number 10. Then over the course of the summer, we

3 may come on to this, the Covid Taskforce was

4 established, and relationships, while not being perfect,

5 seemed to me to be -- very far from perfect -- seemed to

6 me to be improved because of the more effective crisis

7 response and synthesis of advice.

8 My reading of the Sir Patrick Vallance diary

9 referred to -- which, as you say, was November 2020,

10 I was unsurprised by that, because that was when there

11 was a very, very public falling out between

12 Dominic Cummings and Lee Cain and the Prime Minister,

13 leading to Mr Cummings and Mr Cain departing

14 Downing Street shortly afterwards.

15 I would also suggest that that was -- that seemed to

16 me, from the outside, to be an internal Number 10

17 falling out rather than a structural disagreement

18 between the Cabinet Office and Number 10, related

19 strongly to the approaches, personalities and

20 relationships between the Prime Minister and some of his

21 closest political advisers.

22 **Q.** May, therefore, the position be summarised in this way:

23 that in the early part of the pandemic, in those early

24 months, the dysfunctionality, if that is what my Lady

25 finds there to be, was reflective of the system,

26

1 the like in order to be able to respond to a crisis?

2 **A.** It's the latter, it is primarily a co-ordination body.

3 **Q.** Does the Civil Contingencies Secretariat act, as it

4 suggests it does, as the secretariat for whatever COBR

5 meeting has been convened?

6 **A.** It does.

7 **Q.** Who may chair a COBR meeting?

8 **A.** Any minister or a senior official. The starting point

9 for who would chair it would be the Prime Minister, but

10 it is entirely reasonable, and often happens, for

11 the Prime Minister to delegate that to another minister

12 whose remit and responsibility and seniority would

13 depend on the nature of the crisis. It is also

14 sometimes possible for a senior official to chair COBR.

15 **Q.** COBR is not engaged, is it, for all crises, the crisis

16 or the emergency has to meet a certain level of

17 seriousness, a certain threshold, in fact it has to be

18 a level 2 or a level 3 emergency before COBR is

19 generally convened?

20 **A.** Generally. I would take slight issue with the "it has

21 to be", because there certainly have been examples --

22 Gordon Brown, you know, famously had quite a low bar for

23 triggering a COBR crisis. There is obviously

24 a political and presentational benefit sometimes to

25 convening a meeting. So the bar for convening a COBR

28

1 has fluctuated depending on the personal preferences of  
2 the Prime Minister. But, yes, if you want  
3 an administrative "What is the test for calling a COBR  
4 meeting?" it's that level 2 response.

5 **Q.** The first COBR meeting concerning the response to Covid  
6 was held on 24 January, was it not?

7 **A.** That's my understanding, yes.

8 **Q.** The material shows that Matt Hancock MP, who was then  
9 secretary of state of the lead government department,  
10 the Department of Health and Social Care, chaired  
11 the COBRs on 24 January, 29 January, 4 February,  
12 12 February and 18 February; is that correct?

13 **A.** That's my understanding, so I --

14 **Q.** There was no COBR convened between 18 February and  
15 2 March, it's an issue we'll be reverting to in due  
16 course, and the Prime Minister, the then Prime Minister,  
17 Mr Johnson, convened or chaired his first COBR on  
18 Monday, 2 March.

19 You have explained how there is no administrative  
20 obligation on the Prime Minister to chair a COBR, but  
21 there may be a presentational advantage in so doing. Is  
22 it your view that presentationally that was  
23 an opportunity missed by the Prime Minister, given  
24 the state of the crisis in late February?

25 **A.** There is a presentational benefit to the Prime Minister  
29

1 invitations, to my mind perfectly naturally, then were  
2 sent to the First and in Northern Ireland First and  
3 deputy First Ministers to attend those COBR meetings.

4 I understand from the Inquiry, but not my own  
5 research, that Mark Drakeford, the First Minister of  
6 Wales, did participate in one earlier COBR meeting.

7 **Q.** So, to be absolutely clear, the health ministers from  
8 the devolved administrations, so that would be  
9 Vaughan Gething from the Welsh Government, Robin Swann  
10 from the Northern Ireland Executive, and Jeane Freeman,  
11 the Scottish Cabinet Secretary for Health, they all  
12 attended from 24 January. Mr Drakeford first attended  
13 on 18 February, but Nicola Sturgeon, Arlene Foster and  
14 Michelle O'Neill attended, respectively, for the first  
15 time from 2 March.

16 **A.** I understand that to be the case. As I say, given  
17 the Prime Minister did not chair COBR until 2 March,  
18 that pattern of invitations doesn't surprise me.  
19 I don't know why Mr Drakeford attended the earlier  
20 meeting. It could have been -- you know, my view would  
21 be that that was either because he was particularly  
22 concerned about the emergence of the crisis, or for  
23 a far more simple administrative reason that  
24 Vaughan Gething perhaps couldn't attend or Mr Drakeford  
25 happened to be in London or, you know, something else.

31

1 in chairing COBR. There is also, I perhaps should have  
2 said, an operational benefit inside government for  
3 particular types of crises to the Prime Minister  
4 chairing COBR.

5 I suppose I have a -- you know, given what we  
6 subsequently know, I would have a, you know, moderate  
7 view that presentationally it would have been beneficial  
8 for the Prime Minister to chair an earlier COBR.  
9 I would have a stronger view, given what we now know,  
10 that the signal it would have sent, that this required  
11 a whole-government response, the Prime Minister was  
12 personally engaged in that, and that all departments  
13 needed to give their maximum possible attention to this  
14 crisis, that is actually the reason I think, rather than  
15 presentation, why it would have been beneficial for  
16 the Prime Minister to chair COBR sooner.

17 **Q.** Have you been able to ascertain what the position was in  
18 relation to representatives of the devolved  
19 administrations in relation to their attendance at COBR?

20 **A.** My understanding, again, and I thank the Inquiry for  
21 brief advance notice of that particular question, is  
22 that when Matt Hancock MP was chairing the COBRs,  
23 the invitations went to the devolved administration  
24 Health Secretary equivalents, and so they attended COBR  
25 until the Prime Minister chaired the 2 March COBR when

30

1 These things often happen.

2 **Q.** My Lady, that I hope answers the question that you posed  
3 yesterday in the course of the hearing as to the first  
4 dates of attendance.

5 Could you please have a look at INQ000273841,  
6 paragraph 43. I'm afraid I don't have a page number.

7 **(Pause)**

8 It will probably be around the late teens. There we  
9 are, thank you very much.

10 Helen MacNamara was a senior civil servant, at one  
11 stage in fact Deputy Cabinet Secretary. This is  
12 an extract from her statement. She says this in  
13 paragraph 43:

14 "One of the things we should have done earlier is  
15 move away from the COBR decision making structure.  
16 Mr Johnson had never warmed to COBR -- it did not suit  
17 his working style to come through to the basement of the  
18 Cabinet Office, away from his study and his political  
19 team. Unusually in my experience of Prime Ministers, he  
20 clearly felt it was not his territory. As the Covid-19  
21 situation became more immediate it was not working and  
22 definitely would not work as the crisis worsened."

23 So the COBR room is in the basement, is it not, of  
24 the Cabinet Office? It's not actually in No 10  
25 Downing Street?

32

1 A. That's correct.

2 Q. In the material that you have seen, have you seen any  
3 material which is reflective of Mr Johnson's view, in  
4 February, of the degree of seriousness of the crisis  
5 which appeared to be emerging?

6 A. I suppose -- I mean, thinking about the material that  
7 I've seen -- you know, judged by his actions and his  
8 decisions about the early COBR meetings and others, but  
9 also as or more relevantly, I think, the publicly  
10 available information about things he said in early  
11 press conferences and so on, my assumption is that he  
12 thought that this was a containable and not --  
13 a containable situation and not a situation that  
14 demonstrated the seriousness which, you know, very  
15 rapidly became evident.

16 Q. COBR, as we can see, continued to sit through March, in  
17 fact it carried on sitting, convening until May. But  
18 where in the middle of March and late March were those  
19 singular and momentous decisions that affected the whole  
20 country actually being taken? So, example, by way of  
21 example, decisions to close schools or to impose social  
22 restrictions, ultimately of course the imposition of  
23 the national lockdown from 23 March with legal effect  
24 from the 26th, where were those decisions taken? Were  
25 they taken in COBR or were they taken elsewhere?

33

1 whatever COBR informed the Prime Minister, any decisions  
2 taken by COBR were liable to be undone, changed or  
3 corrected by the Prime Minister.

4 A. Well, COBR could provide a forum particularly, as  
5 Helen MacNamara makes the point there, that the devolved  
6 administrations were part of the COBR meeting, to  
7 discuss possible approaches -- well, to first receive  
8 information from what was happening on the ground and  
9 then discuss possible approaches that could legitimately  
10 inform a Prime Ministerial decision in whatever forum.  
11 That obviously leaves certain lacuna, the most obvious  
12 being the devolved administrations' actual involvement  
13 in those decisions.

14 So again, this architecture -- so you asked about  
15 the value of it, you know, it is not uncommon in  
16 government for meetings or institutional architecture to  
17 outlive its usefulness. There's a path dependency to  
18 that. So, as Ms MacNamara says there, you know, I'm not  
19 surprised by her view that they should have moved away  
20 from it earlier, but in and of itself, if COBR was  
21 providing a useful input to Prime Ministerial  
22 decision-making, it's not inherently illegitimate for it  
23 to continue to exist.

24 That was a little convoluted, I apologise, but  
25 I hope you get my drift.

35

1 A. From the material I've seen, it seems that most of those  
2 were taken elsewhere, in meetings in Number 10 or in  
3 other, you know, Cabinet committees or ad hoc fora.  
4 I think there is, we may come on to this, plenty to  
5 criticise about how that decision-making structure might  
6 have worked. I don't think inherently it was wrong not  
7 to take them in COBR, because, as we discussed earlier,  
8 COBR is primarily a co-ordination and immediate crisis  
9 response function. It functions well if, for example,  
10 there was a -- you know, could always be improved, but  
11 if there was a terrorist incident or a major  
12 environmental incident that principally required  
13 operational co-ordination.

14 COBR, in my experience and view, is not a policy  
15 decision-making forum. So one of the institutional gaps  
16 that it seems to me existed at this time was  
17 an authoritative and coherent policy making forum that  
18 was well advised by synthesised advice from across  
19 government.

20 Q. Putting it another way, Mr Thomas, what was the point of  
21 having COBR convened and to continue to be convened  
22 through March if, in reality, the momentous decisions of  
23 which I've spoken were being taken in a study in  
24 Number 10 by the Prime Minister on the advice of his  
25 closest advisers? Because whatever COBR decided, or

34

1 Q. But if COBR, although a useful contributor, was not  
2 the primary decision-making forum, as it is meant to be  
3 in a crisis, and if, at least to some extent, it became  
4 something of a Potemkin village, it became  
5 an opportunity for the devolved administrations to be  
6 seen to be part of the process but then the decisions  
7 were actually being taken elsewhere, then it wasn't  
8 really fulfilling the terms of its instructions?

9 A. I agree, but I would also return to the point -- and  
10 I would return to the point that COBR is not designed to  
11 be a policy-deciding forum. It is a forum that, if you  
12 like, applies policies that already exist to  
13 the operation of the situation on the ground, and allows  
14 ministers to input to control that and to influence that  
15 situation. But I would -- you know, I agree with your  
16 principal point, which was that it would appear that  
17 there was a meeting happening that was steadily losing  
18 whatever value it had, and it outlasted its usefulness.

19 Q. The civil service, and in particular  
20 the Cabinet Secretary, Mark Sedwill, appreciated that  
21 there had to be change, and around 17 March did  
22 Lord Sedwill, then I think Sir Mark Sedwill, recommend  
23 the establishment of what were known as ministerial  
24 implementation groups to deal with four areas, four key  
25 areas: health, public services, economic response and

36

1 international aspects, each group chaired by a different  
2 senior minister?

3 **A.** That's correct, as I understand it.

4 **Q.** Around the same time, did the core decision-making,  
5 particularly insofar as it revolved around  
6 the Prime Minister, start to take place at a meeting or  
7 meetings held at 9.15 every morning in Number 10?

8 **A.** That's my understanding.

9 **Q.** Could we have, please, INQ000182338. This is the  
10 Cabinet Secretary's note recommending the changes to  
11 what are called machinery of government. "Covid-19:  
12 next phase", it's dated 13 March:

13 "1. We need to step up a gear ... A pandemic of  
14 this scale is no longer solely a health crisis ...

15 "2. In times like this people need to know that the  
16 Government has their back and is competent,  
17 compassionate and calm."

18 He tells the Prime Minister in paragraph 3:

19 "You have brilliantly managed public messaging and  
20 decision-making in this first phase."

21 But nevertheless he proceeds to say that  
22 the structure of government requires significant reform,  
23 and if we go over the page to page 2, he proposes the  
24 ministerial implementation groups and the daily smaller  
25 meeting. It says:

37

1 not structurally the Cabinet Office and Number 10 and  
2 the decision-making process at the heart of  
3 the government was actually performing effectively?

4 **A.** Yes.

5 **Q.** Do you know why, in general terms, the MIG system,  
6 the four ministerial implementation group system, was  
7 replaced so relatively soon after its commencement?

8 **A.** I believe that there were two principal reasons. One,  
9 from the documents I've seen as part of the Inquiry and  
10 elsewhere, was that it quite rapidly became clear that  
11 there were overlapping remits, that the co-ordination  
12 between these four MIG structures was not working well,  
13 they were trespassing on each others' policy and  
14 operational functions, and that decision-making through  
15 those MIGs was proving difficult.

16 The second reason, that I haven't seen through  
17 the Inquiry papers but I feel -- it's my fairly strong  
18 view about how the Cabinet Office and Cabinet committees  
19 work best, is that a number of them were chaired by  
20 the relevant Secretary of State. So the  
21 Foreign Secretary was chairing the foreign policy  
22 committee, the Chancellor the economic and business  
23 committee. I think in general, a Cabinet committee or  
24 similar group works better if it is chaired by a senior  
25 minister who is able to hold departments to account from

39

1 "This would be your 9.00 meeting with a small group  
2 of Ministers and key advisers ... We will hold  
3 a pre-meet ... at 8.15", and so on.

4 But in fact it became a 9.15 meeting.

5 The 8.15 meeting did take place and was generally  
6 attended by officials and advisers; is that right?

7 **A.** That's my understanding. And this is a familiar rhythm  
8 from the time of David Cameron onwards to organise  
9 a Prime Minister's day, obviously not in this context,  
10 but, you know, an 8 o'clock-ish meeting with special  
11 advisers and private secretaries, and others in  
12 Number 10, and then a 9 o'clock or, in this case,  
13 9.15 meeting with the Prime Minister. It seems to me  
14 they adapted that kind of quite well established rhythm  
15 of prime ministerial meetings from previous generations  
16 of prime ministers to reflect the situation as it was at  
17 the time.

18 **Q.** Did this new structure stand the test of time?

19 **A.** It did not.

20 **Q.** When or rather how long did it last for?

21 **A.** I would have to check with the dates, but I think it  
22 lasted for about two months, six weeks, something like  
23 that.

24 **Q.** Because in May the civil service and again the  
25 Cabinet Secretary returned to this issue of whether or

38

1 outside the department rather than inside.

2 So I have a personal view, which is that one of  
3 the problems with these MIGs was that they were owned  
4 and held accountable by the relevant  
5 secretaries of state rather than by the Chancellor of  
6 the Duchy of Lancaster, probably, in this instance,  
7 holding those departments to account.

8 The exception was, I believe, the Public Services  
9 Committee, which was chaired by Michael Gove.

10 **Q.** So these important departments of -- government  
11 departments of state, in this committee structure, to  
12 some extent marked their own homework?

13 **A.** Correct.

14 **Q.** The 9.15 meeting, formally, was that meeting therefore  
15 an ad hoc informal meeting, or was it, as a result of  
16 this change of government -- or, was it a result of the  
17 way in which the change of government machinery was used  
18 to institute the 9.15 meeting mean that it was more  
19 formal, for example a type of Cabinet subcommittee?

20 **A.** I don't get the impression it was in any way akin to  
21 a Cabinet subcommittee. I would say from what I know  
22 that it was more formal than a sort of chew the fat  
23 Prime Ministerial meeting, you know, "What's in the  
24 headlines today? What have we got on?" type  
25 David Cameron-style morning meeting, in that over time

40

1 data and dashboards were considered by that meeting and  
2 other evidence and advice.

3 Both in terms of cast list and agenda, it does not  
4 appear to me to be anything like as formal as a normal  
5 decision-making Cabinet committee.

6 **Q.** At paragraph 70 of your report, you say both the C-19  
7 daily meetings, by which you mean the 9.15 meetings, and  
8 the MIGs, as Cabinet committees, could take decisions  
9 themselves, so not everything was reported upwards from  
10 the MIGs to the C-19 meeting or from the C-19 meeting to  
11 Cabinet.

12 So by that do you mean the MIGs were formal Cabinet  
13 subcommittees, the C-19 morning meeting was not, but  
14 over time that 9.15 meeting took on the ability or  
15 the power to make decisions which had a degree of  
16 formality to them which meant that effectively Cabinet  
17 was bypassed?

18 **A.** My understanding is that that is a fair summary.  
19 I should add that this is, you know, this is quite hazy,  
20 which is, you know, a point to reflect on in itself.  
21 I do not have a clear sense in my own mind of how, when  
22 and whether those C-19 meetings took on a different  
23 form. I think that would usefully be something that  
24 the Inquiry could ask those who were part of those  
25 meetings.

41

1 It's about four pages in, I'm afraid, I'm sorry to  
2 do that to you. The last page, actually, the last few  
3 pages, are an annex. So maybe page 3. And then one  
4 further on. There we are, thank you.

5 Helen MacNamara and Simon Case. So two very senior  
6 civil servants, Simon Case was not by then yet  
7 Cabinet Secretary.

8 Page 3 of this document, please, at paragraph 6.  
9 There is a reference there to the fact that the devolved  
10 administrations had been involved in decision-making  
11 through the ministerial implementation groups and in  
12 COBR, and that there had to be a mechanism to discuss  
13 and agree on a four nation approach. So if the MIGs  
14 were being abolished, which is what this paper proposed,  
15 to be replaced by Covid-S and Covid-O, the authors of  
16 the paper recognised, did they not, that if, in  
17 addition, COBR would stop meeting, there needed to be  
18 an additional structure for policy matters at which  
19 the DAs could be engaged?

20 **A.** Clearly, yes.

21 **Q.** In fact they suggested to the Prime Minister that that  
22 JMC route, the Joint Ministerial Committee route, be  
23 used to manage conversations with the DAs?

24 **A.** Yes.

25 **Q.** My Lady has heard evidence that the Joint Ministerial

43

1 **Q.** The MIGs came to an end in the summer. The C-19  
2 9.15 meetings continued. But in early June, did  
3 Lord Sedwill propose the establishment of two new formal  
4 committees, Covid-O, Covid operation -- or operational,  
5 and Covid-S, Covid strategy, chaired by ministers to  
6 provide the ministerial building block for committee  
7 meetings going forward to deal with Covid-19 and  
8 the pandemic?

9 **A.** That's correct, I think.

10 **Q.** And the Covid-S was chaired by the Prime Minister,  
11 Covid-O was chaired by the Chancellor of the Duchy of  
12 Lancaster, Michael Gove MP.

13 **LADY HALLETT:** Are we going to a slightly different subject?

14 **MR KEITH:** Yes, we are.

15 **LADY HALLETT:** 11.30, please.

16 **(11.15 am)**

**(A short break)**

17 **(11.30 am)**

18 **LADY HALLETT:** Sorry, I caught everyone by surprise again.

19 **MR KEITH:** Mr Thomas, Covid-O and Covid-S, could we have,  
20 please, INQ000137215.

21 This was a paper prepared for the Prime Minister by  
22 Simon Case and Helen MacNamara. If we just go to  
23 the last page, if we may, I think we should see the  
24 names of the authors.  
25

42

1 Committee did not, in fact, meet, or if it did it met  
2 very rarely, but the devolved administrations were  
3 engaged, were they not, in particular through Covid-O;  
4 is that correct?

5 **A.** Correct, as I understand it.

6 **Q.** All right. And Covid-O was a ministerial committee, it  
7 was a formal subcommittee of Cabinet, because it was  
8 part of this change of government procedure, and it was  
9 an important ministerial committee which the devolved  
10 administrations could take part in?

11 **A.** Yes, although, as I understand it, it was by invitation  
12 rather than as standing members.

13 **Q.** Did they nevertheless attend?

14 **A.** I would need to check to be sure of that.

15 **Q.** All right.

16 The benefit of Covid-O was that it was a committee,  
17 was it not, at which ministers and officials and experts  
18 could convene and debate, in Covid-O's case, the  
19 operational matters which were required to be decided?

20 **A.** Yes.

21 **Q.** So what view do you have on the efficacy of that  
22 committee and its replacement of the MIG system?

23 **A.** I think it was more effective for -- because it  
24 addressed the two problems that I identified previously,  
25 the coherence of the different policy and departmental

44

1 remits, and the fact that Michael Gove, as Chancellor of  
2 the Duchy of Lancaster, was chairing rather than  
3 departmental secretaries of state.

4 **Q.** But it was a system that wasn't put into place until  
5 June 2020?

6 **A.** Correct.

7 **Q.** At the same time, the government brought together or  
8 instituted the Covid-19 Taskforce. Could you just  
9 describe for us, please, how that differed from  
10 the Covid-S and Covid-O ministerial committee structure?  
11 To what extent was it a secretariat or an operational  
12 body?

13 **A.** So my understanding is that the Covid Taskforce was  
14 a grouping that sat within the Cabinet Office, that  
15 acted both as a sort of formal day-to-day secretariat  
16 for the Covid strategy and operations meetings in terms  
17 of preparing papers, setting agendas, and taking  
18 minutes; but also in a -- you know, a not uncommon  
19 approach within the civil service was a policy and  
20 operation synthesis unit, so it included policy  
21 specialists, analysts, those from across government, to  
22 be able to provide the Covid Cabinet committees,  
23 subcommittees, with analysis in order to take  
24 the decisions that they needed to take.

25 **LADY HALLETT:** It seems an awful lot of groups.

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1 the Prime Minister at the time, so that he could chair  
2 and engage with the big picture questions, and that it  
3 then created a forum whereby Michael Gove could convene  
4 the people -- you know, the experts, who knew their  
5 subject and operational remits, to actually hash things  
6 out and get things done.

7 It was modelled on the Brexit strategy and  
8 operations committees. I -- you know, for the record of  
9 the Inquiry, I occasionally sat on the Brexit-O Cabinet  
10 subcommittee. That -- while much of the work was,  
11 you know, painful and frustrating, dealing  
12 with no-deal Brexit planning -- was a functional  
13 Cabinet committee. And I think it was wise of those  
14 officials and ultimately the Prime Minister to adopt  
15 that model that worked.

16 **LADY HALLETT:** Thank you.

17 **MR KEITH:** Evidence has been received already, Mr Thomas, to  
18 the effect that SAGE, the Scientific Advisory Group for  
19 Emergencies, as it says on the tin, provided advice on  
20 the scientific plane, but that there was no equivalent  
21 committee which brought together expert advice in the  
22 economic and societal fields.

23 Moreover, there doesn't appear to have been a body,  
24 an overarching body, that brought together all the areas  
25 of information, scientific, economic, societal, pandemic

47

1 **A.** I think the advantage, my Lady, of the taskforce is that  
2 it reduced the number of groups that had previously  
3 existed. It is coherent, in my mind, to have a Covid  
4 strategy meeting, a small strategy direction setting  
5 meeting chaired by the Prime Minister, an operations  
6 committee chaired by Michael Gove, and then a supporting  
7 structure for those two committees. I think it's  
8 important not to think of the taskforce as a different  
9 group with its own, you know, policy leadership  
10 structure. There were no extra committees on top of  
11 the taskforce. I imagine the senior civil servants  
12 within the taskforce had their own, you know, executive  
13 team to talk about pay and rations and so on. But the  
14 advantage of the taskforce was that it was a single  
15 group in the Cabinet Office servicing these two  
16 committees, and inextricably, in that sense, linked to  
17 those two committees.

18 So that is more coherent than having four separate  
19 groups, or not even those groups, each of which had its  
20 own secretariat, and without the single synthesising  
21 function that then began over time to exist within  
22 the taskforce.

23 **LADY HALLETT:** And you approve of separating strategy from  
24 operations?

25 **A.** I do. I think it both suited the personal style of

46

1 management, clinical, public health considerations,  
2 whatever it might be. But to what extent did, by  
3 the time it got going, the Covid Taskforce, together  
4 with its ministerial committees above it, fulfil that  
5 function?

6 **A.** I think over time it began to fulfil that function.  
7 I think it took some time, months and possibly more, to  
8 get fully operational, but I think inside  
9 the government, inside the Cabinet Office, the taskforce  
10 began to build the expertise and the authority to do  
11 that synthesis.

12 What it didn't do, and we may come on to this, stop  
13 me if we will, is rectify the gap in distinct expert  
14 analysis in the economic sphere in particular, and  
15 the public attention and distorting consequences of  
16 an extreme focus on SAGE giving scientific advice as  
17 opposed to other experts giving advice in those other  
18 fields.

19 **Q.** We'll come back to that, indeed.

20 You've read the Rule 9 witness statements from  
21 a number of civil servants, including Simon Ridley, who  
22 was the head of the Covid Taskforce, as well as that of  
23 Helen MacNamara, who was the Deputy Cabinet Secretary,  
24 and also you've read the letter from Mr Cummings to  
25 the Inquiry.

48

1 A. Sorry to interrupt, I haven't actually seen  
2 Helen MacNamara's or Mr Cummings' evidence, I have seen  
3 Simon Ridley's.

4 Q. Yes, you've seen Mr Cummings' letter, you haven't seen  
5 his statement, because that's not something that we have  
6 yet either.

7 A. I'm not sure I have seen the letter.

8 Q. All right.

9 A. Anyway, just to be open.

10 Q. All right. It's a document which the core participants  
11 have received.

12 Ms MacNamara's statement and Mr Cummings' letter  
13 make plain that one of the consequences of  
14 the institution of the Covid Taskforce is that it pushed  
15 decisions through without going through Cabinet  
16 collective decision-making processes.

17 What is Cabinet collective decision-making?

18 A. So it is the supreme form of decision-making in  
19 the United Kingdom Government --

20 Q. Who says it's the supreme form of government decision --

21 A. Our uncodified constitution says that.

22 At its pinnacle it involves the Prime Minister and  
23 his or her Cabinet agreeing, either in a meeting or by  
24 written correspondence on a particular policy decision  
25 or indeed on anything else.

49

1 Taskforce as a decision-making thing. It only makes  
2 decisions that are made -- well, decisions are already  
3 made, that are made by Covid-S or Covid-O. The  
4 taskforce itself could take some very, very low level,  
5 sort of administrative almost, decisions, but anything  
6 of any policy import would need to go through those  
7 Cabinet committees, otherwise it wouldn't exist as  
8 a decision, if you see what I mean. There wasn't  
9 a separate authority that the Covid Taskforce would have  
10 to make those decisions.

11 Q. Why then do you think, and we'll obviously hear from  
12 them directly, that Ms MacNamara observes that the CTF  
13 was able to make decisions without going through Cabinet  
14 collective decision-making and Mr Cummings observes that  
15 the CTF becomes much more important than either Cabinet  
16 or Cabinet committees in essentially monitoring  
17 the crisis and advising the Prime Minister?

18 A. I don't know. As I said, I haven't seen those --

19 Q. All right.

20 A. -- those documents. I think a secretariat can be of  
21 huge importance, because it sets the terms of  
22 the decision, it determines which evidence goes forward  
23 for decision, and provides the advice that informs  
24 the decision, so it can be powerful, but it would seem  
25 to me if there is evidence -- which, as I say, I haven't

51

1 Cabinet authority can and very often is delegated to  
2 a subcommittee of Cabinet which is able to exercise the  
3 same authority as would the whole Cabinet sitting  
4 together.

5 Q. So pausing there and picking up some of the threads, of  
6 course you've already told us that there was a Covid-O  
7 and a Covid-S formal Cabinet subcommittee, so were they  
8 able, therefore, to discharge the constitutionally vital  
9 role of Cabinet through those two subcommittees?

10 A. Yes.

11 Q. Nevertheless, have you been able to reach a view as to  
12 the extent to which the decision-making that was taking  
13 place in the CTF was passed through Cabinet or its  
14 subcommittees for, as you've described it, their supreme  
15 imprimatur?

16 A. From what I have seen, the policy and operational  
17 decisions were, you know, appropriately passed through  
18 the Covid-S or Covid-O subcommittees. I don't know  
19 about Cabinet as a whole, but, as I say, that's entirely  
20 proper.

21 Two caveats to that. One, I suppose, I don't know  
22 what I don't know. I don't know every decision that may  
23 or may not have been taken in other fora. The second,  
24 just to explore the nature of your question for  
25 a moment, is I think it's wrong to think of the Covid

50

1 seen -- that there were decisions, there were  
2 substantive policy decisions being made outside of  
3 Covid-S and Covid-O, that would be something that was  
4 not consistent with Cabinet collective responsibility.

5 Q. In general terms, have you been able to form a view as  
6 to the ability of the then Cabinet to be engaged in, to  
7 be part of the core decision-making process between  
8 March and September?

9 A. It seems to me that, from the evidence in the media and  
10 elsewhere, from our research, but particularly from  
11 the evidence the Inquiry has received that I have seen,  
12 that there was no shortage of discussion in Cabinet.  
13 There was an amount of debate in Cabinet, clearly to  
14 some extent informed by the Chief Medical Officer and  
15 the Government Chief Scientific Adviser.

16 My strong sense, though, is that the actual  
17 decisions were made in Covid-S and Covid-O and often  
18 formulated, discussed and, you know, aerated, if you  
19 like, in those Prime Ministerial 9.15 and other  
20 meetings.

21 Q. When you say aerated, can you reach a view, have you  
22 been able to reach a view as to whether, by and large,  
23 the decision-making actually took place in the 9.15  
24 meetings, with the Prime Minister and his closest  
25 advisers, or at Covid-S and Covid-O?

52

1 **A.** I think this might get slightly to the point you were  
 2 drawing out a moment ago. I would expect, and,  
 3 you know, haven't seen anything that suggests that  
 4 formal policy decisions were made elsewhere than Covid-S  
 5 and Covid-O. That does not mean that those were the  
 6 fora where the decision was actually framed. It is  
 7 quite common in government for pre-meetings,  
 8 discussions, meetings at official level and ministerial  
 9 level, and ultimately around the Prime Minister, to  
 10 agree the desired outcome of a meeting that, you know,  
 11 often will be the actual outcome of a meeting. That  
 12 doesn't mean then that a secretary of state or  
 13 a minister at the formal set piece Cabinet committee or  
 14 Cabinet subcommittee, can't say, "Hang on a minute,  
 15 I don't like this, I'm going to raise it to debate", and  
 16 that might take the decision in a different direction or  
 17 it might mean a decision isn't made.

18 **Q.** Bluntly, the evidence appears to show that on Sunday,  
 19 22 March, on the eve of the lockdown on the Monday,  
 20 the decision of whether or not to impose a national  
 21 lockdown was debated in ferocious terms in front of  
 22 the Prime Minister. He appears to have decided that  
 23 there will be, there has to be a lockdown, but he  
 24 demands, quite rightly, that the matter also go to COBR,  
 25 which is sitting the following day, in order for that

53

1 Then there is a trolley emoji:  
 2 "Full [trolley] mode.  
 3 "It didn't take til weekend!"  
 4 [Simon Case] "Spectacular today -- we want to open  
 5 up the economy ASAP, forget the bloody virus."  
 6 [Lee Cain] "I blame the messaging #CommsProblem.  
 7 "Hancock has got to go. Joker."  
 8 And:  
 9 "Yup. And liar."  
 10 The view expressed of ministers by government  
 11 officials is, of itself, extremely regrettable, is it  
 12 not?

13 **A.** Yes. I should just also say, with reference to what  
 14 I said earlier, if this is the Dominic Cummings letter,  
 15 I have seen extracts of these previously, so just to  
 16 clarify what I said, I haven't seen a sort of formal  
 17 letter, but I have seen these.  
 18 But yes.

19 **Q.** To what extent does it matter that ministers appear to  
 20 have been held in such low regard by civil servants and  
 21 political advisers?  
 22 **A.** It's regrettable, as I say. You know, I would note that  
 23 the least temperate language there was from two special  
 24 advisers rather than Simon Case. I think the --  
 25 **Q.** I think just pause there. Is that correct?

55

1 decision formally to be promulgated. Is that how it  
 2 might work?  
 3 **A.** Yes.  
 4 **Q.** Thank you.  
 5 Can we have, please, INQ000048313, it's Mr Cummings'  
 6 letter, at page 54 of 69.  
 7 This is a WhatsApp taken from a WhatsApp group,  
 8 "SimonC", that's Simon Case, by September on the cusp of  
 9 becoming Cabinet Secretary but at that time I think  
 10 a first or second permanent secretary in the  
 11 Cabinet Office, "Caino", Lee Cain, and "dom",  
 12 Dominic Cummings, 8 September:  
 13 "As always discussions with these ministers is  
 14 moronic. They cannot understand priorities.  
 15 "They didn't even understand what they were talking  
 16 about for most this meeting."  
 17 [Simon Case] "Quite."  
 18 "This is embarrassing."  
 19 Then this:  
 20 "By weekend he'll be saying '6 is untenable a total  
 21 disaster we've got to get everybody back to work!.'  
 22 That appears to be an observation on  
 23 the Prime Minister's approach to the rule of group of  
 24 six, which was under debate at that time.  
 25 [Lee Cain] "Yes."

54

1 Simon Case, Simon says "Quite", on the left-hand  
 2 box, and is therefore presumed not to be the  
 3 interlocutor beforehand, which is somebody else.  
 4 **A.** So it seems to me to say that it's Dominic Cummings  
 5 saying:  
 6 "Full [trolley] mode.  
 7 "It didn't take til weekend!"  
 8 Lee Cain saying:  
 9 "What's his issue? Xmas cancelled stuff?"  
 10 And then Simon Case saying:  
 11 "Spectacular today -- we want to open up ..."  
 12 And I would read that as sort of semi-quoting  
 13 the Prime Minister as saying, "We want to open up the  
 14 economy", et cetera, and then Lee Cain coming back in  
 15 with what I assume is a joke about blaming the  
 16 comms messaging, for which he was partly responsible,  
 17 and the message about Matt Hancock.  
 18 So, regrettable. I think what it clearly speaks to  
 19 is an environment amongst the Prime Minister's closest  
 20 and most senior advisers where they had, privately at  
 21 least, entirely lost confidence in his ability to take  
 22 consistent decisions. I think that's the most  
 23 regrettable thing, both their loss of confidence and  
 24 presumably his failure to take those consistent  
 25 decisions.

56

1 I think it is not uncommon, particularly for,  
 2 you know, political advisers who might have a close  
 3 relationship with their ministers, to be less formal  
 4 than civil servants, but I think all of the language  
 5 here is clearly, you know, unfortunate.

6 **Q.** Does it extend beyond that to a serious issue,  
 7 the serious issue of the loss of confidence in  
 8 ministers, because there is a direct and very personal  
 9 attack on the Secretary of State for Health and Social  
 10 Care there as well?

11 **A.** Yes. And of course it is not ... it is not  
 12 unprecedented for advisers and civil servants in  
 13 Number 10, in the Cabinet Office, elsewhere, to,  
 14 you know, express concerns about ministers privately.  
 15 The decisions about the competence and capability of  
 16 ministers, though, are entirely in the Prime Minister's  
 17 sphere. It has to be the Prime Minister's decision  
 18 about the confidence and capability of his ministers.  
 19 The extent to which those political advisers had,  
 20 you know, influence over the Prime Minister, I guess, is  
 21 the question that most relates to the government's  
 22 administration of Boris Johnson's government at that  
 23 time.

24 **Q.** So are there two levels here, Mr Thomas: firstly, the  
 25 objective issue of ministers' competence, are you able

57

1 advisers' view as to the lack of competence on occasion  
 2 or perhaps more generally on the part of ministers?

3 **A.** Yes. You can take the boy out of the civil service, you  
 4 can't always take the civil service out of the boy.

5 **LADY HALLETT:** I think Mr Keith is being unduly harsh on  
 6 you, Mr Thomas. I understood what you were saying,  
 7 which is that consistency is not always a virtue if  
 8 there is a change of circumstance.

9 **A.** Yes.

10 **LADY HALLETT:** But you have to make sure you've thought  
 11 everything through properly and considered the material  
 12 before you make a change of decision, because it impacts  
 13 everybody.

14 **A.** Yes, my Lady. And I think if there is a reason behind  
 15 my -- the circumspection in some of my language, to  
 16 revert to Sir Humphrey, it's because it is quite easy,  
 17 looking at these messages, to have both an emotional and  
 18 quite a stark personal reaction to them. They are not  
 19 comfortable to read. And I can only imagine if you are  
 20 a victim of or related to someone who suffered or died  
 21 from Covid, this is appalling to read. What I'm trying  
 22 to do through perhaps my caution is to assist  
 23 the Inquiry in understanding that in the crucible of  
 24 Number 10 and the Cabinet Office, this is perhaps not  
 25 particularly unusual. It is regrettable, as we

59

1 to say whether or not there was any basis, any proper or  
 2 genuine basis for concern to be expressed about the  
 3 general competence of ministers? Putting it another  
 4 way, were these advisers and civil servants' views  
 5 entirely without justification or not?

6 **A.** From the evidence I've seen there are, you know, many  
 7 comments that one could make about what was happening  
 8 over the course of that year in particular. It is,  
 9 you know, pretty clear -- well, it is clear to me that  
 10 the consistency of decision-making was something that  
 11 could legitimately be criticised and be a cause for  
 12 concern, which is not at all to say that ministers or  
 13 a Prime Minister should not change their mind. I think  
 14 it's healthy for ministers to be open to changing their  
 15 mind. But I think that has to be on the basis of  
 16 a changed situation or reasoned reflection rather than  
 17 in the ad hoc way that they seem to be suggesting.

18 **Q.** I must commend you, if I may say so, perhaps on account  
 19 of your previous civil service history, for some  
 20 wonderful civil service phraseology there.

21 **A.** Apologies.

22 **Q.** "... the consistency of decision-making was something  
 23 that could legitimately be criticised and be a cause for  
 24 concern ..."

25 There was a basis for the civil servants' and

58

1 discussed earlier, but I -- and it should be called out  
 2 as regrettable, but the critical thing is the decisions  
 3 that were made, the way that they were communicated and  
 4 the relevance of these messages is about the context in  
 5 which the decisions were made rather than the messages  
 6 themselves, if that makes sense to you, my Lady.

7 **MR KEITH:** Mr Thomas, in the course of opening this module,  
 8 I myself observed that a degree of caution has to be  
 9 applied, naturally, when drawing conclusions from this  
 10 sort of material.

11 But to revert to the point I put to you, whilst  
 12 paying due deference to that point and applying  
 13 a distinct level of caution as to what can be read into  
 14 these messages, because of their intemperate nature,  
 15 because of the crucible that was Number 10, because of  
 16 the high octane and aggressive atmosphere which appears  
 17 to have percolated through its veins, nevertheless  
 18 the messages show that serious concerns were being  
 19 expressed, between people who were in a position to  
 20 know, as to the competence of ministers and in  
 21 particular the competence of the Prime Minister.

22 **A.** With that I completely agree.

23 **Q.** The second point is, who carries ultimate responsibility  
 24 for changes in personnel, for selecting the correct  
 25 team, with perhaps a higher degree of competence, when

60

1 faced with evidence of lack of competence on the part of  
 2 members of that team?  
 3 **A.** Well, the leader of that team, in this case  
 4 the Prime Minister.  
 5 **Q.** Lead government departments is another area that you've  
 6 looked at in your report. The Department of Health and  
 7 Social Care was the lead government department, and  
 8 the Inquiry heard a great deal of evidence in Module 1  
 9 as to the significance of the lead government  
 10 department, and you're aware both from  
 11 government-produced papers, a UK Government Resilience  
 12 Framework of December 2022, which the Inquiry looked at  
 13 in some detail through the evidence of Oliver Letwin in  
 14 Module 1, and also a report called "Crisis capabilities  
 15 review: responding to crises from the centre of  
 16 government", a report dated February 2022, that the lead  
 17 government department model has its very distinct  
 18 limitations?  
 19 **A.** Yes.  
 20 **Q.** In the face of an immediate crisis, a health crisis, in  
 21 the case of the DHSC, it plays a very important, perhaps  
 22 a vital role. But in the face of a whole-country  
 23 crisis, involving a multitude of government departments,  
 24 does that model start to break down because it places  
 25 too much weight on the lead government department and  
 61

1 department to side-step the whole-government aspects of  
 2 preparedness for a crisis.  
 3 **Q.** And you've described, of course, the important role that  
 4 the Cabinet Office plays at the heart of government in  
 5 bringing the various departments together, in  
 6 synthesising information, broking, if you like,  
 7 the position between departments. It the lead  
 8 government department is institutionally unable or  
 9 unwilling to be able to act and the Cabinet Office, as  
 10 you have described, lacks the institutional levers of  
 11 power to be able to bring about a successful outcome,  
 12 where does that leave government departments?  
 13 **A.** It leaves a gap. And I think, to add to your  
 14 Cabinet Office point, one of the points in our research  
 15 we've made is that the Civil Contingencies Secretariat  
 16 in particular put aside the architecture of the other  
 17 secretariats and the policy synthesis in the run-up to  
 18 the pandemic. CCS did not have the capacity or remit to  
 19 fully interrogate the plans of lead and non-lead  
 20 government departments. That, as I understand, is  
 21 something that has been rectified, but that created  
 22 a gap in the assurance process as well as the structural  
 23 gap you identified in your question.  
 24 **Q.** Finally on this issue of lead government departments, in  
 25 practice, and at a much more prosaic, perhaps personal  
 63

1 an expectation that it will be in the driving seat in  
 2 terms of responding to that whole-government crisis?  
 3 **A.** Yes, I agree with you that there are circumstances, many  
 4 circumstances, in which the lead government department  
 5 model can be effective. For example, not to labour it,  
 6 but I was involved in a number of crises in DEFRA, the  
 7 environment department, around animal diseases, animal  
 8 diesel outbreaks, that were, in one sense  
 9 whole-government, crises, many different government  
 10 departments were involved, but were manageable through  
 11 that model.  
 12 The thing I would add to your correct criticism  
 13 about the lead department model breaking down in  
 14 a whole-government crisis is that there's a flaw in the  
 15 preparation for the crisis as well. I think in theory  
 16 the Department of Health and Social Care should have  
 17 been holding, for example, the Department for Education  
 18 to account for its preparedness for a pandemic of this  
 19 kind. It is clear to me from what transpired that  
 20 the Department for Education did not have plans for  
 21 a pandemic of this kind or, if they did, they were  
 22 superficial.  
 23 So I think the lead department model, while  
 24 correctly assigning accountability, does not give enough  
 25 authority to the lead department, or allows the lead  
 62

1 level, have you seen signs or in your review of  
 2 the material did you see signs of government meetings,  
 3 whether they be 9.15 meetings or COBR meetings or  
 4 Covid-S, Covid-O meetings, at which, on account of the  
 5 DHSC being the lead government department, its  
 6 secretary of state or officials kept too much within  
 7 the DHSC, that is to say they resented encroachment upon  
 8 what they saw as their turf, that they weren't open  
 9 enough with other government departments and with the  
 10 centre, and they resented challenge?  
 11 **A.** I think there is a natural and, in some senses,  
 12 admirable tendency in government departments to want to  
 13 present solutions as well as problems, but I think in  
 14 a crisis like this that strength can become a weakness.  
 15 There is also an institutional -- sometimes  
 16 an institutional tendency to hoard information or to see  
 17 Number 10 or the Cabinet Office as the enemy.  
 18 I think, from the material that I've seen, there  
 19 were, you know, moments when certainly some of  
 20 the actors in this system felt that DHSC was both not  
 21 playing ball but also not sufficiently gripping  
 22 the situation.  
 23 I would also add a sort of personal reflection that  
 24 that is perhaps less about DHSC as a department or its  
 25 leadership but about the somewhat inchoate structure  
 64

1 around -- I know you have looked at and will look at  
2 Public Health England, the relationship between DHSC and  
3 NHS England. DHSC, it has often seemed to me, is  
4 a department squeezed between Number 10, the Treasury,  
5 on the one hand, and NHS England on the other. So  
6 I think there's a question of DHSC's, you know,  
7 authority as lead government department in this crisis.

8 **Q.** And is there a link between that observation and some of  
9 the comments made by Mr Cummings in particular, but  
10 Number 10 officials more widely, to the effect that  
11 there was a tendency on the part of the DHSC to attend  
12 meetings and to pull what might be described as a DHSC  
13 rabbit out of the hat, or, to use Mr Cummings' word, to  
14 make it up?

15 **A.** I'm not sure I could comment on making it up. It does  
16 not surprise me at all that there were people in  
17 Number 10 and the Cabinet Office who were frustrated  
18 with DHSC. That can be quite common, for some of  
19 the reasons we've talked about. But I also think -- we  
20 may or may not cover it, but the data flows and data  
21 analysis within government were not strong in the early  
22 part of the pandemic, and if there was a lack of  
23 solidity to data and information that was flowing in,  
24 that could be one source of frustration.

25 **Q.** Now, just a few questions on a handful, shortly, of  
65

1 as the pandemic went on, but clearly there were well  
2 publicised events where local and regional government  
3 leaders were not sufficiently involved. I think partly  
4 that was a problem of the national government's own  
5 making as it got deeper into the tiering approach, that  
6 got ever more complicated and ever more difficult to  
7 untangle the different financial support, enforcement,  
8 and other aspects of the operation across the country.

9 **Q.** To what extent were those difficulties reflective of  
10 the structures and pre-existing systems for  
11 communication, as opposed to the personalities,  
12 of course, the personalities of the First Ministers and  
13 the Prime Minister, who ultimately drive that system of  
14 collaboration?

15 **A.** I think ultimately it comes down to the latter, but that  
16 is not something really that we can legislate for, that  
17 depends on who is elected. So I think some of the --  
18 there were clearly deficiencies in the system, the Joint  
19 Ministerial Committee, for example, I would say,  
20 you know, could operate well on paper but rarely  
21 operated that well in practice and the government has  
22 made various reforms to that structure to hopefully  
23 improve it, with which I agree.

24 So there was a structural gap in how central  
25 government engaged with all these different tiers,  
67

1 disparate, separate points. In relation to the devolved  
2 administrations, you've told us about the participation  
3 of the devolved administrations in COBR and in Covid-O  
4 and Covid-S and the JMC structure.

5 Do you reach in your report the view that there were  
6 significant failings in the degree of co-ordination  
7 between the United Kingdom Government and the devolved  
8 administrations in terms of the latter's input into  
9 the core decision-making?

10 **A.** I think, yes, that is fair. I think it is entirely  
11 legitimate for the UK Government to take decisions on  
12 behalf of England and for the devolved administrations  
13 to take decisions on behalf of those nations. But  
14 I think in a -- what, excluding Northern Ireland, we in  
15 DEFRA used to call a sort of single epidemiological  
16 area, and given the interlinkages between all  
17 the different parts of the country, consistency and  
18 co-ordination to the extent possible would have been  
19 good, and there were times when that communication and  
20 input seemed to break down.

21 **Q.** Were the working relationships and communication between  
22 the central government in the United Kingdom and  
23 regional and local government any more or less  
24 effective?

25 **A.** I think, on that score, it probably got more effective  
66

1 because the architecture was not sufficiently clear and  
2 authoritative.

3 **Q.** SAGE. I can deal with this briefly, because this is  
4 an area which the participants in SAGE have themselves  
5 commented on, and they will continue to do so during  
6 the course of the evidence next week, but did you look  
7 at, structurally, the position of SAGE and the role that  
8 it played in the provision of advice to central  
9 government?

10 **A.** Yes, and we as the IFG and in part I personally have  
11 looked at this. I think SAGE on its own terms did  
12 a good job. There are legitimate criticisms that I know  
13 the Inquiry has considered about diversity of input and  
14 experience, and something of a delay to  
15 the transparency, which I would, you know, commend  
16 Sir Patrick Vallance for pushing inside and outside  
17 government.

18 The main -- I also think that -- I've thought about  
19 this quite a lot -- I think the model of a Chief  
20 Scientific Adviser and Chief Medical Officer is  
21 the right one. I know there is a view that ministers  
22 should have more direct and personal access to a range  
23 of experts, and I think something of an opening up of  
24 the SAGE experts would be beneficial, but I think  
25 ultimately channelling that through the CMO and the GCSA  
68

1 is the right model.

2 The main gap, and I won't labour it because we've  
3 talked about it, is the other forms of evidence that  
4 were going into decision-making.

5 **Q.** Yes. So that, Mr Thomas, we can be assured that  
6 the Inquiry has focused its attention on the right  
7 aspects of SAGE, would you agree with this summary of  
8 your report, that these are the following areas in which  
9 you invite the Inquiry's focus: firstly, the make-up of  
10 the committee, that it was largely epidemiologists,  
11 modellers and behavioural scientists. There is an issue  
12 about the lack of diversity of expertise, a requirement  
13 for experts in pandemic management, crisis management,  
14 social scientists and the like. So that's the first  
15 area.

16 The second area concerns the -- you describe it as  
17 the way in which, because the government commissioned  
18 work, it slowed down the decision-making, because SAGE  
19 was always responsive to specific requests.

20 Third, because it was designed to address questions  
21 put to it, there may have been a caution on its own part  
22 or a sense of caution that led it to be less proactive;  
23 it waited for commission as opposed to wanting to  
24 proactively recommend, in a precautionary way, specific  
25 recommendations.

69

1 analysis and modelling in the course of the crisis?

2 **A.** So there was a report that -- well, in my report it does  
3 briefly cover that, with more detail, with other IFG  
4 material, yes.

5 **Q.** In general terms -- well, are there two points that you  
6 make: firstly, in the early part of the pandemic, some  
7 of the best decision-making was in the economic sphere,  
8 because of the speed and the coherence with which  
9 the Treasury was able to produce the business support  
10 schemes at very rapid pace?

11 **A.** Correct.

12 **Q.** But that, secondly, throughout the whole course of  
13 the pandemic, there were perhaps self-imposed  
14 constraints put into place by the Treasury which  
15 prevented it from properly sharing economic analysis and  
16 its thinking in its reports with the rest of government?

17 **A.** Yes, one of the criticisms that I think is often fairly  
18 levelled at the Treasury is that they are hoarders of  
19 information and data, and I think that did not, and our  
20 research work would suggest that that did not always  
21 lead to the best cross-government decision-making.

22 **Q.** You've told us, and you've commented upon some of  
23 the WhatsApps and the informal methods of communication  
24 utilised by advisers and civil servants and politicians.  
25 It is self-evident that WhatsApps and text messages are

71

1 **A.** Yep.

2 **Q.** Fourthly, there is an issue, is there not, with the way  
3 in which minutes were compiled as reflective of  
4 the consensus position, and therefore may not have  
5 actually adequately reflected the hugely important  
6 nuances in the debate.

7 Fifthly, SAGE had no clear evidence of what  
8 the government's objectives or direction was, and so  
9 felt themselves unable to be able to fill the void.

10 You've discussed already the requirement for  
11 a synthesis of not just scientific advisory evidence but  
12 public health, economic, societal and pandemic  
13 managements to be brought together.

14 And lastly, in relation to the government's  
15 messaging, to what extent do you feel that  
16 the government's message or mantra of "following the  
17 science" was a proper reflection of the boundaries  
18 between scientific advice and policy decision?

19 **A.** It was not a proper reflection of the boundaries.

20 I think "informed by the science" is a nuanced but  
21 important distinction.

22 **Q.** All right.

23 Economic analysis and modelling. Did you look in  
24 your report at the degree to which the Treasury in  
25 particular had provided differing levels of economic

70

1 a convenient and swift form of communication, but  
2 of course they lack nuance and they can't possibly  
3 reflect the give and take of a particularly complex  
4 policy issue.

5 Is there in the field of political science and in  
6 the academic world concerning the efficacy of  
7 government, been a number of reports making  
8 recommendations about the use by ministers, advisers and  
9 officials of personal phones, WhatsApps and messaging  
10 devices?

11 **A.** Yes, there have, including one from the Institute for  
12 Government that talked about the importance of recording  
13 and properly using WhatsApps, and also that they could  
14 be beneficial for informal communication but shouldn't  
15 be used to take formal decisions.

16 One reflection I have where my view has changed  
17 a little, thanks to reviewing some of the documentation  
18 in the Inquiry, is that for all the extreme discomfort  
19 in looking at many of these informal WhatsApp messages,  
20 it is relatively hard to find a substantial policy  
21 decision in the material that I have seen that was  
22 actually made on WhatsApp. So my concern is now more  
23 about the context for the decision that the WhatsApps  
24 set, rather than the actual formality of  
25 the decision-making.

72

1 Q. By that, do you mean it is extremely important to have  
2 a proper record-keeping system, a means by which those  
3 policy decisions are scrutinised and can be  
4 transparently examined subsequently, if they're not, as  
5 you rightly say, set out clearly on the WhatsApp system?

6 A. Yes. And the actual decision should be made through  
7 a proper, you know, sometimes rapid but reflective  
8 process in Cabinet committees.

9 Again, that said, we know more about what was in  
10 the minds of some of the key actors in this crisis  
11 through WhatsApps, so they are not without their use for  
12 the public record, but that depends on them being,  
13 you know, available and retained.

14 Q. But by and large that material tells us a great deal  
15 about the authors' views on competence, reliability,  
16 integrity, the personal attributes, if you like, of  
17 the persons within government, rather than anything  
18 about the substantive policy making?

19 A. Correct.

20 Q. Has this issue of "sofa government", of momentous  
21 decisions being taken without being properly recorded  
22 and without being transparently made, long been an issue  
23 at the heart of government?

24 A. Well, I make reference in my evidence to the Chilcot  
25 report into the circumstances around the decision to go

73

1 particularly ministers and their experience, in terms of  
2 the resilience of the Cabinet Office in particular but  
3 all government departments, and in terms of  
4 the political context in which government had been --  
5 the top of government had been operating for the last  
6 three, four, five years.

7 Q. To what extent does proper crisis management depend on  
8 having the right people in the right position?

9 A. Clearly to a huge extent, but also the right structures.

10 Q. How important is the identification of a clear strategy  
11 to proper crisis management and response?

12 A. Very important. And I think -- I saw the evidence from  
13 Lord O'Donnell, Gus O'Donnell, and I would entirely  
14 agree with some of his critique about the lack of  
15 a framework, a strategy that could then be applied into  
16 a framework that allowed ministers and senior officials  
17 to grapple with these extremely difficult decisions.  
18 There was not enough, let's call it, complete  
19 decision-making.

20 Q. At what level should the Inquiry be examining the nature  
21 of those strategic decisions, or to what extent does  
22 the identification of strategy matter? Are you talking  
23 about the sort of overarching approach, the debate about  
24 suppression or mitigation, of whether there would be  
25 a first or second wave, of herd immunity, whether we

75

1 to war in Iraq. Clearly one of the core critiques of  
2 that report was around informality of decision-making.  
3 I think -- I think it comes back to the Prime Minister.  
4 I think prime ministers -- this goes to  
5 the Helen MacNamara evidence you drew our attention to  
6 earlier about COBR. Prime ministers tend to make  
7 decisions in the fora and in the manner with which they  
8 are most comfortable. Those decisions -- the process by  
9 which they make those decisions is not always conducive  
10 to a thorough consideration of the evidence and a proper  
11 reflection on the consequences of that decision.

12 Q. On the dawning of the pandemic, the Johnson government  
13 was, in your words, a relatively new and inexperienced  
14 one. It took over power in a system which had been  
15 placed under considerable strain by the demands and  
16 complexities of no-deal Brexit planning, and it was  
17 a system which had still not yet settled down, if you  
18 like, after the impact of the change of Prime Minister  
19 and the general election in 2019.

20 To what extent did those systemic issues impact upon  
21 the calibre of the individual decisions that this  
22 Inquiry is looking at?

23 A. I think it is hard to see how they could have -- how it  
24 could have been anything other than a great extent, on  
25 the calibre, both in terms of the individuals,

74

1 allow the fatal consequences of the virus to spread or  
2 whether we crack down completely on the spread of  
3 the virus? Is that the sort of level of debate that you  
4 have in mind?

5 A. Yes, it is. And clearly those are all issues for  
6 the Inquiry.

7 You know, in the field in which we have been  
8 discussing this morning, around the nature of  
9 decision-making at the heart of government, for me it's  
10 the mechanism by which all different aspects of society  
11 were properly considered in the decisions that were  
12 made, from the economy through to education, through to  
13 health, and so on. I think -- I entirely understand,  
14 for example, the reasons for the "protect the NHS"  
15 objective that was clearly central to the government's  
16 approach, but that still seems to me to be limited as  
17 a strategic objective for government, and I think that  
18 is an important area for the Inquiry to consider.

19 Q. You've referred to the systems generally that were in  
20 place on the dawn of the pandemic, and you've described  
21 for us how the government systems evolved over time, but  
22 I want to show you, please, a document, INQ000136755,  
23 which was a document prepared by Helen MacNamara  
24 regarding how Number 10 and the Cabinet Office could  
25 better support the Prime Minister. It's a document

76

1 from, we believe, May 2020.

2 Just picking up some of the threads, please,  
3 Mr Thomas -- if we could scroll in a little bit more on  
4 the top of the page so we can read it. Thank you.

5 Helen MacNamara spoke to over 45 people over  
6 three days in Number 10 and the Cabinet Office, did she  
7 not?

8 **A.** Yes.

9 **Q.** And she identified what she describes as some universal  
10 themes: too many meetings, poorly structured and  
11 prepared, repetitious policy discussions, too many  
12 people in the room, the top two tiers of leadership  
13 spending all their time in the same meetings, fights  
14 over ownership, senior people negotiating with each  
15 other rather than doing stuff, bad behaviours from  
16 senior leaders tolerated, too much politics, explosions  
17 of new people causing chaos, Number 10 always at war  
18 with someone, lots of people mentioned junior women  
19 being talked over or ignored, "We need a modern culture  
20 of organised collaboration not superhero bunfight". The  
21 Cabinet Office team has fallen out of shape, it has too  
22 many senior leaders, they can't take decisions without  
23 consulting others. The Cabinet Office has lost its way  
24 in making the Whitehall machine work for Number 10.  
25 Superhero culture prevalent. No one had a clear picture

77

1 setting from the Prime Minister. That is  
2 an overwhelming feature of how government works, and  
3 where that is not present, as we've seen from some of  
4 the material this morning, it clearly breaks down.

5 **Q.** Is it implicit in that answer that leadership and  
6 consistency of decision-making are absolutely vital in  
7 a crisis?

8 **A.** Yes.

9 **Q.** Do you conclude that, in effect, Mr Johnson's leadership  
10 engendered a chaotic government system, with competing  
11 power sources, unclear lines of responsibility and,  
12 ultimately, poor decision-making?

13 **A.** I think that's clear from the material we've seen, yes.

14 **Q.** You make a number of recommendations in your report.  
15 I'm not going to go through them all, because you've set  
16 them out plainly, but do you suggest, in broad terms,  
17 the following immediate or urgent or important changes:

18 One, that there is a supercharged overarching body  
19 above SAGE to bring together and synthesise all those  
20 issues, economic, societal, public health, pandemic  
21 management, matters which may all be relevant to  
22 a crisis, to make recommendations to politicians,  
23 ultimately the Prime Minister, for a better  
24 decision-making process?

25 **A.** Yes, I can see the case for that, as long as it is

79

1 of who was doing what and who is supposed to be doing  
2 what. The work isn't good enough. It's not clear who  
3 is calling out what. Everyone knows something is wrong  
4 and not true, but that's not brought it to a head.

5 That is as damning an indictment of the system of  
6 government in Number 10 and the Cabinet Office as it is  
7 possible to imagine, is it not?

8 **A.** Yes, and Helen MacNamara is an extremely experienced and  
9 also, as I think comes out from that, empathetic senior  
10 civil servant. I, you know, when I read this, it's  
11 distressing and difficult to read, from somebody who  
12 knows many of the characters involved, though I can't  
13 say that I was particularly surprised, from what I heard  
14 from people at the time.

15 **Q.** You're obviously aware of the diary entries from  
16 Sir Patrick Vallance, in which he describes the general  
17 levels of chaos, of flip-flopping by the Prime Minister,  
18 of the way in which a decision would be taken or  
19 a strategy identified, only for him to go into reverse  
20 within hours or days and to reach a completely different  
21 outcome on seemingly the same material?

22 **A.** Yes. And clearly that is one person's perspective, but  
23 it's an authoritative person's perspective.

24 The British system, and this may well be a deep flaw  
25 in the British system, responds to clarity and direction

78

1 flexible and responsive enough to deal with different  
2 crises as they emerge.

3 **Q.** A supercharged Covid-O, if you like, because it would  
4 comprise ministers and officials and experts?

5 **A.** Yes, I think there is great value in ministers and  
6 officials and experts, as long as the right people are  
7 in the room to reflect the best possible discussion in  
8 being in the same place and hashing these things out.

9 **Q.** Do the structures around the Prime Minister need to be  
10 tightened up and formalised in order to ensure that he  
11 or she is given the best possible advice in  
12 a transparent and clear way to enable them to make  
13 the best possible decisions?

14 **A.** Yes.

15 **Q.** Does there need to be a significant reduction in  
16 the churn, the rotation of ministers and advisers?

17 **A.** And civil servants, yes.

18 **Q.** Does there need to be substantial training in civil  
19 contingency management for advisers, civil servants and  
20 ministers?

21 **A.** Yes. I am mildly sceptical about how far that will gain  
22 purchase on ministers once they're in office, but  
23 I think it is still worth doing. I also think that  
24 before ministers take office there is something that we  
25 should do to prepare them better for so doing.

80

1 **Q.** You mentioned earlier that the UK system is reliant,  
 2 perhaps too reliant, in a crisis on the personal  
 3 attributes of the sitting Prime Minister. It's plain,  
 4 Mr Thomas, that there is a limit upon which any Inquiry  
 5 can make recommendations, given the deference that is  
 6 paid to a Prime Minister under our unwritten  
 7 constitution, on account of their absolute discretion to  
 8 appoint Cabinet and set up committees and appoint  
 9 advisers. But can the civil service structure around  
 10 the Prime Minister be reformed in order to address, one  
 11 hopes, some of the major concerns that you've expressed?

12 **A.** For all the reasons and all the discussion that we've  
 13 had this morning, I think yes. But I would agree with  
 14 and emphasise your point about democracy and the need  
 15 for governments, prime ministers and ministers to be  
 16 accountable to Parliament. I think there is a danger,  
 17 we feel it at the Institute for Government all the time,  
 18 of sometimes taking a slightly sort of desiccated,  
 19 institutional view of these things. It is healthy for  
 20 there to be vigorous and rigorous debate, it is healthy  
 21 for the population to have a chance to elect  
 22 the governing party and, by extension, the  
 23 Prime Minister of their choice, but I think it is also  
 24 healthy for the ability to operate in government to be  
 25 a full part of those considerations.

81

1 all means.  
 2 **LADY HALLETT:** And you're ready to proceed, Mr O'Connor?

3 **(Pause)**

4 Mr O'Connor, are you ready for the witnesses to be  
 5 sworn?

6 **MR O'CONNOR:** Yes, I am, thank you, my Lady.

7 **LADY HALLETT:** Yes, please.

8 **DR RACHAEL EVANS (affirmed)**

9 **PROFESSOR CHRISTOPHER BRIGHTLING (affirmed)**

10 **Questions from COUNSEL TO THE INQUIRY**

11 **LADY HALLETT:** Mr O'Connor.

12 **MR O'CONNOR:** Thank you, my Lady.

13 You are Professor Chris Brightling and

14 Dr Rachael Evans; I think that's right?

15 **PROFESSOR BRIGHTLING:** Correct.

16 **MR O'CONNOR:** Between the two of you, you have written for  
 17 us a report relating to Long Covid; is that right?

18 **DR EVANS:** Correct.

19 **MR O'CONNOR:** We have it on screen. It's a lengthy  
 20 document, but we see that on the first page there is  
 21 a statement which reflects, is this right, your  
 22 understanding of the duties upon you in writing this  
 23 report, the duties of an expert witness, and that you  
 24 understand those duties and that you've complied with  
 25 them, and then both your names, both dated 26 September

83

1 **Q.** Are you saying, on account of the fact that ministers  
 2 are democratically accountable to the population  
 3 through, of course, directly elected MPs, holding  
 4 a majority in the House of Commons, and thereby forming  
 5 government, there is a limit to what can be done in  
 6 terms of improving the personal competence of ministers,  
 7 but the systems around them are capable of significant  
 8 reform?

9 **A.** Correct.

10 **MR KEITH:** Thank you.

11 My Lady, I don't believe we have any questions.

12 **LADY HALLETT:** No, we don't.

13 Thank you very much indeed, Mr Thomas. I'm very  
 14 grateful, and I think you get also the gratitude from  
 15 our stenographer for being a very well paced witness.

16 So thank you very much indeed for all your help.

17 **THE WITNESS:** Thank you, my Lady, and it is a privilege to  
 18 be able to give evidence to this important endeavour.

19 **LADY HALLETT:** Thank you.

20 **(The witness withdrew)**

21 **LADY HALLETT:** I was asked to break, but I think every time  
 22 I break it takes a bit of time and I can catch you all  
 23 by surprise too, so I think unless anyone insists I have  
 24 to break, we just need to get another chair.

25 **MR KEITH:** My Lady, I believe the witnesses are here, so by

82

1 of this year. Is that right?

2 **DR EVANS:** Correct.

3 **PROFESSOR BRIGHTLING:** I do.

4 **MR O'CONNOR:** Thank you.

5 Professor Brightling, there is a lengthy account of  
 6 your career on the second page of the report, I don't  
 7 ask that we bring it up. In summary, you're a professor  
 8 of respiratory medicine at the University of Leicester;  
 9 is that right?

10 **PROFESSOR BRIGHTLING:** That's correct.

11 **MR O'CONNOR:** You have been a consultant since 2004.

12 **PROFESSOR BRIGHTLING:** Correct.

13 **MR O'CONNOR:** And you remain a treating consultant  
 14 physician.

15 **PROFESSOR BRIGHTLING:** Yes.

16 **MR O'CONNOR:** Of important relevance for us today, you have  
 17 been considerably involved since 2020 in both studying  
 18 Long Covid and also treating those who have that  
 19 condition.

20 **PROFESSOR BRIGHTLING:** That's correct.

21 **MR O'CONNOR:** Dr Evans, you are an honorary respiratory  
 22 consultant physician at the Glenfield Hospital, which is  
 23 part of the University Hospitals of Leicester NHS Trust.

24 **DR EVANS:** Correct.

25 **MR O'CONNOR:** And you are also an associate professor at the

84

1 University of Leicester, and with Professor Brightling,  
2 as we will hear, you have also been involved in studying  
3 Long Covid and also treating those who have developed  
4 that condition.

5 **DR EVANS:** That's correct.

6 **MR O'CONNOR:** Now, I'm going, Professor Brightling and  
7 Dr Evans, to take you through various topics which more  
8 or less mirror the contents of your report.

9 You are giving evidence together. It's very  
10 important that we try to avoid overspeaking between  
11 the two of you. I know, because I have discussed this  
12 with you, that there are various parts of the report  
13 that each of you are more familiar with or reflect more  
14 fully your experience, so I'm not going to sort of  
15 direct my questions to one or the other of you, but  
16 perhaps I can invite whichever of you feels most sort of  
17 authoritative in that area to address the particular  
18 issues, and of course, once whoever that is has done so,  
19 if the other one has anything to add then please feel  
20 free, but we will take it slowly and try to avoid  
21 interrupting each other.

22 I'm going to start with what is a very general  
23 issue, but it forms, if you like, the sort of precursor  
24 to considering Long Covid, and that is just the question  
25 of: what is a post-viral syndrome? We'll come to some

85

1 variable.

2 **MR O'CONNOR:** Yes. But nonetheless, when we are talking  
3 about classified post-viral syndromes, there are, as  
4 we'll come to see with Long Covid, understood  
5 definitions, and therefore a physician will normally be  
6 able to reach a diagnosis?

7 **DR EVANS:** Absolutely, they are conditions where you can  
8 give what we would call a positive diagnosis. So even  
9 though you might not have a specific test that tells you  
10 what the syndrome is, that clinical picture, that  
11 clinical history can give you the diagnosis.

12 **MR O'CONNOR:** And you've referred, Dr Evans, to some of  
13 the symptoms involving fatigue, lasting fatigue. You  
14 haven't yet mentioned chronic fatigue syndrome, but that  
15 is a syndrome which occupies much the same area as  
16 the one you've just been describing, is it not?

17 **DR EVANS:** So you can have a post-viral syndrome that's not  
18 necessarily going to lead on to chronic fatigue  
19 syndrome, so chronic fatigue syndrome and ME have a very  
20 precise definition across -- but there are many  
21 different definitions for it.

22 So the CDC have defined chronic fatigue syndrome as  
23 that you must have fatigue and that it's fatigue in  
24 response to an activity or a stressor where you wouldn't  
25 expect necessarily someone to be fatigued from that.

87

1 of the detail around this issue, but my first question  
2 perhaps is whether there's just a simple definition of  
3 a post-viral syndrome?

4 **DR EVANS:** Well, post-viral syndromes cover a wide group of  
5 conditions. There's always an original insult by  
6 a virus, but that virus can affect any part of the body.  
7 Sometimes the acute illness is severe, sometimes it can  
8 be very, very minor.

9 The ongoing sequelae of that virus is what we terms  
10 the post-viral syndromes, those typical symptoms of  
11 fatigue, brain fog, sometimes muscle pain, and a whole  
12 constellation of symptoms. They can be multisystem, so  
13 meaning they can affect any part of the body, and they  
14 can be very variable, so for any particular virus there  
15 might be a syndrome for that particular virus which can  
16 look very different and last for different lengths of  
17 time.

18 **MR O'CONNOR:** Thank you, Dr Evans. And is it right then,  
19 following what you say, that as a result of  
20 the variability of the symptoms, these post-viral  
21 syndrome conditions can be more difficult to diagnose  
22 than other conditions?

23 **DR EVANS:** So, yes, because they're very variable, so you  
24 can predict that for any virus you may get a post-viral  
25 syndrome, but what exactly that looks like may be very

86

1 And then symptoms of something called post-exertional  
2 malaise or post-exertional symptom exacerbation where  
3 that would infer that the person gets symptoms after  
4 an activity or a stressful event or it can be  
5 a cognitive stressor.

6 Then, on top of that, they also have to have  
7 unrefreshing sleep. So that's one definition. And  
8 those symptoms then go on for over six months.

9 **MR O'CONNOR:** All right, that's very helpful. So would it  
10 be right to say that post-viral syndromes can cause  
11 chronic fatigue syndrome, but they don't always?

12 **DR EVANS:** That's right.

13 **MR O'CONNOR:** And as we'll come to address in detail,  
14 Long Covid has amongst its symptoms fatigue but there  
15 are other symptoms which some people suffer which don't  
16 include fatigue?

17 **DR EVANS:** That's correct.

18 **MR O'CONNOR:** Let me ask you a further question, Dr Evans,  
19 a little bit more focused. Can you give us some  
20 examples of viruses that have caused these long-term  
21 sequelae, the post-viral syndromes?

22 **DR EVANS:** Yes. So if we think back to the early part of  
23 the pandemic where the coronavirus was mainly causing  
24 acute lung injury, that was very similar to other viral  
25 pathogens that we've seen, the original SARS CoV virus

88

1 and the MERS pandemic, both of those viruses were  
 2 respiratory viruses that caused ongoing lung issues, but  
 3 there can be viruses, such as the Epstein-Barr virus,  
 4 which we normally think of as causing glandular fever in  
 5 teenagers, and then there are a proportion of teenagers  
 6 that go on and develop ongoing fatigue from that.

7 **MR O'CONNOR:** So that's glandular fever, but just switching  
 8 back to SARS and MERS, those of course are both  
 9 coronaviruses?

10 **PROFESSOR BRIGHTLING:** If I may take that. So SARS-CoV-1  
 11 led to an epidemic in 2002 to 2004. The scale was  
 12 considerably less than SARS-CoV-2, so less than  
 13 10,000 people actually were affected, and fewer than  
 14 1,000 people died of that. And the best data in terms  
 15 of the long-term effects came from studies in Hong Kong,  
 16 so they looked at a relatively small number of  
 17 100 individuals, and followed them up, for a year in  
 18 their initial publication and two years in the  
 19 subsequent publication, and they found symptoms such as  
 20 breathlessness and fatigue, but they also did lung  
 21 function testing, and when they did that they found that  
 22 the lung function was impaired, in particular a test  
 23 which we know goes with -- is associated with lung  
 24 scarring, and that was seen in a quarter of the people  
 25 with SARS-CoV-1.

89

1 I was also the chair of the Science Council for the  
 2 European Respiratory Society, so I was getting -- I was  
 3 in regular contact and had a number of conversations  
 4 with others in China but also particularly in Europe,  
 5 and obviously in Italy, was already hearing about some  
 6 of the early things that people were finding after  
 7 the Covid infection, so it was foreseeable to us before  
 8 the pandemic, because we were aware of what had happened  
 9 with SARS-CoV-1, and it was even more apparent early on  
 10 in the pandemic that this would be a potential problem.

11 **MR O'CONNOR:** So just to be clear, Professor Brightling,  
 12 when you say "before the pandemic", do you mean in 2019,  
 13 before we'd even heard of any cases, your understanding  
 14 of SARS-CoV-1 gave you to believe that a further  
 15 coronavirus similar to it would cause long-term  
 16 sequelae?

17 **PROFESSOR BRIGHTLING:** Correct. So the SARS-CoV-1  
 18 post-viral syndrome data was in the public domain  
 19 by 2010, and had been presented and discussed at  
 20 scientific meetings ahead of that. So although  
 21 the numbers were very small, we were aware of the  
 22 post SARS-Cov-1 syndrome, as well as the other viruses  
 23 that Dr Evans has described.

24 **MR O'CONNOR:** Then I think you've explained that as soon as  
 25 the news started to come in of the developing epidemic,

91

1 So using SARS-CoV-1 as an example really gave us  
 2 some clarity about the likelihood of what might happen  
 3 in SARS-CoV-2.

4 **MR O'CONNOR:** Let me turn to that, then, which is my next  
 5 topic, which is the question of the foreseeability of  
 6 long-term sequelae from Covid-19. Perhaps if I can ask  
 7 the question, at least first of all from the perspective  
 8 of what was known in very early 2020 as, as we've heard,  
 9 the information started to come out of China about this  
 10 new virus. Of course we've learnt a huge amount since  
 11 then, but just on the basis of what was known in those  
 12 early days and weeks in January 2020, was it foreseeable  
 13 to those of you who understand these things that there  
 14 might be long-term sequelae from Covid-19?

15 **PROFESSOR BRIGHTLING:** So very early on we were already  
 16 considering that there was a number of clear areas that  
 17 needed to be addressed: certainly addressing the acute  
 18 condition and trying to improve management in the  
 19 hospital; vaccination to try and then be part of the  
 20 public health measure; and also then the likelihood of  
 21 long-term effects.

22 So this is something that we had recognised very  
 23 early on and then developed a programme of work, which  
 24 we then wrote up in the March of 2020. And we were  
 25 learning things from others as well, so at that time

90

1 pandemic in China, you swiftly drew the conclusion that  
 2 there might well be long-term sequelae from that virus?

3 **PROFESSOR BRIGHTLING:** Correct. And we really became very  
 4 much in an activated stage to then actually write up  
 5 the protocols then in the March, when it seemed apparent  
 6 to us that there really needed to be work done and why  
 7 shouldn't we be the ones doing it.

8 **MR O'CONNOR:** When you talk about writing up the protocols,  
 9 we'll come to hear more, probably after lunch now, about  
 10 the study that the two of you were deeply involved with  
 11 in terms of hospitalised patients of Covid. Was it at  
 12 that stage that you started planning and moving towards  
 13 undertaking that study?

14 **PROFESSOR BRIGHTLING:** So the point where we more formally  
 15 wrote up the protocol was from the middle of March.

16 **MR O'CONNOR:** Yes.

17 Just before we leave this topic, you've told us, and  
 18 explained why, when you believed long-term sequelae were  
 19 certainly foreseeable. That's a binary issue: are there  
 20 going to be long-term sequelae or not? At that very  
 21 early stage, how confident were you able to be about  
 22 the incidence of these sequelae, of their severity,  
 23 exactly what form they would take and so on?

24 **PROFESSOR BRIGHTLING:** So there's two important things to  
 25 consider there. One is how big a scale the pandemic

92

1 would be, and certainly we now know really just how huge  
2 an effect it's had on the entire planet. So, first of  
3 all, it's how big is the pandemic, and then it's what's  
4 the proportion of those that then have subsequent, as we  
5 now know it, Long Covid, because of the infection. And  
6 neither of those were really known.

7 So we felt that there was likely to be a problem  
8 coming, but we didn't know the true scale of that until  
9 we understood the size of the pandemic and then had  
10 early data coming in around the potential prevalence.

11 **MR O'CONNOR:** Yes, thank you.

12 I want to move to the next topic, if I may, which is  
13 just an overview of the emergence of Long Covid during  
14 2020 and perhaps a little into 2021.

15 I've referred to your study which related to  
16 hospitalised patients suffering from Covid, and you  
17 describe in your report how the early work and the early  
18 understanding of these long-term sequelae was quite  
19 sharply focused on those people suffering from Covid who  
20 were hospitalised.

21 Can you give us a little bit more detail on that,  
22 please?

23 **DR EVANS:** Yes. So, following on from the last line of  
24 questioning, the other group that we had information  
25 about is patients where they have a very severe lung

93

1 **DR EVANS:** Yes.

2 **MR O'CONNOR:** It's in fact the Post-hospitalisation COVID-19  
3 study --

4 **DR EVANS:** That's correct.

5 **MR O'CONNOR:** -- as we say, focusing on this quite sharply  
6 defined cohort of really very ill people who have been  
7 hospitalised with severe lung symptoms, injury, needing  
8 oxygen and so on. And one of the points you make in  
9 your report is that people who have undergone  
10 an experience like that, particularly if they have been  
11 in an ICU unit, may have sort of continuing symptoms,  
12 almost just because of the intensity of their treatment  
13 in hospital, which is something rather different from  
14 the continuing perhaps post-viral syndrome associated  
15 with their initial infection; is that right?

16 **DR EVANS:** Yes, so there's a spectrum of problems that  
17 somebody in hospital after or because of SARS-CoV-2 will  
18 get. That can be, like you're saying, that people might  
19 end up on the intensive care unit where they're  
20 having -- they're needing organ support, so support for  
21 their breathing, support for their kidneys, and multiple  
22 drugs, and there are things about that illness on  
23 intensive care, something that's often called post-ICU  
24 syndrome, which again can last many months, many years,  
25 that is well documented. But apart from that, being in

95

1 injury ending in hospital, requiring oxygen and  
2 sometimes breathing machines to help them. And people  
3 with those conditions, so either acute lung injury or  
4 something known as adult respiratory distress syndrome,  
5 can, we know from other studies, particularly large  
6 studies from Canada showing that those patients can have  
7 ongoing consequences for many, many years -- both health  
8 consequences and consequences for occupation, so the  
9 fact that -- the SARS-CoV-2 virus, we knew from China  
10 quite early on that the predominant illness at that  
11 point was very much the acute lung injury, so that was  
12 one element to why we were looking at those people that  
13 were in hospital.

14 But there were also some logistical challenges  
15 around setting up a research study. So people in  
16 hospital had a clear diagnosis from a clinician, even if  
17 we didn't have the testing confirmed right at  
18 the beginning. So you had a firm start point and then  
19 a follow-up. Scientifically it would have been very  
20 difficult at that time, without thought before, because  
21 of the lack of testing as well in the community, so it  
22 was quite challenging to study that group.

23 **MR O'CONNOR:** At any rate, that was the cohort that you  
24 focused on in setting up this study, which was, we see  
25 the acronym, PHOSP-Covid -- is that how you refer to it?

94

1 hospital, being inactive and unwell for prolonged  
2 periods can have other consequences, so on top of also  
3 having the potential for post-viral syndromes.

4 **MR O'CONNOR:** Yes. So all of this, then, is very much  
5 focused on those people who were in hospital and who  
6 were extremely ill in hospital, but, as you've  
7 explained, those were the people who you were able to  
8 confidently make the subject of the study.

9 It's right, though, isn't it -- and I'm going to  
10 come to this after lunch -- that there was a very  
11 different cohort of people in 2020 who, as we now know,  
12 were suffering from Long Covid; they may not have had  
13 a diagnosis, they may not even have known what was wrong  
14 with them, and they weren't the subject of the study  
15 that you were undertaking?

16 **DR EVANS:** That is correct.

17 **MR O'CONNOR:** My Lady, that is a slightly different topic,  
18 and I was proposing to turn to it after lunch.

19 **LADY HALLETT:** Certainly. Thank you very much. I shall  
20 return at 2 o'clock. I hope you were warned that we  
21 would break over lunch.

22 **DR EVANS:** Yes, thank you.

23 (12.58 pm)

(The short adjournment)

24 (2.00 pm)

96

1 **LADY HALLETT:** Mr O'Connor.

2 **MR O'CONNOR:** I'm grateful, my Lady.

3 Professor Brightling, Dr Evans, before lunch I had  
4 asked you some questions about that cohort of patients  
5 in hospital who you had begun to study in the early  
6 months of the pandemic, who were suffering from  
7 long-term symptoms.

8 But then just before we finished, I mentioned that  
9 other group of people who were suffering longer  
10 symptoms, who in fact turned out to be a much larger  
11 group, did they not, in the community? It's right,  
12 isn't it, that their situation became known largely as  
13 a result of their own voicing of their concerns about  
14 the symptoms they were suffering?

15 **DR EVANS:** Yes, absolutely, there wasn't the testing in  
16 the community at the beginning, and there really wasn't  
17 the recognition of what we now know as Long Covid, and  
18 actually the patients really got together as one voice  
19 to really advocate for what we know now as Long Covid,  
20 indeed actually defined Long Covid, and a number of  
21 different charities that now exist that got together in  
22 those early months, May and June of 2020.

23 **MR O'CONNOR:** Some of those groups are of course  
24 core participants before this Inquiry, and we'll be  
25 hearing some evidence later this afternoon in relation

97

1 organically to look after the people post hospital, many  
2 clinics across the UK were set up in that fashion, or  
3 doctors that had looked after people in acute care were  
4 naturally following that group up, but the people with  
5 that lived experience of ongoing symptoms for many  
6 months were then trying to seek healthcare themselves.  
7 And you will see in the report that that was incredibly  
8 challenging. But some people then were getting referred  
9 into the NHS clinics, so actually clinicians like myself  
10 across the UK were becoming more family with this  
11 syndrome.

12 **MR O'CONNOR:** Yes, and NICE, as we will see, and I'll come  
13 back to it, but towards the end of that year, in I think  
14 October and December of 2020, issued guidance and also  
15 an important definition of the condition.

16 **DR EVANS:** Absolutely. And although it was early days and  
17 we didn't know all about Long Covid, it was really  
18 important to have that definition and particularly for  
19 people with the lived experience to actually have the  
20 symptoms that they were suffering from actually  
21 recognised.

22 So those definitions included post-Covid syndrome,  
23 where you've got ongoing symptoms for many weeks and  
24 without another underlying condition. And I spoke about  
25 a positive diagnosis earlier and that's what we as

99

1 to them.

2 As you say, the term "Long Covid" I think was coined  
3 by the patient advocates of those groups.

4 **DR EVANS:** Absolutely.

5 **MR O'CONNOR:** Looking back on it, do you think that the NHS  
6 or public health authorities could have done more in  
7 those early months to have responded to the developing  
8 picture relating to Long Covid sufferers in  
9 the community?

10 **DR EVANS:** So I think with hindsight the answer to that is  
11 absolutely yes, that they were left alone with what is  
12 a very frightening condition, that they didn't know what  
13 was happening, healthcare professionals weren't there to  
14 support them and the research wasn't there, and perhaps  
15 more could have been done at the start, before  
16 the pandemic, to actually prepare for what those  
17 post-viral syndromes might have been.

18 **MR O'CONNOR:** As we know, and as you describe in your  
19 report, you've just mentioned May and June, but as that  
20 year went on, no doubt partly because of the campaigns  
21 that we'll hear more about that were being mounted by  
22 those various patient advocacy groups, there was, was  
23 there not, more engagement from the National Health and  
24 other public health authorities relating to Long Covid?

25 **DR EVANS:** Absolutely. So there were clinics started very

98

1 clinicians would do.

2 **MR O'CONNOR:** I'm going to come on to ask you a few more  
3 questions focusing on diagnosis in a little while, but  
4 just sticking with the chronology and those events  
5 towards the end of 2020, in October, I think it's on  
6 7 October 2020, NHS England announced what they called  
7 a five-point plan relating to Long Covid, did they not?

8 **DR EVANS:** That is right.

9 **MR O'CONNOR:** And it's been helpfully brought up on  
10 the screen. This is how you've presented it within your  
11 report, and we can see there, if we just look at  
12 the points in this plan, first of all:

13 "New guidance from NICE ..."

14 That's what we've just been talking about, isn't it?

15 But the second point:

16 "An online website of supported self-management  
17 called Your Covid Recovery ..."

18 Tell us a little about that.

19 **DR EVANS:** Yeah, so that, again, started early in the  
20 pandemic and was released, I think, in July of that  
21 year, and it was really to help the supported  
22 self-management of people. Again, it was rather focused  
23 on the post-hospital group to begin with, but through  
24 all the advocacy of those patient support groups they  
25 did work together and actually make it more acceptable

100

1 and more appropriate for the whole of the ongoing  
2 symptoms after Covid. And that was funded through NHSE  
3 and led by Professor Sally Singh at Leicester  
4 University.

5 **MR O'CONNOR:** Point 3, I think you already referred to  
6 the development of clinics. You referred to people  
7 going seeing their GPs, but the plan seems to have been  
8 to move towards designated Long Covid clinics.

9 **DR EVANS:** That's right, so that when people do seek  
10 healthcare in the UK through their primary care team  
11 that they then have got the option of being referred to  
12 a specialist clinic by people that are aware of  
13 the syndrome, familiar with it, can talk through all  
14 the different problems, and at least help with that  
15 supported self-management.

16 **MR O'CONNOR:** And the fourth point is funding for research.  
17 We've already touched on your research, which by this  
18 stage was well under way, was it not, but there was more  
19 research which came a little later and amplified  
20 the research that you had started? Is that fair?

21 **DR EVANS:** That's correct, yeah.

22 **MR O'CONNOR:** Then the last point -- I'm sorry.

23 **DR EVANS:** Can I just add, and that research call, just so  
24 that it's clear, was for people that had not been  
25 hospitalised for their Covid-19. That was the important

101

1 starting in the autumn?

2 **PROFESSOR BRIGHTLING:** That's correct. So the evolution in  
3 terms of timing, things were all happening very close  
4 together, so you had interactions through reports from  
5 the Academy of Medical Sciences and also things that  
6 were then presented to SAGE, which I'm sure you might  
7 want to come back to shortly, and that really led to  
8 then that first meeting which was the end of July which  
9 was then chaired by the Secretary of State, which then  
10 led a little bit later to then the setting up of  
11 the roundtables that were chaired by Lord Bethell. And,  
12 as Dr Evans has described, that also included people  
13 with lived experience.

14 **MR O'CONNOR:** Yes.

15 **PROFESSOR BRIGHTLING:** And between those two was actually  
16 when that five-point plan was published. The five-point  
17 plan was published a week before the start of those  
18 regular meetings.

19 **MR O'CONNOR:** This is all explained in your report, but just  
20 to get this out, those roundtables, as you say chaired  
21 by Lord Bethell, continued I think for 12, 18 months on  
22 a regular basis after that; is that right?

23 **PROFESSOR BRIGHTLING:** Correct, they went into the following  
24 year.

25 **MR O'CONNOR:** As I say, there is a lot more detail in your

103

1 difference --

2 **MR O'CONNOR:** So the community --

3 **DR EVANS:** Yeah, absolutely.

4 **MR O'CONNOR:** -- cases.

5 Then the last point, the setting up of something  
6 called the NHS-England Long Covid taskforce. Is that  
7 something that either of you two were personally  
8 involved with?

9 **DR EVANS:** Yes. Well, we both had involvement in slightly  
10 different ways. There were different workstreams within  
11 the Long Covid taskforce, so there were clinicians,  
12 academics and people with lived experience. I was  
13 involved more closely in the clinical workstream, around  
14 the clinic set-up, and Professor Brightling was in  
15 the research workstream, and Professor Sally Singh that  
16 I've mentioned was in the rehabilitation stream.

17 **MR O'CONNOR:** Thank you. That's all I wanted to ask about  
18 that plan.

19 The next point is that, perhaps running alongside  
20 the development of the five-point plan, in very much  
21 the same period, there was engagement from the DHSC  
22 itself, and a series of ministerial roundtable meetings  
23 which, Professor Brightling, I think you were involved  
24 with, starting with a sort of pre-meeting, I think, in  
25 the summer, and then a series of more formal meetings

102

1 report about these various initiatives and developments,  
2 but would it be fair to say that, possibly from a slow  
3 start, as Dr Evans said, towards the end of that year  
4 things did gather pace in terms of engaging with  
5 the calls from the patient advocates and trying to  
6 understand this new condition?

7 **PROFESSOR BRIGHTLING:** Yes, I mean, I think it was -- as  
8 we've already said, I mean, it was slow paced initially,  
9 primarily because of the focus of those who have been  
10 hospitalised, and then very much it was taken on board  
11 that this is clearly a condition that also affects  
12 people who had Covid in the community, and then  
13 the community calls, as Dr Evans described, then came  
14 out at the end of the year. So the main tranche of  
15 funding after the initial funding for our study then  
16 came very much as a focus around those who had been  
17 affected in the community.

18 **MR O'CONNOR:** Let me go on and ask you more questions about  
19 your study, and for these purposes if we could go to  
20 page 10 of your report, and it's the top of that page,  
21 we see there the reference to your PHOSP-Covid study.  
22 And at the bottom of that paragraph, which has been  
23 enlarged on the screen, you summarise the aims of  
24 the report: first of all, to determine the long-term  
25 sequelae; second, to investigate the longer-term effects

104

1 of acute and post-discharge treatments, perhaps  
2 reminding us that you were focusing entirely on  
3 hospitalised patients; and finally, to provide  
4 a platform for future studies of emergent symptoms and  
5 worsening of pre-existing disease to improve care for  
6 current and future patients.

7 With that in mind, can you give us a brief summary  
8 of the course of the study and what it showed at its  
9 conclusion?

10 **PROFESSOR BRIGHTLING:** So, as you can see, we really wanted  
11 to understand what was the impact, and a lot of our  
12 focus was on the group of patients where we had  
13 in-clinic assessments, so they were then seen at two  
14 time points, approximately five to six months and one  
15 year; and what we were interested in is we were  
16 interested in how many of those had recovered, so that  
17 was a self-reported question -- we had a whole series of  
18 different patient-reported outcomes, and the way we put  
19 this together was, right from the outset, we recognised  
20 this is a condition that's likely to affect multiple  
21 organs, as Dr Evans described before lunch, and  
22 therefore we would need working groups with different  
23 specialists. So we'd actually engaged, through what's  
24 called the translational research collaboration network,  
25 which is part of the NIHR biomedical research network,

105

1 were discussing before lunch, that although you were  
2 reasonably confident once you knew about the virus that  
3 there would be long-term sequelae, you didn't know how  
4 bad they would be and when you found out it was  
5 a surprise to you?

6 **DR EVANS:** Absolutely, and really, really showed the need  
7 for absolute proactive healthcare for this group.

8 **PROFESSOR BRIGHTLING:** But it gave us some clues. So  
9 although we were somewhat surprised and we were also  
10 very concerned about the scale of the problem, it also  
11 gave us some clues about what to do next. So we then  
12 had clues around the way different groups of symptoms  
13 came together, and we also found that there were certain  
14 measurements in the blood, particularly those related to  
15 inflammation, that could identify a group of patients  
16 that might then be -- might be actually open to  
17 a potential intervention. And then we've moved on to  
18 then developing an intervention study that Dr Evans  
19 leads, which will be starting very soon, which then has  
20 a target where we know what the likely mechanism is in  
21 that group. So it's been very revealing, so that's gone  
22 right through to step 3.

23 **MR O'CONNOR:** Yes. Just going back to the point we've  
24 mentioned more than once about the focus of this study  
25 on hospitalised patients, of course from the chronology

107

1 and that allowed us to then have experts across a number  
2 of different disciplines, and in so doing we were then  
3 able to then collect all of these patient-reported  
4 outcomes. As well as that we were able to then do  
5 tests, so physiological tests, such as breathing tests  
6 and blood tests.

7 Our main early findings, I'm going to turn to  
8 Dr Evans, because Dr Evans was the first author for  
9 those papers, around the effects in terms of  
10 the proportions recovered and the types of things we  
11 found in those patients.

12 **DR EVANS:** So we were really quite alarmed by the first  
13 few -- the results of the first few months, because even  
14 though I'd been running clinics, we knew there were  
15 a proportion of people that weren't fully recovered but  
16 actually our study showed that it was over 70% of people  
17 that were not fully recovered by five to six months, and  
18 our one-year data shows that there is very little  
19 recovery from six months to one year. It demonstrated  
20 the multisystem organ impairment that was involved and  
21 obviously the constellation of very difficult symptoms,  
22 the impact on occupation and things outside of health,  
23 and an impact on health-related quality of life that we  
24 would see with other devastating long-term conditions.

25 **MR O'CONNOR:** So does this bring us back to the point we

106

1 we've discussed, as the study was really getting going  
2 that was very much the time that you were realising that  
3 there were these other community patients. Did you  
4 consider at that stage expanding the study so that you  
5 could include those patients in the work as well as  
6 those in hospital?

7 **PROFESSOR BRIGHTLING:** So, we did. So we applied -- so in  
8 that first round of funding we've described that was  
9 focused on people who had been affected in  
10 the community, we had as part of that, led by  
11 Professor Paul Little from Southampton, worked very  
12 closely with him, and a consortium, to put in a similar  
13 design study which would build on the experience from  
14 PHOSP. But that wasn't one of the studies that was then  
15 supported.

16 **MR O'CONNOR:** You mean not funded?

17 **PROFESSOR BRIGHTLING:** Not funded.

18 **MR O'CONNOR:** Right. I'm going to move on in a moment but,  
19 just to be clear, we have focused on this study  
20 of course because it was the first and the study that  
21 you were both deeply involved with, but we do know,  
22 don't we, we saw the point on the action plan, that  
23 funding did become available and there are a range of  
24 other studies that were ongoing from sort of late 2020  
25 and over for the rest of the pandemic; is that right?

108

1 **DR EVANS:** The funding I think started February 2021, so it  
2 was really a year after those first people in  
3 February/March 2020 had first got Covid and then got  
4 their symptoms.

5 **MR O'CONNOR:** Does that perhaps teach us a lesson about  
6 future pandemics? There are such things, I know, as  
7 hibernating studies, and what those are, as I understand  
8 it, is, as it were, a study that is prepared in advance,  
9 for example, of a pandemic in rather neutral terms, but  
10 is then sort of on the blocks and ready to go. And so  
11 had such a study been hibernating in early 2020, it  
12 would have been much quicker and easier for you to have,  
13 as it were, brought it to life, and you could have then  
14 hit the ground running and it would have been a much  
15 more effective exercise in the last pandemic?

16 **DR EVANS:** Absolutely, and we would have needed that  
17 wide-scale testing much earlier in order to do that,  
18 because in the study of the disease, if you don't have  
19 that first marker of when the infection happened, it's  
20 very difficult or impossible to study. So you need  
21 both, you need the hibernating study and then  
22 the appropriate testing to be set up at scale.

23 **PROFESSOR BRIGHTLING:** Good to show the real value of that,  
24 if I may. So the ISARIC study, which I'm sure you may  
25 have talked about here already, which was

109

1 **DR EVANS:** I don't, but I know that page.

2 **MR O'CONNOR:** So it's the bottom paragraph, and, Dr Evans,  
3 we need to look, don't we, about six lines up from  
4 the bottom, do we see on the right-hand side there is  
5 a sentence starting "Post-Covid-19 syndrome is defined",  
6 that was the NICE definition provided in December 2020,  
7 was it not? And before we look at it, is it right that  
8 that has become a sort of accepted definition that's  
9 used certainly in this country?

10 **DR EVANS:** In this country, absolutely. And then the WHO  
11 developed, through a consortium, and a Delphi process,  
12 which means getting lots of experts and people with  
13 lived experience together, came up with a definition of  
14 post-Covid condition, which is also given in that  
15 section, and they're very similar. So people have to  
16 have experienced ongoing symptoms for 12 weeks, and,  
17 importantly, another condition, another explanation has  
18 to be excluded. But you can still make that diagnosis  
19 with the positive clinical findings.

20 **MR O'CONNOR:** Right. Was that the WHO definition or the  
21 NICE definition that you were summarising there?

22 **DR EVANS:** So --

23 **MR O'CONNOR:** They're very similar.

24 **DR EVANS:** They're very similar.

25 **MR O'CONNOR:** Let's just look at the language on the page:

111

1 the observational study of patients who were admitted  
2 into hospital with Covid-19, was a hibernating study,  
3 and that meant that data was then feeding through into  
4 decision-making really early, so if there had been  
5 a parallel arm that had been hibernating, then it could  
6 have gone alongside the activity of the ISARIC study,  
7 and we certainly would recommend that for future  
8 pandemic preparedness.

9 **MR O'CONNOR:** Are, to your knowledge, plans being made or  
10 have they been made for hibernating studies relating to  
11 post-viral syndromes in relation to a future pandemic?

12 **PROFESSOR BRIGHTLING:** So we're not aware that that's been  
13 formalised but it's something that we're actually part  
14 of developing ourselves, and we will then clearly share  
15 that with the appropriate people in government.

16 **MR O'CONNOR:** Thank you.

17 Let's move on. I want to ask you just a few more  
18 detailed questions about Long Covid itself, starting  
19 with diagnosis. We've touched on the NICE definition  
20 that was provided back in December 2020. Perhaps if we  
21 could call that up, it's quoted in your report --

22 **DR EVANS:** Section 1.6.

23 **MR O'CONNOR:** Yes, thank you very much. So it's  
24 paragraph 1.6, page 6 of the report.

25 **LADY HALLETT:** Do you know it off by heart?

110

1 "Post-Covid syndrome is defined as signs and  
2 symptoms that develop during or after an infection  
3 consistent with Covid-19 ..."

4 One.

5 Two:

6 "... continue for more than 12 weeks ..."

7 Three:

8 "... not explained by an alternative diagnosis."

9 And that would be the definition that physicians up  
10 and down the country would be using when they were  
11 seeing patients?

12 **DR EVANS:** Absolutely. But we also use the language  
13 "Long Covid" because it's a patient-derived term and we  
14 have kept that.

15 **MR O'CONNOR:** Yes. Now, the next -- well, there's no test,  
16 is there, for example, a blood test or any other test of  
17 that nature, that can be done to determine one way or  
18 another whether someone has Long Covid; is that right?

19 **DR EVANS:** That's correct.

20 **MR O'CONNOR:** So if a doctor is diagnosing Long Covid, he or  
21 she simply has to go on the wording that we see in front  
22 of us and make a decision for themselves about whether  
23 the patient meets that definition?

24 **DR EVANS:** That's correct.

25 **MR O'CONNOR:** Is there anything particularly unusual about

112

1 having to make a diagnosis as a doctor without a piece  
 2 of science that tells us definitively one way or the  
 3 other what the answer is?  
 4 **DR EVANS:** So, no, there's nothing unusual about that.  
 5 Indeed, if we go back in time a few decades, that's how  
 6 medicine started. We are fortunate now that for many  
 7 conditions you do have a diagnostic test that helps us  
 8 confirm a diagnosis. But actually all diagnoses are  
 9 mainly based predominantly on people's symptoms and then  
 10 the investigations support that.  
 11 **MR O'CONNOR:** So the fact that there isn't a test that can  
 12 be done and a print-out proving the answer doesn't make  
 13 it any less of an illness and it provides no grounds for  
 14 scepticism about the existence of the illness?  
 15 **DR EVANS:** Definitely not.  
 16 **MR O'CONNOR:** You're very clear about that. You refer in  
 17 your report, at least in the early stages, to a certain  
 18 amount of scepticism even from doctors, the medical  
 19 professionals, about Long Covid.  
 20 **DR EVANS:** Sadly that's correct, yes. And we heard that  
 21 actually largely through the qualitative work.  
 22 Qualitative research interviews people and gets their  
 23 experience. It's very scientific, it's recorded, you  
 24 have trained professionals at knowing how to extrapolate  
 25 things out of those interviews. And it came really very  
 113

1 the most common symptoms that are found?  
 2 **DR EVANS:** Yes.  
 3 **MR O'CONNOR:** But you then go on to say:  
 4 "... but over 200 symptoms have been reported."  
 5 Does that take us back to the point you were making,  
 6 Dr Evans, at the start, about all or at least perhaps  
 7 many post-viral syndromes, which is that by their  
 8 definition the symptoms can be very variable?  
 9 **DR EVANS:** Absolutely, and the way people express their  
 10 symptoms can also be very variable.  
 11 **MR O'CONNOR:** Further down the page, you talk about  
 12 "clusters of symptoms". Is that a feature of  
 13 Long Covid?  
 14 **DR EVANS:** It is, and by "clusters" we, researchers, tend to  
 15 be discussing that in terms of a mathematical model to  
 16 actually group those symptoms together, but it does look  
 17 like there are certain symptoms that group together,  
 18 which Professor Brightling also briefly mentioned  
 19 earlier.  
 20 **MR O'CONNOR:** Yes.  
 21 Just moving on, if I may, then, the related question  
 22 of incidence, in other words who you find gets  
 23 Long Covid. I'm going to ask you about children in  
 24 a moment, but if I can talk about the adult population  
 25 first, and for these purposes if we can go to page 19 of  
 115

1 loud and clear, both when we're speaking to the patient  
 2 support groups but also in the research itself, that  
 3 they were finding it difficult to get believed and  
 4 difficult to access appropriate healthcare.  
 5 **MR O'CONNOR:** But in your view at any rate such scepticism  
 6 is completely misplaced?  
 7 **DR EVANS:** Yes.  
 8 **MR O'CONNOR:** And physicians should simply diagnose  
 9 according to this definition on the basis of what they  
 10 see before them and what the patients tell them?  
 11 **DR EVANS:** Yes. And I would say that primary care have  
 12 a difficult time, and obviously that definition only --  
 13 because they look after everything, that definition only  
 14 came about towards the end of the year.  
 15 **MR O'CONNOR:** Yes.  
 16 **DR EVANS:** But yes, there isn't a place for scepticism.  
 17 **MR O'CONNOR:** Let me turn if I may and ask you something  
 18 about the symptoms of Long Covid. It's something we've  
 19 already heard some evidence about, but if we go to  
 20 page 12 of your report, please, at the top, at the very  
 21 top we see paragraph 1.14, you say:  
 22 "Long Covid is frequently characterised by symptoms  
 23 of fatigue, breathlessness, brain-fog, joint and muscle  
 24 pain ..."  
 25 Pausing there, do we take it that those are perhaps  
 114

1 your report, and it's at the very bottom there, the last  
 2 two lines, you refer to the fact that "any adult is at  
 3 risk of developing Long Covid".  
 4 **DR EVANS:** That's right. That's an important public health  
 5 message, that even though we have people that might be  
 6 more at risk, that actually anyone can develop  
 7 Long Covid. So anyone that's contracting the infection  
 8 can end up unfortunately with this very prolonged  
 9 illness.  
 10 **MR O'CONNOR:** You then go on to say that those who perhaps  
 11 are at greater risk, shown by the statistics, are people  
 12 of middle age, people who are female sex, obese, lower  
 13 socioeconomic status with bring existing comorbidities,  
 14 those are the groups that you refer to as being more  
 15 likely to develop Long Covid.  
 16 **DR EVANS:** That's right, and that's been shown in multiple  
 17 different studies, which actually then supports that  
 18 there is something more robust about that when you've  
 19 got it in -- you know, a good handful of studies have  
 20 all shown the same things.  
 21 **MR O'CONNOR:** We know that for Covid itself certainly people  
 22 who tend to develop worse symptoms of Covid, it tends to  
 23 be -- there's a bias the other way, in the sense that  
 24 it's men who the statistics show have more worse  
 25 symptoms. Is there any understanding at this stage as  
 116

1 to why women seem to be more at risk of developing  
2 Long Covid?  
3 **PROFESSOR BRIGHTLING:** So if I go back to the acute setting,  
4 so men are more likely to have acute Covid that leads  
5 into more severe disease and are -- those who are older  
6 are also more affected, and there is a concept around  
7 immune senescence and there is also an increased  
8 inflammatory response in men compared to women, so to  
9 some of this hyperinflammatory effect that might then  
10 lead on to the acute lung injury. It's important to  
11 remember again that you can be of either sex and you can  
12 be of any age, but it is more common in those who are  
13 men and older.

14 In Long Covid, as you said, the demographics are  
15 different and the demographics are actually more similar  
16 to what we would see in things like autoimmune  
17 conditions such as rheumatoid arthritis, so this has led  
18 us to then consider whether there may be an ongoing  
19 inflammatory response and possibly an immune-mediated  
20 response that is then affecting this group.

21 **MR O'CONNOR:** It's apparent from what you say perhaps two  
22 things. First of all, although it's the acute Covid  
23 that triggers Long Covid, they are actually really quite  
24 different conditions and therefore these different  
25 profiles can be readily explained. But secondly, as

117

1 Long Covid, it's more common in adults than it is in  
2 children, but the prevalence estimates, or in the most  
3 recent estimates since the vaccine, would still suggest  
4 that it's in the region of 5% in adults and 1% in  
5 children. So although the number of children are  
6 considerably fewer than adults that's still  
7 a substantial proportion when you're then thinking about  
8 your own children or other family members. It's really  
9 important to those children and their parents. Yes. And  
10 as we've heard, not least in the impact video that was  
11 shown at the very start of our hearings, there are some  
12 children who very sadly suffer from very serious  
13 long-term symptoms from Long Covid.

14 **DR EVANS:** That's correct, yeah, sadly.

15 **MR O'CONNOR:** I'd like to move on, if I may.

16 Professor, you mentioned this earlier, that I might  
17 come back and ask you a few more questions about SAGE  
18 and the interaction between SAGE and issues of  
19 Long Covid.

20 Within your report, and of course it's -- we will be  
21 publishing it on the Inquiry website for people to read  
22 in due course, there is a chapter in your report where  
23 you review quite carefully the SAGE minutes, which  
24 of course have already been published, and you chart how  
25 SAGE during the pandemic referred to Long Covid, kept in

119

1 we've heard from other witnesses, it's still very early  
2 days in understanding Long Covid and it may be that in  
3 months or years' time you understand these matters  
4 better?

5 **PROFESSOR BRIGHTLING:** It's extremely likely that there is  
6 more than one mechanism that's actually driving  
7 Long Covid, and one of the things that we're working  
8 very hard at is to try to understand what are those  
9 underlying drivers. So I mentioned a little bit earlier  
10 about one of the groups that have this persistent  
11 inflammation, and this is really critical because then  
12 that could lead us on to more of what we would think of  
13 as a precision medicine approach, where we would have  
14 then have diagnostics that then could start to pick up  
15 what might be driving your type of Long Covid, and then  
16 most importantly then actually lead on to different  
17 treatment strategies for different people.

18 **MR O'CONNOR:** I said I would come back to children, we have  
19 been talking about the adult population, you explain in  
20 your report that Long Covid manifests rather differently  
21 in children. Are you able to sort of summarise  
22 the position in that regard?

23 **PROFESSOR BRIGHTLING:** So in children it's less common for  
24 them to have severe disease, so fewer children then were  
25 admitted into hospital. In terms of the prevalence of

118

1 touch with the developing understanding of  
2 the condition, and on one occasion, I think in 2021,  
3 commissioned some further work relating -- a report  
4 relating to SAGE.

5 You of course weren't on -- neither of you sat on  
6 SAGE. We have heard from two people who were sat on  
7 SAGE or associated with it, both Professor Khunti and  
8 Professor Medley, that perhaps one of the limiting  
9 factors for SAGE during the pandemic with regard to  
10 Long Covid was the very fact that so little was  
11 understood about Long Covid. That's, in general terms,  
12 a view they've expressed.

13 I'd like to ask you -- perhaps,  
14 Professor Brightling, you on this occasion -- whether  
15 you, having reviewed the SAGE minutes and your  
16 understanding of the position at the time, think that  
17 SAGE might have done more during the pandemic to  
18 understand Long Covid or to give advice to policymakers  
19 about the risks that it posed?

20 **PROFESSOR BRIGHTLING:** So SAGE did acknowledge very early on  
21 in very early meetings that the duration of symptoms  
22 after the acute Covid was very variable. They  
23 highlighted at the end of April that there was a need to  
24 look at the -- particularly the post hospitalisation  
25 group at that time and asked Professor Calum Semple, who

120

1 is on SAGE but also was one of the principal  
2 investigators of ISARIC, to then look at  
3 the consequences in the ISARIC population.

4 There was also an Academy of Medical Sciences report  
5 that I was part of that was then presented to SAGE in  
6 the July and endorsed, and this was preparing for  
7 the winter, the challenging winter, and that included  
8 a section on post-Covid conditions.

9 However, after that, there really was very little  
10 until coming into early 2021 when the early reports were  
11 coming through from ONS and then the report from  
12 Calum Semple, and also then the report from PHOSP-Covid,  
13 which all happened in the March, and that led to  
14 the commissioned report that you referred to that was  
15 then presented in the July.

16 So although there's a chronology of certain points  
17 where they were reflecting and going back to what we now  
18 know as Long Covid, there was such a focus at  
19 the beginning of the acute disease and the move towards  
20 accelerating the vaccine programme that it's clear that  
21 the amount of the time spent in SAGE to the long-term  
22 consequences, certainly by reflecting on the minutes,  
23 not having been in the meetings, the minutes do suggest  
24 that there was really very little time spent on thinking  
25 about the long-term consequences until coming into 2021.

121

1 at the centre of government. For these purposes I just  
2 need to show you a few documents. First of all, could  
3 we have on screen, please, INQ000251916.

4 Now, this is a note, we haven't, as an Inquiry, seen  
5 this before, but I'm sure we will look at it again. We  
6 can see in fact from the last page -- perhaps if we  
7 could just look at the last page now. Yes, thank you.

8 So it's three pages long. It's a note by  
9 Chris Whitty, the Chief Medical Officer, it's dated  
10 31 May 2021. We may have seen, if we go back to  
11 the first page, it's addressed to the private secretary  
12 to the Prime Minister, and it is, as the title suggests,  
13 a short note describing his understanding of Long Covid  
14 as at May 2021.

15 As I say, I'm sure we will look at this document as  
16 an Inquiry again. I know you've read it. Can I simply  
17 ask whether you regard that as a fair and  
18 a comprehensive account of the state of knowledge about  
19 Long Covid on the date that it was written?

20 **PROFESSOR BRIGHTLING:** Yes. Yes, it is. It would have also  
21 been a fair statement a few months before it was written  
22 as well.

23 **MR O'CONNOR:** Yes, and we will see a little more about how  
24 this note came to be written with future witnesses.

25 That was all I wanted to ask about that document,

123

1 Again, coming back to this idea of hibernating  
2 studies and thinking about preparedness, if they'd had  
3 data earlier then the discussions could have been  
4 considered earlier, and they also would have been able  
5 to have had reports coming into SAGE very early on of  
6 progress of those studies and what was being found and  
7 how do you then develop clinical services and plans for  
8 future treatments.

9 So I think there was an opportunity missed in terms  
10 of timing because of the focus, and quite rightly  
11 a focus, on the acute episode and the vaccine, but then  
12 as a consequence not really very much time was spent on  
13 Long Covid.

14 **MR O'CONNOR:** So in terms of looking to the future, does  
15 that bring us back to, first of all, the need, as you  
16 say, to set up these hibernating studies which would be  
17 ready to address long-term sequelae of any future  
18 pandemic?

19 **PROFESSOR BRIGHTLING:** Yes, and a clear plan not only for  
20 the hibernating studies but how those hibernating  
21 studies then actually inform clinical practice and then  
22 inform potential treatments.

23 **MR O'CONNOR:** Yes. Thank you.

24 Lastly, Professor and Dr Evans, I want to ask you  
25 just a few questions about understanding of Long Covid

122

1 thank you.

2 The other two documents I'm going to show you both  
3 relate to the Prime Minister, Boris Johnson, and they  
4 reflect his views about Long Covid. First of all, as we  
5 will see, in October 2020, and then some months later in  
6 February 2021.

7 So just to remind ourselves of the chronology that  
8 we've already been through, it was late 2020, was it  
9 not, when we were talking about the NICE guidelines,  
10 the roundtable meetings at the Department of Health, and  
11 those other sort of innovations towards the end of that  
12 year?

13 So, first of all, let's have a look -- I see it's  
14 already on the screen -- at this box note  
15 [INQ000251910]. You can see that's actually dated  
16 9 October and it's a note to the Prime Minister about  
17 various matters that were arising that week.

18 If we can go to page 9, please, we can see that  
19 point 25 on this list is headed "Long COVID review", and  
20 in fact it does refer to one of the things that  
21 Lord Bethell was engaged with at the time, a report that  
22 was being prepared, and we see amongst other things  
23 a list of the symptoms very similar to the list that we  
24 have just been discussing.

25 But we see that the Prime Minister against that

124

1 wrote the words:  
 2 "Bollocks. This is Gulf War syndrome stuff."  
 3 Before I ask for your comment on that, let's look at  
 4 the other document as well.  
 5 So if we can now go to document INQ000214216,  
 6 please. In fact, if we could just -- sorry, just give  
 7 me a moment.  
 8 **(Pause)**  
 9 Could we just go to the page before that one,  
 10 please.  
 11 What we see at the very bottom of that page is we  
 12 see the date, which is 21 February. Do you see that?  
 13 In fact it's after midnight, and a message from  
 14 Boris Johnson on this, this is a WhatsApp. So if we now  
 15 go on to the next page [page 52/75], there is a series  
 16 of listed points he makes, and it's point number -- yes,  
 17 so if we go down a bit. It's point number 30, so the  
 18 last point he makes:  
 19 "do we really believe in long covid? why can't we  
 20 hedge it more? I bet it is complete gulf war syndrome  
 21 stuff."  
 22 So two comments, one in October 2020, the other in  
 23 February 2021, of a similar character.  
 24 What's your reaction, having been involved in  
 25 Long Covid at that time, to those views expressed by  
 125

1 have that view sustained right through to the beginning  
 2 of the year in suggesting that this was something that  
 3 could be continued to be ignored.  
 4 I mean, it's just ... out of all the things that we  
 5 see, it's yet another unbelievable thing that happened,  
 6 and what I don't know, clearly, is -- we don't know how  
 7 much this influenced the activity from government  
 8 and what government then did. But you would expect, if  
 9 the Prime Minister's view was such, it may well have had  
 10 an influence on other people in government.  
 11 And I know, Rachael, you feel very strongly as well  
 12 about it.  
 13 **MR O'CONNOR:** Dr Evans?  
 14 **DR EVANS:** Yeah, I mean, absolutely, it's shocking and just  
 15 beyond disappointing, and I still feel very emotive when  
 16 you see it, because obviously we've got people here, as  
 17 Chris has said, that are living through this absolutely  
 18 dreadful illness. And there is some distrust, we've  
 19 already heard that some clinicians weren't believing  
 20 them, but to see that your own Prime Minister has  
 21 written something like that, I just can't -- yeah, can't  
 22 begin to think how people living through it feel.  
 23 And actually as clinicians and researchers, we were  
 24 already feeding back very clear descriptions of what  
 25 this illness looked like, even if we didn't know exactly  
 127

1 the Prime Minister? Perhaps I'll ask you first,  
 2 Professor.  
 3 **PROFESSOR BRIGHTLING:** So the timing of the first document  
 4 was the week after the release of the five-point plan,  
 5 and the same week that the roundtable was -- actually  
 6 met with Lord Bethell, with people with lived experience  
 7 and with academics, including ourselves.  
 8 So what was written there was accurate, it was  
 9 an accurate description of the activity, it was  
 10 an accurate description of the problem.  
 11 I've seen this document a couple of times now over  
 12 the last couple of weeks, and I feel exactly the same,  
 13 it's -- I'm deeply saddened and extremely angry at  
 14 the same time. There are people in this room, there are  
 15 people who are watching, who have either suffered with  
 16 Long Covid themselves or their loved ones had  
 17 Long Covid, and I would be surprised if there are people  
 18 in this room who do not at least know somebody who has  
 19 had Long Covid.  
 20 So to -- I mean, I'm not even quite sure what he  
 21 means. Does he mean bollocks to the science? Well,  
 22 that's clearly wrong because the science was already  
 23 quite compelling that this was a problem. Is it  
 24 bollocks to the patients, because he actually didn't  
 25 really feel that they deserved a voice? And then to  
 126

1 what was causing it and all the rest of it, it was  
 2 a very real and is a very real phenomenon.  
 3 **MR O'CONNOR:** Thank you very much, Dr Evans,  
 4 Professor Brightling. Those are all the questions we  
 5 have for you. There aren't any CPs questions.  
 6 **LADY HALLETT:** Thank you, Mr O'Connor.  
 7 Thank you both very much indeed, not only for the  
 8 research and the treatment that you do, but for being  
 9 an advocate, for getting recognition for what is  
 10 obviously a dreadful condition. So thank you for all  
 11 that you've done. Thank you for your help.  
 12 **(The witnesses withdrew)**  
 13 **MR O'CONNOR:** My Lady, we have one further witness this  
 14 afternoon, and that is Ondine Sherwood.  
 15 **MS ONDINE SHERWOOD (affirmed)**  
 16 **Questions from COUNSEL TO THE INQUIRY**  
 17 **LADY HALLETT:** Ms Sherwood, can I first of all apologise for  
 18 the fact the timetabling has meant that we've had to  
 19 hear from you this afternoon when Mr Metzger can't be  
 20 with us in person. I am so sorry.  
 21 **THE WITNESS:** It's okay.  
 22 **LADY HALLETT:** I've apologised to him too, but as you can  
 23 see, if you look on the screen, he is attending  
 24 remotely, albeit I have no idea what time it is where he  
 25 is. But as you know, but others may not, he had  
 128

1 a long-standing --

2 **THE WITNESS:** Early morning, I think.

3 **LADY HALLETT:** -- morning engagement that he had to fulfil.

4 So I'm really sorry.

5 **THE WITNESS:** That's fine, thank you.

6 **MR O'CONNOR:** Could you give us your name, please.

7 **A.** Yes, my name is Ondine Sherwood.

8 **Q.** Ms Sherwood, you are one of the founding members of

9 a group called Long Covid SOS.

10 **A.** Yes, I'm a founding member of Long Covid SOS. I'm here

11 actually representing two other groups, Long Covid Kids

12 and Long Covid Support. And we'd all like to offer our

13 sincerest condolences to the bereaved families.

14 **Q.** Thank you. As you say, I'll come to the other

15 two groups in a moment, but on behalf of Long Covid SOS

16 you have provided the Inquiry with a statement.

17 **A.** I have.

18 **Q.** And I see it's helpfully on screen, and at the end of

19 that statement, I don't ask for us to go there, but you

20 have signed the statement stating that you believe

21 the contents of it are true, with the date of

22 25 September --

23 **A.** Absolutely.

24 **Q.** -- 2023.

25 **A.** Yes.

129

1 very much with the chronology we were just discussing

2 with Professor Brightling and Dr Evans, and you say that

3 you helped to found that organisation. I take it there

4 were other people involved at the start as well?

5 **A.** Yes.

6 **Q.** You describe the organisation as a "volunteer-run

7 patient advocacy and campaign group". Can you tell us

8 a little bit about how it started?

9 **A.** Yes. I, having not recovered from Covid, which

10 I developed at the end of March, I really couldn't

11 understand why I wasn't recovering. It was very odd.

12 And I initially thought it must be something wrong with

13 me: why on earth was I not able to throw off this virus?

14 Which -- I hadn't had a particularly severe infection.

15 But I came across an article written by a young

16 woman in America in the New York Times where she

17 described ongoing symptoms and that she had set up

18 a support group. So I joined that support group and was

19 quite astonished to see the messages going back and

20 forth in that group. How many people were in there, the

21 ages, the symptoms they were experiencing, and it was

22 shocking. It really was. And it put it all into

23 context for me. I realised I was not alone.

24 After a few weeks --

25 **Q.** Just pause there, Ms Sherwood.

131

1 **Q.** As you've indicated, Long Covid SOS is the group that

2 you are here to represent, it's the group that you

3 helped to found, but there two other Long Covid support

4 groups that have core participant representation before

5 the Inquiry, and witness statements have been filed on

6 behalf of those two groups as well. Perhaps if we can

7 just call them up briefly, the first is a statement from

8 Natalie Rogers on behalf of an organisation called

9 Long Covid Support, and I imagine you're familiar with

10 that statement?

11 **A.** I am, yes.

12 **Q.** Secondly, there is a statement from Sammie McFarland, on

13 behalf of Long Covid Kids, and those are, are they not,

14 the three groups that are represented before

15 the Inquiry --

16 **A.** Yes.

17 **Q.** -- on behalf of Long Covid, and no doubt there are many

18 other support groups relating to Long Covid throughout

19 the country?

20 **A.** Yes, there will be.

21 **Q.** Let's focus, for the moment at least, Ms Sherwood, on

22 your organisation, Long Covid SOS.

23 If we look at page 2 of your statement and

24 paragraph 3, we see you say there that the group was

25 established in June 2020. That date, of course, fits

130

1 **A.** Sorry?

2 **Q.** Just tell us, it was shocking because you realised that

3 other people were suffering the same as you, or because

4 a lot of other people were suffering?

5 **A.** It was shocking the extent of their suffering, because

6 their -- remember, at the time Covid was described as

7 a mild illness unless you were very sick in hospital and

8 that the prime symptoms were fever and a new continuous

9 cough, yet the range of symptoms that these people were

10 suffering was far wider, and many of the symptoms were

11 frightening and debilitating and many of the people in

12 that group were very young and had been very fit.

13 **LADY HALLETT:** Could you slow down, please.

14 **A.** Oh, I'm sorry, am I talking too fast?

15 **LADY HALLETT:** Don't worry, I speak too quickly as well.

16 **A.** Okay, I will slow down.

17 Yes, that was what was shocking: the symptoms,

18 the people experiencing the symptoms, the number of

19 people, all over the world, a lot of them were in

20 America. And the most shocking of all was the fact they

21 weren't getting any help. They were all saying, "No one

22 can help me", and that was -- it was extraordinary. It

23 really was. And that really motivated me to answer

24 a call from one of my co-founders to march on

25 Parliament, because I felt something had to be done.

132

1 **MR O'CONNOR:** So those were the circumstances in which you  
 2 set up, with others --  
 3 **A.** Yes.  
 4 **Q.** -- this group.  
 5 I want to go back to something you said, you  
 6 yourself, as you've explained, had continuing symptoms  
 7 of Covid?  
 8 **A.** Yes.  
 9 **Q.** Do you in fact continue to suffer --  
 10 **A.** I still -- I'm much, much better, but I think I have  
 11 a vulnerability in that if I overdo things I will have  
 12 what we term a relapse, and I can have a day or few days  
 13 of feeling unwell. And that will happen if, you know,  
 14 I've exerted myself too much or particularly if there  
 15 has been a lot of stress. So I think that is something  
 16 residual that I may always have, but fortunately, unlike  
 17 many, I have managed to get my life back.  
 18 **Q.** Coming back to the group, you were starting to tell us,  
 19 and it's a core theme of your statement, that the group  
 20 was formed for the purpose of what we've seen described  
 21 as patient advocacy.  
 22 **A.** Mm-hm.  
 23 **Q.** Was that because you and others felt you weren't being  
 24 properly supported at the time?  
 25 **A.** Yes, we were being -- we felt abandoned. The film we  
 133

1 "... my ongoing symptoms were often met with  
 2 scepticism and a degree of 'gaslighting'."  
 3 **A.** Yes.  
 4 **Q.** Was that a common experience?  
 5 **A.** Very common. It was very common because the doctors  
 6 didn't seem prepared for this, even though post-viral --  
 7 post-viral syndromes were known, but they weren't  
 8 prepared for this, they probably weren't prepared for  
 9 the extent of it. Some of the symptoms they interpreted  
 10 as anxiety, and many patients were told they were  
 11 anxious and sent home, including people whose children  
 12 were presenting with symptoms, where they were told  
 13 their children were being influenced by their parents  
 14 and that these symptoms were fabricated.  
 15 So there was a huge amount of gaslighting,  
 16 I'm afraid that is a word that was used a lot in  
 17 the support group, and people really felt that.  
 18 And I have to add that it has been said by many  
 19 people that the trauma of not being believed was one of  
 20 the worst aspects of their experience.  
 21 **Q.** Yes. The steps that you took as an organisation, as you  
 22 describe in your witness statement, became largely  
 23 engaging with, attempting to lobby and advocate with  
 24 the government.  
 25 **A.** Mm-hm.  
 135

1 made in those early days was called *Message in a Bottle*,  
 2 and that was really to illustrate how many people felt  
 3 that they were really on their own, that they had been  
 4 abandoned by the government, they weren't getting any  
 5 healthcare, doctors didn't understand their condition.  
 6 In fact, when I was in the acute phase, it struck me  
 7 that with all the emphasis on hospitalisations and  
 8 deaths, but nobody was really examining the people in  
 9 the community, no one was looking at us, no one was  
 10 researching us, you know, suffering at home.  
 11 **Q.** Just pause there for a moment. If you can try and  
 12 keep --  
 13 **A.** Oh --  
 14 **Q.** I'm sorry to --  
 15 **A.** Slower, sorry.  
 16 **Q.** -- come back to it, but if you can try and keep your --  
 17 **A.** Yes.  
 18 **Q.** -- keep it slower, that would be much appreciated.  
 19 **A.** Okay.  
 20 **Q.** You were suffering at home, and what you've said picks  
 21 up another one of the themes of your statement, which is  
 22 that you and others perhaps were misunderstood. I just  
 23 want to quote one of the accounts that you give in your  
 24 witness statement, not from you but from one of the  
 25 people involved in your group. What was said is:  
 134

1 **Q.** Perhaps we can turn to page 6 of your statement,  
 2 paragraph 23, which starts at the bottom, and you say  
 3 that:  
 4 "While our advocacy initially focused on the need  
 5 for formal recognition for and treatment of Long Covid,  
 6 we soon discovered that we also had to work hard to put  
 7 pressure on key decision makers so that important issues  
 8 such as counting cases of Long Covid were addressed."  
 9 You refer also to the impact of decisions around  
 10 easing restrictions, distribution of vaccines and so on.  
 11 **A.** Yeah.  
 12 **Q.** You then list what I think are the sort of key topics or  
 13 the key aims of your advocacy over that period --  
 14 **A.** Yes.  
 15 **Q.** -- of the pandemic:  
 16 Campaigning for formal recognition of Long Covid;  
 17 advocacy for the incorporation of Long Covid in  
 18 government decision-making; counting Long Covid,  
 19 advocacy for improved treatment; and other matters.  
 20 I want to go, if I may, to a letter that you wrote  
 21 right at the start of your campaigning. You refer to  
 22 it, in fact, I think lower down on that page, but if we  
 23 could call the letter itself up on the screen, please,  
 24 it's INQ00238582, and so we can see, Ms Sherwood, it's  
 25 dated 3 July, so within a month or so of your  
 136

1 organisation coming together?

2 **A.** Yes.

3 **Q.** We see that it's addressed to a series of people,  
4 the Prime Minister, the Health Secretary, Chris Whitty,  
5 Patrick Vallance, and then the chief executive of  
6 NHS England, and also the chief executives of health  
7 authorities in the devolved nations, and also the chief  
8 executive of Public Health England.

9 Could I just ask you about the devolved nations,  
10 something that this Inquiry takes an interest in. Was  
11 your group, is your group one that spans all of the UK  
12 or is it an English group?

13 **A.** Our focus has become England mainly because our --  
14 the core members, the core volunteers, all live in  
15 England and we've -- also because, as I may tell you  
16 later, we work quite closely with NHS England, so that  
17 became our focus.

18 The other two groups who form the Long Covid groups  
19 both have organisations or suborganisations who work  
20 with the devolved nations, and so they do more work with  
21 Scotland, Wales and Northern Ireland than we do, because  
22 we've really worked hard with NHS England and that's  
23 been our focus. But we did write to the devolved health  
24 authorities and we did get replies from two of them.

25 **Q.** Yes. Unlike some of the people in this country that you  
137

1 statement about how many people you have following  
2 your --

3 **A.** Yes.

4 **Q.** -- feeds and so on.

5 **A.** Yes.

6 **Q.** Is it right to say that you, as an organisation, now  
7 anyway, you reach tens of thousands of people?

8 **A.** Definitely, yes. Yes.

9 **Q.** At the start how many people were involved --

10 **A.** Well, we didn't have -- we weren't running a support  
11 group, so we didn't have people signing up to a support  
12 group, we were running as a campaigning organisation.  
13 But our social media accounts grew fairly quickly, as  
14 did -- the website attracted quite a lot of people  
15 signing up as well, and at the beginning it was  
16 difficult to know how many people we were representing.  
17 We knew that, for instance, Long Covid Support had  
18 a Facebook group, which at the time I think was -- I may  
19 be wrong, but I think it was at the beginning -- round  
20 about this time it was about 3,000, 5,000 people. So we  
21 knew that there were a lot of people involved, but  
22 nobody really knew how many.

23 **Q.** Yes. Just going back to the letter, if we can go down  
24 a bit further down the page, about halfway down the next  
25 paragraph, you refer to the fact that people had been  
139

1 wrote to?

2 **A.** Yes.

3 **Q.** Well, we'll come back to that. I don't want to -- we  
4 won't go line by line through this letter, but I just  
5 want to pick up on a few of the points that are made  
6 in it.

7 First of all, the first substantive paragraph, you  
8 talk about representing thousands of forgotten victims  
9 of Covid-19, and you describe them as struggling to get  
10 help from the medical community for their continuing  
11 disease and feeling "abandoned" by the government.

12 That's quite a strong term, but was that how you  
13 felt at the time?

14 **A.** Yes, I think that encapsulates the feelings of most  
15 people who weren't able to get any help, and of course  
16 the thousands was an estimate.

17 **Q.** It was, but perhaps I should have asked you this  
18 earlier, I was going to, in terms of the reach of your  
19 organisation, I think it's right to say it's not  
20 a sort of old-fashioned membership organisation, where  
21 people sort of join and have a membership card, you're  
22 a -- largely based on a -- as a sort of social  
23 networking site --

24 **A.** Yes.

25 **Q.** -- and so on. But you do give some details in your  
138

1 told that they only had mild symptoms, they were told to  
2 go home, they had to struggle on on their own, and that  
3 there was, as it were, a dissonance between, on the one  
4 hand, all the public health messaging saying, "It's  
5 a mild condition, don't worry about it", and on  
6 the other hand, these alarming ongoing symptoms that  
7 people were suffering?

8 **A.** Yes. Certainly, you know, many, many people who  
9 probably should have been in hospital, but they weren't  
10 able to go to hospital because their symptoms weren't  
11 considered quite bad enough by 111, but even if they  
12 weren't eligible for hospital or they weren't as bad as  
13 that, they were quite ill, and this use of the word mild  
14 is very misleading, because for most people it wasn't  
15 mild.

16 **Q.** I suppose we have to bear in mind or remember quite what  
17 it was like during 2020, still the early months of the  
18 pandemic, and a great concern, perhaps, about going to  
19 hospitals if one didn't feel one really needed to be  
20 there?

21 **A.** Yes, I think there were a lot of people who would rather  
22 have stayed out of hospital, but those that were -- who  
23 should have been admitted were -- some of them, their  
24 loved ones were asked to keep an eye of them every hour  
25 in the night, in case something went wrong. So many  
140

1 people had a very traumatic acute Covid experience.  
 2 **Q.** Yes. Let's look over the page, if we can, and  
 3 the sort of third paragraph down, in the middle of that  
 4 paragraph we can see there is a sentence starting  
 5 "Unfortunately".  
 6 **A.** Mm.  
 7 **Q.** You describe people who have been infected with Covid-19  
 8 being told, it would seem rather dismissively, that  
 9 they're just suffering from anxiety, and in fact a range  
 10 of other diagnoses, some sort of post-viral symptom,  
 11 fatigue.

12 Is what you're trying to capture there, going back  
 13 to this point about just uncertainty amongst the group  
 14 as to what it is that's wrong with them?

15 **A.** I think that amongst doctors -- and this is kind of  
 16 speculation, but it's something we've discussed at  
 17 length -- the doctors didn't understand the symptoms,  
 18 and many don't really like to express to their patients  
 19 that they don't know and they don't understand, and so  
 20 they fall back on something they do understand: "Well,  
 21 this could be anxiety, you know, it's an anxious time,  
 22 we're in a pandemic, and breathlessness, fatigue, can be  
 23 symptoms of anxiety, so let's hope that's what it is."

24 And post-viral fatigue, which was what I was told  
 25 I had, I don't think it captures the experience that

141

1 penultimate line, you say:

2 "We did not receive any response from the UK  
 3 Government [to that letter] ..."

4 **A.** No, no one from government replied.

5 **Q.** I'm not going to call it back up, but you wrote to  
 6 the Prime Minister, to Matt Hancock, to Chris Whitty, to  
 7 Patrick Vallance?

8 **A.** We had replies from the devolved health authorities, we  
 9 had a reply eventually from Professor Stephen Powis,  
 10 from NHS England, we had a response from Public Health  
 11 England suggesting we contact the Department of Health  
 12 and Social Care, and we had -- I copied it to all  
 13 the MPs, so we had responses from some MPs supporting  
 14 us, mostly Opposition MPs, as far as I remember, but no,  
 15 we didn't get anything back from government.

16 **Q.** Now, we've heard from Professor Brightling and Dr Evans  
 17 a little bit about what happened later, for the second  
 18 half of that year, and there were various developments,  
 19 for example the roundtable meetings at the Department of  
 20 Health and the setting up of the Long Covid taskforce,  
 21 to name two. I think it's right to say that your groups  
 22 or groups like it were involved in those various  
 23 initiatives?

24 **A.** That's right, yeah, we were.

25 **Q.** Were you personally involved in either at the roundtable

143

1 people were having.

2 **Q.** Yes.

3 If we just look at the next paragraph down, we see  
 4 essentially the core complaint of the letter, which is,  
 5 looking at the first sentence, there appears to be very  
 6 little focus on the part of government on the ongoing  
 7 very poor health of potentially hundreds of thousands of  
 8 people, it's imperative that the needs of this group are  
 9 addressed. And that's really what your group was trying  
 10 to do at that stage?

11 **A.** Yes.

12 **Q.** Bring it to the attention of the government?

13 **A.** Yes, because it seemed almost -- it was almost  
 14 impossible to understand how so many people could be so  
 15 sick and nobody was talking about it. It wasn't present  
 16 in any conversation. It was only starting to be -- it  
 17 was in certain news articles from maybe May, but very  
 18 few, and it simply was not mentioned by government or by  
 19 public health messaging. It just wasn't there.

20 **Q.** Yes.

21 I'm just ... yes, if we can call up, go back to your  
 22 witness statement, please, it's the bottom of page 7,  
 23 it's paragraph 27 at the bottom of that page where you  
 24 describe the letter we've just been looking at in  
 25 detail, but if we pick it up at the end of the

142

1 meetings --

2 **A.** Yes.

3 **Q.** -- or in the taskforce?

4 **A.** Yes, because we worked with -- by the time the taskforce  
 5 was set up, we were having regular meetings with  
 6 NHS England, and in fact we encouraged them to publicise  
 7 something, that announcement they made in October about  
 8 the five-point plan, because we were getting so many  
 9 people saying, "What's happening? What's happening?  
 10 Why aren't we getting any help? What are we going to  
 11 do?" And we were working with NHS England and we said,  
 12 "Well, what are we supposed to say? Is anything  
 13 happening?"

14 So that's why you will see that there is a quote  
 15 from our organisation on that press release, and we were  
 16 part of the taskforce and invited to sit on  
 17 the roundtable.

18 **Q.** In a few sentences, what was your impression of those  
 19 initiatives? Did you feel that they were effective?  
 20 Perhaps, over time your view changed on them, but tell  
 21 us what your views were.

22 **A.** Well, the taskforce was much more focused on the NHS and  
 23 on care, and it was obviously very encouraging when that  
 24 was set up, and it was very good to be in a forum with  
 25 scientists and doctors and talking about this condition,

144

1 and having the condition taken seriously and discussed  
 2 in the serious manner. It did seem -- it became obvious  
 3 after a while that decisions weren't going to be made at  
 4 that taskforce, it was a forum for discussion and that  
 5 anything that happened would take place in between  
 6 meetings. The subgroups that were set up -- actually  
 7 also it was our initiative to set up subgroups in the  
 8 taskforce -- they were very good because we could have  
 9 much more focused discussions.

10 So after a while we did begin to wonder, you know,  
 11 where is it leading us, because we were still having  
 12 trouble getting any treatments established for  
 13 Long Covid and people were complaining about the clinics  
 14 and so on, so there was some frustration there.

15 As far as the roundtable goes, that was also a very  
 16 exciting moment, that we were going to be having  
 17 meetings with the government minister, and certainly  
 18 the government ministers, which as well as Lord Bethell,  
 19 included Matt Hancock and Sajid Javid, when taking part  
 20 in these meetings were very receptive, were very  
 21 interested and were very willing to listen and to  
 22 sympathise.

23 **Q.** Yes.

24 **A.** However, we felt that it tended to stop there. We  
 25 couldn't get these -- and the need that we felt for

145

1 and the elderly would be vaccinated first. So those  
 2 were the people who get severe acute Covid. So that  
 3 made sense, but it didn't take into account the fact  
 4 that Long Covid can affect anybody. So we had already  
 5 heard announcements by Boris Johnson that, "Once we've  
 6 vaccinated the vulnerable and the elderly we'll be able  
 7 to open up the country", and of course that concerned us  
 8 greatly, because then the country would be completely  
 9 opened up and all the younger people would be mixing in  
 10 large numbers and would get Covid, and they may not go  
 11 to hospital or end up dead, but they would be liable to  
 12 get Long Covid. And they weren't vaccinated. We can  
 13 see that there seems to be lesser incidence of  
 14 Long Covid in vaccinated adults, but these people  
 15 weren't vaccinated. And of course the children weren't  
 16 vaccinated -- there were no plans to vaccinate  
 17 the children at all.

18 **Q.** So, in summary, was your concern that the focus was very  
 19 much on the acute Covid and the prospect that  
 20 the vaccine programme would reduce the risk of  
 21 acute Covid and, on that principle, allow more opening  
 22 up --

23 **A.** Yes.

24 **Q.** -- but that rather different analysis applied to  
 25 Long Covid --

147

1 changes in policy, even though we were sitting with  
 2 ministers, it didn't seem -- it didn't happen. And that  
 3 was very frustrating.

4 **Q.** Right.

5 I want to move on, perhaps finally, and ask you just  
 6 about a sort of series of events later on in  
 7 the pandemic, six months or so later. For these  
 8 purposes, perhaps we can go to page 13 of your witness  
 9 statement, please, and it's paragraphs 50 to 51.

10 So we're now in January 2021, and then I'm going to  
 11 move later into 2021 in a moment, but in summary,  
 12 Ms Sherwood, we'll all remember that it was around that  
 13 time that the vaccine roll-out started, and although it  
 14 was clearly going to take a while, as you say in your  
 15 statement, there started to be discussion about lifting  
 16 restrictions once people had been properly vaccinated.  
 17 This was something that gave your group some concern,  
 18 was it not? Explain perhaps in a few sentences, and if  
 19 you can try to keep the pace down, that would be  
 20 appreciated.

21 **A.** Sorry.

22 **Q.** Please explain what -- the slightly different set of  
 23 concerns you had about that prospect.

24 **A.** Yes, okay. When the vaccine roll-out was first  
 25 announced, it was made clear that the vulnerable groups

146

1 **A.** Yes.

2 **Q.** -- and that that might risk infecting people, which  
 3 would see a rise in Long Covid?

4 **A.** Well, infecting a lot of people. And as it happened,  
 5 of course, this was the time when we'd just come out  
 6 Alpha, Delta was on its way, and there was the potential  
 7 for large numbers of people to get infected because we  
 8 would be without restrictions.

9 And it was clear that the thought processes of  
 10 government were just not considering Long Covid as being  
 11 anything -- as being something that needed to be  
 12 considered. Certainly from our point of view we didn't  
 13 see any evidence that Long Covid was a consideration.

14 **Q.** Yes. In the passage of your witness statement that  
 15 we're looking at now, you refer to a letter there that  
 16 you wrote about these concerns in January 2021, and then  
 17 further down the page you refer to the fact that you  
 18 then wrote on very much the same theme, in the last  
 19 paragraph, on 6 July --

20 **A.** Yes.

21 **Q.** -- the January letter warning of this problem and July  
 22 saying it's still there?

23 **A.** It's happening, yes.

24 **Q.** And we may all remember, I think it was  
 25 the 20-somethingth of July 2021 that was badged as sort

148

1 of "freedom day" --

2 **A.** Yes.

3 **Q.** -- and it was in advance of that that you wrote this

4 other letter --

5 **A.** Yes.

6 **Q.** -- Mr Javid by this stage being the Health Secretary,

7 essentially renewing your --

8 **A.** Yes.

9 **Q.** -- concerns on this basis.

10 **A.** Can I just add that the other concern was not only was

11 Long Covid not considered by government, it wasn't

12 being -- there was no public messaging about Long Covid

13 at all, so not only were people at risk of getting --

14 developing Long Covid, they didn't know about that risk,

15 so they were unaware of the risk. "Freedom day" just

16 sends a message that we can all just go out and party

17 and it's all over, which of course it wasn't, but what

18 it doesn't express is that actually 5%, 10%, you know,

19 it could be somewhere in between, of people don't get

20 better after two weeks, and some of them will be very,

21 very unwell for a long time. But that information

22 wasn't out there and so how could the public assess

23 their risk?

24 **Q.** Of course those are the people who, some of them at any

25 rate, were members of your group, and it was their

149

1 way that we can in order to give this condition a little

2 bit more publicity. Because there are many people in

3 this country unfortunately who think Long Covid is made

4 up, that it doesn't exist, that people who have got it,

5 oh, they must all be public servants because they just

6 don't want to work. I mean, there are some really nasty

7 comments that we get on social media and -- you know,

8 there are some beliefs that go around, and maybe it's

9 worse on social media, which really stigmatise and

10 denigrate the people who have this condition.

11 **Q.** Yes.

12 Well, Ms Sherwood, I'm very grateful, and perhaps

13 one can add that of course your involvement in this

14 Inquiry and the involvement of the other groups is part

15 of that campaigning function.

16 **A.** Yes.

17 **MR O'CONNOR:** And it's one for which I'm sure we're all very

18 grateful.

19 But, as I've said, we have your statement, we also

20 have the statement of Ms Rogers and Sammie McFarland,

21 which we will adduce in full, and which we have for our

22 work, and I'm very grateful for you coming along and

23 sharing your experiences with us this afternoon.

24 Those are all the questions I have for you.

25 **THE WITNESS:** Thank you very much for having me.

151

1 experiences that you were very familiar with yourself?

2 **A.** Yes.

3 **Q.** Can I just, and just finally, Ms Sherwood, bring us

4 forward. You describe these, the sort of campaigning

5 actions that we've discussed already, and others,

6 including on the point about messaging, in your

7 statement. But can you bring us up to date? What are

8 your sort of campaigning objectives at the moment?

9 **A.** We felt at one point that we'd sort of lost the public

10 health battle, that we weren't going to be able to

11 influence the government to take precautions in order

12 to -- or to encourage people to take more precautions to

13 avoid getting Covid. At the moment we're very concerned

14 that there are no -- there's no mandates for precautions

15 even in hospitals, which is very, very difficult for

16 people who don't want to catch Covid. If you go into

17 any hospital now, most people who are working there are

18 not wearing masks, and we've heard stories of that

19 happening in wards with vulnerable patients.

20 So people with Long Covid, along with the clinically

21 vulnerable, find it very difficult to go back into

22 society really and to mix in the way that other people

23 are. So, as well as using our voice to inform people

24 about Long Covid, to inform people how to get help,

25 we're still very interested in changing policy in any

150

1 **LADY HALLETT:** Thank you very much, Ms Sherwood, a very

2 eloquent advocate. And do I hear in the breathing, is

3 that --

4 **THE WITNESS:** Well, it may not be related, but I am a bit

5 chesty, yeah.

6 **LADY HALLETT:** Well, I hope that the recovery does continue.

7 **THE WITNESS:** Thank you very much indeed.

8 **LADY HALLETT:** So thank you very much for your help indeed.

9 **(The witness withdrew)**

10 **MR O'CONNOR:** My Lady, there's one very brief practical

11 matter I've been asked to raise with you.

12 You'll appreciate that Ms Sherwood's evidence brings

13 us to the end of the impact evidence that we have heard.

14 So may I invite you to order that, first of all,

15 the questionnaire responses that have been summarised

16 during the various tranches of evidence, and also

17 the witness statements of Southall Black Sisters,

18 Long Covid groups and the children's organisations, that

19 they are all published on the Inquiry website and

20 adduced into evidence.

21 **LADY HALLETT:** Most certainly.

22 **MR O'CONNOR:** I'm grateful, my Lady. That's everything.

23 **LADY HALLETT:** That's it? That's it for this week.

24 Thank you all very much for attending online, and

25 thank you, Mr Metzger, if you're still there, for

152

1 attending despite your long journey, and thank you to  
2 everybody here, and I will see everybody at 10.30 on  
3 Monday.

4 **MR O'CONNOR:** Yes.

5 **LADY HALLETT:** Thank you.

6 (3.15 pm)

7 (The hearing adjourned until 10.30 am  
8 on Monday, 16 October 2023)

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19  
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21  
22  
23  
24  
25

INDEX	PAGE
3 MR ALEX THOMAS (affirmed) .....	1
5 Questions from LEAD COUNSEL TO THE INQUIRY1	
7 DR RACHAEL EVANS (affirmed) .....	83
9 PROFESSOR CHRISTOPHER BRIGHTLING .....	83
10 (affirmed)	
12 Questions from COUNSEL TO THE INQUIRY ....	83
14 MS ONDINE SHERWOOD (affirmed) .....	128
16 Questions from COUNSEL TO THE INQUIRY ...	128

25

<b>DR EVANS: [54]</b> 83/18 84/2 84/24 85/5 86/4 86/23 87/7 87/17 88/12 88/17 88/22 93/23 95/1 95/4 95/16 96/16 96/22 97/15 98/4 98/10 98/25 99/16 100/8 100/19 101/9 101/21 101/23 102/3 102/9 106/12 107/6 109/1 109/16 110/22 111/1 111/10 111/22 111/24 112/12 112/19 112/24 113/4 113/15 113/20 114/7 114/11 114/16 115/2 115/9 115/14 116/4 116/16 119/14 127/14	<b>PROFESSOR BRIGHTLING: [29]</b> 83/15 84/3 84/10 84/12 84/15 84/20 89/10 90/15 91/17 92/3 92/14 92/24 103/2 103/15 103/23 104/7 105/10 107/8 108/7 108/17 109/23 110/12 117/3 118/5 118/23 120/20 122/19 123/20 126/3 <b>THE WITNESS: [7]</b> 82/17 128/21 129/2 129/5 151/25 152/4 152/7	<b>13 March [1]</b> 37/12 <b>13 October 2023 [1]</b> 1/1 <b>14 March [1]</b> 21/25 <b>15 years [1]</b> 2/6 <b>16 October 2023 [1]</b> 153/8 <b>17 March [1]</b> 36/21 <b>18 February [3]</b> 29/12 29/14 31/13 <b>18 months [1]</b> 103/21 <b>19 [19]</b> 32/20 37/11 41/6 41/10 41/10 41/13 41/22 42/1 42/7 90/6 90/14 95/2 101/25 110/2 111/5 112/3 115/25 138/9 141/7 <b>1918 [1]</b> 22/21	<b>26 September [1]</b> 83/25 <b>26th [1]</b> 33/24 <b>27 [1]</b> 142/23 <b>29 January [1]</b> 29/11 <b>3</b> <b>3 July [1]</b> 136/25 <b>3,000 [1]</b> 139/20 <b>3.15 pm [1]</b> 153/6 <b>30 [1]</b> 125/17 <b>300 [1]</b> 18/14 <b>31 May 2021 [1]</b> 123/10 <b>4</b> <b>4 February [1]</b> 29/11 <b>43 [2]</b> 32/6 32/13 <b>45 [1]</b> 77/5 <b>5</b> <b>5,000 [1]</b> 139/20 <b>50 [1]</b> 146/9 <b>51 [1]</b> 146/9 <b>52/75 [1]</b> 125/15 <b>54 [1]</b> 54/6 <b>56 [1]</b> 23/9 <b>57 [1]</b> 23/9 <b>6</b> <b>6 July [1]</b> 148/19 <b>69 [1]</b> 54/6 <b>7</b> <b>7 October 2020 [1]</b> 100/6 <b>70 [2]</b> 41/6 106/16 <b>75 [1]</b> 125/15 <b>8</b> <b>8 September [1]</b> 54/12 <b>8.15 [1]</b> 38/3 <b>9</b> <b>9 October [1]</b> 124/16 <b>9.00 [1]</b> 38/1 <b>9.15 [5]</b> 37/7 41/7 52/19 52/23 64/3 <b>9.15 meeting [4]</b> 38/13 40/14 40/18 41/14 <b>9.15 meetings [1]</b> 42/2 <b>A</b> <b>abandoned [3]</b> 133/25 134/4 138/11 <b>abilities [1]</b> 14/25 <b>ability [14]</b> 4/20 10/18 11/9 12/7 12/18 14/13 16/3 16/13 16/17 19/8 41/14 52/6 56/21 81/24	<b>able [31]</b> 11/9 16/3 22/13 28/1 30/17 39/25 45/22 50/2 50/8 50/11 51/13 52/5 52/22 57/25 63/9 63/11 70/9 71/9 82/18 87/6 92/21 96/7 106/3 106/4 118/21 122/4 131/13 138/15 140/10 147/6 150/10 <b>abolished [1]</b> 43/14 <b>about [135]</b> 2/6 4/23 5/8 5/23 7/6 11/2 18/3 18/16 19/22 20/22 20/24 21/2 25/20 31/22 33/6 33/8 33/10 34/5 35/14 38/22 39/18 43/1 46/13 50/19 54/16 56/15 56/17 57/14 57/15 57/18 58/2 58/7 60/4 62/13 63/11 64/24 64/25 65/19 66/2 68/13 68/18 69/3 69/12 72/8 72/12 72/23 73/9 73/15 73/18 74/6 75/14 75/23 75/23 80/21 81/14 87/3 90/2 90/9 91/5 92/8 92/9 92/21 93/25 95/22 97/4 97/13 98/21 99/17 99/24 100/14 100/18 102/17 104/1 104/18 107/2 107/10 107/11 107/24 109/5 109/25 110/18 111/3 112/22 112/25 113/4 113/14 113/16 113/19 114/14 114/18 114/19 115/6 115/11 115/23 115/24 116/18 118/10 118/19 119/7 119/17 120/11 120/19 121/25 122/2 122/25 123/18 123/23 123/25 124/4 124/9 124/16 127/12 131/8 137/9 138/8 139/1 139/20 139/20 139/24 140/5 140/18 141/13 142/15 143/17 144/7 144/25 145/13 146/6 146/15 146/23 148/16 149/12 149/14 150/6 150/24 <b>above [2]</b> 48/4 79/19 <b>absolute [3]</b> 18/9 81/7 107/7 <b>absolutely [19]</b> 17/24 18/4 31/7 79/6 87/7 97/15 98/4 98/11 98/25 99/16 102/3 107/6 109/16 111/10 112/12 115/9 127/14
<b>LADY HALLETT:</b> <b>[31]</b> 1/5 22/7 42/13 42/15 42/19 45/25 46/23 47/16 59/5 59/10 82/12 82/19 82/21 83/2 83/7 83/11 96/19 97/1 110/25 128/6 128/17 128/22 129/3 132/13 132/15 152/1 152/6 152/8 152/21 152/23 153/5 <b>MR KEITH: [9]</b> 1/6 1/10 22/13 42/14 42/20 47/17 60/7 82/10 82/25 <b>MR O'CONNOR: [87]</b> 83/6 83/12 83/16 83/19 84/4 84/11 84/13 84/16 84/21 84/25 85/6 86/18 87/2 87/12 88/9 88/13 88/18 89/7 90/4 91/11 91/24 92/8 92/16 93/11 94/23 95/2 95/5 96/4 96/17 97/2 97/23 98/5 98/18 99/12 100/2 100/9 101/5 101/16 101/22 102/2 102/4 102/17 103/14 103/19 103/25 104/18 106/25 107/23 108/16 108/18 109/5 110/9 110/16 110/23 111/2 111/20 111/23 111/25 112/15 112/20 112/25 113/11 113/16 114/5 114/8 114/15 114/17 115/3 115/11 115/20 116/10 116/21 117/21 118/18 119/15 122/14 122/23 123/23 127/13 128/3 128/13 129/6 133/1 151/17 152/10 152/22 153/4	<b>'6 [1]</b> 54/20 <b>'gaslighting' [1]</b> 135/2 <b>'the [1]</b> 23/3 <b>1</b> <b>1,000 [1]</b> 89/14 <b>1.14 [1]</b> 114/21 <b>1.6 [2]</b> 110/22 110/24 <b>10 [44]</b> 16/16 16/23 16/25 17/1 17/3 17/6 17/9 17/20 17/23 17/23 18/4 18/8 18/10 18/12 18/23 19/23 20/14 24/21 24/22 24/25 25/17 26/2 26/16 26/18 32/24 34/2 34/24 37/7 38/12 39/1 57/13 59/24 60/15 64/17 65/4 65/10 65/17 76/24 77/6 77/17 77/24 78/6 104/20 149/18 <b>10,000 people [1]</b> 89/13 <b>10.00 am [1]</b> 1/2 <b>10.04 [1]</b> 1/4 <b>10.30 [1]</b> 153/2 <b>10.30 am [1]</b> 153/7 <b>100 individuals [1]</b> 89/17 <b>11.15 am [1]</b> 42/16 <b>11.30 [1]</b> 42/15 <b>11.30 am [1]</b> 42/18 <b>111 [1]</b> 140/11 <b>12 [2]</b> 103/21 114/20 <b>12 February [1]</b> 29/12 <b>12 March [1]</b> 19/4 <b>12 weeks [2]</b> 111/16 112/6 <b>12.58 pm [1]</b> 96/23 <b>13 [2]</b> 23/14 146/8 <b>13 July [1]</b> 23/18 <b>13 July 2020 [1]</b> 23/11	<b>2</b> <b>2 March [5]</b> 29/15 29/18 30/25 31/15 31/17 <b>2 o'clock [1]</b> 96/20 <b>2.00 pm [1]</b> 96/25 <b>200 [2]</b> 18/14 115/4 <b>2002 [1]</b> 89/11 <b>2003 [1]</b> 4/2 <b>2004 [2]</b> 84/11 89/11 <b>2010 [2]</b> 9/12 91/19 <b>2011 [1]</b> 4/4 <b>2019 [4]</b> 4/3 4/4 74/19 91/12 <b>2020 [30]</b> 3/8 14/4 17/4 17/5 23/11 24/24 25/25 26/9 45/5 77/1 84/17 90/8 90/12 90/24 93/14 96/11 97/22 99/14 100/5 100/6 108/24 109/3 109/11 110/20 111/6 124/5 124/8 125/22 130/25 140/17 <b>2021 [14]</b> 3/8 93/14 109/1 120/2 121/10 121/25 123/10 123/14 124/6 125/23 146/10 146/11 148/16 148/25 <b>2022 [2]</b> 61/12 61/16 <b>2023 [3]</b> 1/1 129/24 153/8 <b>21 February [1]</b> 125/12 <b>22 [1]</b> 18/25 <b>22 March [1]</b> 53/19 <b>23 [1]</b> 136/2 <b>23 March [1]</b> 33/23 <b>24 January [3]</b> 29/6 29/11 31/12 <b>25 [1]</b> 124/19 <b>25 September [1]</b> 129/22	<b>26 September [1]</b> 83/25 <b>26th [1]</b> 33/24 <b>27 [1]</b> 142/23 <b>29 January [1]</b> 29/11 <b>3</b> <b>3 July [1]</b> 136/25 <b>3,000 [1]</b> 139/20 <b>3.15 pm [1]</b> 153/6 <b>30 [1]</b> 125/17 <b>300 [1]</b> 18/14 <b>31 May 2021 [1]</b> 123/10 <b>4</b> <b>4 February [1]</b> 29/11 <b>43 [2]</b> 32/6 32/13 <b>45 [1]</b> 77/5 <b>5</b> <b>5,000 [1]</b> 139/20 <b>50 [1]</b> 146/9 <b>51 [1]</b> 146/9 <b>52/75 [1]</b> 125/15 <b>54 [1]</b> 54/6 <b>56 [1]</b> 23/9 <b>57 [1]</b> 23/9 <b>6</b> <b>6 July [1]</b> 148/19 <b>69 [1]</b> 54/6 <b>7</b> <b>7 October 2020 [1]</b> 100/6 <b>70 [2]</b> 41/6 106/16 <b>75 [1]</b> 125/15 <b>8</b> <b>8 September [1]</b> 54/12 <b>8.15 [1]</b> 38/3 <b>9</b> <b>9 October [1]</b> 124/16 <b>9.00 [1]</b> 38/1 <b>9.15 [5]</b> 37/7 41/7 52/19 52/23 64/3 <b>9.15 meeting [4]</b> 38/13 40/14 40/18 41/14 <b>9.15 meetings [1]</b> 42/2 <b>A</b> <b>abandoned [3]</b> 133/25 134/4 138/11 <b>abilities [1]</b> 14/25 <b>ability [14]</b> 4/20 10/18 11/9 12/7 12/18 14/13 16/3 16/13 16/17 19/8 41/14 52/6 56/21 81/24	

<b>A</b>	32/24 33/20 36/7 39/3 43/2 47/5 49/1 52/23 53/6 70/5 72/22 89/13 92/4 97/18 97/20 98/16 99/9 99/19 99/20 100/25 103/15 105/23 106/16 107/16 110/13 113/8 113/21 115/16 116/6 116/17 117/15 117/23 118/6 118/16 122/21 124/15 126/5 126/24 127/23 129/11 145/6 149/18 <b>acute [19]</b> 86/7 88/24 90/17 94/3 94/11 99/3 105/1 117/3 117/4 117/10 117/22 120/22 121/19 122/11 134/6 141/1 147/2 147/19 147/21 <b>acute Covid [1]</b> 147/21 <b>ad [3]</b> 34/3 40/15 58/17 <b>ad hoc [2]</b> 34/3 58/17 <b>adapted [1]</b> 38/14 <b>add [10]</b> 11/13 41/19 62/12 63/13 64/23 85/19 101/23 135/18 149/10 151/13 <b>addition [1]</b> 43/17 <b>additional [1]</b> 43/18 <b>address [5]</b> 69/20 81/10 85/17 88/13 122/17 <b>addressed [6]</b> 44/24 90/17 123/11 136/8 137/3 142/9 <b>addressing [1]</b> 90/17 <b>adduce [1]</b> 151/21 <b>adduced [1]</b> 152/20 <b>adequately [1]</b> 70/5 <b>adjourned [1]</b> 153/7 <b>adjournment [1]</b> 96/24 <b>administer [1]</b> 5/14 <b>administration [3]</b> 5/1 30/23 57/22 <b>administrations [11]</b> 30/19 31/8 35/6 36/5 43/10 44/2 44/10 66/2 66/3 66/8 66/12 <b>administrations' [1]</b> 35/12 <b>administrative [11]</b> 1/16 7/10 8/8 10/11 10/25 13/1 13/4 29/3 29/19 31/23 51/5 <b>administratively [1]</b> 7/23 <b>admirable [1]</b> 64/12 <b>admitted [3]</b> 110/1 118/25 140/23 <b>adopt [1]</b> 47/14	<b>adult [4]</b> 94/4 115/24 116/2 118/19 <b>adults [4]</b> 119/1 119/4 119/6 147/14 <b>advance [4]</b> 1/18 30/21 109/8 149/3 <b>advantage [3]</b> 29/21 46/1 46/14 <b>advice [17]</b> 10/7 10/24 18/17 18/18 26/7 34/18 34/24 41/2 47/19 47/21 48/16 48/17 51/23 68/8 70/18 80/11 120/18 <b>advise [1]</b> 20/1 <b>advised [1]</b> 34/18 <b>adviser [11]</b> 7/15 10/6 10/14 14/21 15/2 17/1 19/13 19/24 20/11 52/15 68/20 <b>advisers [20]</b> 16/11 21/4 26/21 34/25 38/2 38/6 38/11 52/25 55/21 55/24 56/20 57/2 57/12 57/19 58/4 71/24 72/8 80/16 80/19 81/9 <b>advisers' [1]</b> 59/1 <b>advising [1]</b> 51/17 <b>advisory [2]</b> 47/18 70/11 <b>advocacy [8]</b> 98/22 100/24 131/7 133/21 136/4 136/13 136/17 136/19 <b>advocate [4]</b> 97/19 128/9 135/23 152/2 <b>advocates [2]</b> 98/3 104/5 <b>aerated [2]</b> 52/18 52/21 <b>affairs [3]</b> 4/10 4/15 9/10 <b>affect [4]</b> 86/6 86/13 105/20 147/4 <b>affected [5]</b> 33/19 89/13 104/17 108/9 117/6 <b>affecting [1]</b> 117/20 <b>affects [1]</b> 104/11 <b>affirmed [8]</b> 1/8 83/8 83/9 128/15 154/3 154/7 154/10 154/14 <b>afraid [3]</b> 32/6 43/1 135/16 <b>after [25]</b> 5/25 39/7 74/18 88/3 91/6 92/9 95/17 96/10 96/18 99/1 99/3 101/2 103/22 104/15 109/2 112/2 114/13 120/22 121/9 125/13 126/4 131/24 145/3 145/10 149/20	<b>afternoon [4]</b> 97/25 128/14 128/19 151/23 <b>afterwards [1]</b> 26/14 <b>again [16]</b> 4/12 6/12 22/25 25/8 30/20 35/14 38/24 42/19 73/9 95/24 100/19 100/22 117/11 122/1 123/5 123/16 <b>against [1]</b> 124/25 <b>age [2]</b> 116/12 117/12 <b>agenda [1]</b> 41/3 <b>agendas [1]</b> 45/17 <b>ages [1]</b> 131/21 <b>aggression [1]</b> 23/7 <b>aggressive [1]</b> 60/16 <b>ago [3]</b> 2/6 10/4 53/2 <b>agree [12]</b> 14/16 23/8 36/9 36/15 43/13 53/10 60/22 62/3 67/23 69/7 75/14 81/13 <b>agreeing [2]</b> 17/13 49/23 <b>ahead [1]</b> 91/20 <b>aims [2]</b> 104/23 136/13 <b>akin [1]</b> 40/20 <b>alarmed [1]</b> 106/12 <b>alarming [1]</b> 140/6 <b>albeit [1]</b> 128/24 <b>Alex [4]</b> 1/7 1/8 1/12 154/3 <b>Alex Thomas [2]</b> 1/7 1/12 <b>all [91]</b> 3/1 4/17 11/10 11/18 12/5 12/21 12/22 19/5 24/4 25/4 28/15 30/12 31/11 44/6 44/15 47/24 49/8 49/10 51/19 57/4 58/12 65/16 66/16 67/25 70/22 72/18 75/3 76/5 76/10 77/13 79/15 79/19 79/21 81/12 81/12 81/17 82/16 82/22 83/1 88/9 90/7 93/3 96/4 99/17 100/12 100/24 101/13 102/17 103/3 103/19 104/24 106/3 113/8 115/6 116/20 117/22 121/13 122/15 123/2 123/25 124/4 124/13 127/4 128/1 128/4 128/10 128/17 129/12 131/22 132/19 132/20 132/21 134/7 137/11 137/14 138/7 140/4 143/12 146/12 147/9 147/17 148/24 149/13 149/16 149/17 151/5	151/17 151/24 152/14 152/19 152/24 <b>All right [8]</b> 4/17 44/6 44/15 49/8 49/10 51/19 70/22 88/9 <b>allow [2]</b> 76/1 147/21 <b>allowed [2]</b> 75/16 106/1 <b>allows [2]</b> 36/13 62/25 <b>almost [5]</b> 6/21 51/5 95/12 142/13 142/13 <b>alone [2]</b> 98/11 131/23 <b>along [3]</b> 13/23 150/20 151/22 <b>alongside [2]</b> 102/19 110/6 <b>Alpha [1]</b> 148/6 <b>already [22]</b> 1/14 3/3 36/12 47/17 50/6 51/2 70/10 90/15 91/5 101/5 101/17 104/8 109/25 114/19 119/24 124/8 124/14 126/22 127/19 127/24 147/4 150/5 <b>also [75]</b> 3/21 3/24 10/12 10/13 11/13 11/14 12/25 17/17 18/8 18/18 20/12 20/19 24/11 24/20 25/10 26/15 28/13 30/1 33/9 36/9 45/18 48/24 53/24 55/13 61/14 64/15 64/21 64/23 65/19 68/18 72/13 75/9 78/9 80/23 81/23 82/14 84/18 84/25 85/2 85/3 88/6 89/20 90/20 91/1 91/4 94/14 96/2 99/14 103/5 103/12 104/11 107/9 107/10 107/13 111/14 112/12 114/2 115/10 115/18 117/6 117/7 121/1 121/4 121/12 122/4 123/20 136/6 136/9 137/6 137/7 137/15 145/7 145/15 151/19 152/16 <b>alternative [1]</b> 112/8 <b>although [11]</b> 9/4 36/1 44/11 91/20 99/16 107/1 107/9 117/22 119/5 121/16 146/13 <b>altogether [1]</b> 10/17 <b>always [12]</b> 12/15 34/10 54/13 59/4 59/7 69/19 71/20 74/9 77/17 86/5 88/11 133/16 <b>am [12]</b> 1/2 1/4 2/3
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<b>A</b>	112/25 143/15 144/12 145/5 148/11 <b>am... [9]</b> 42/16 42/18 80/21 83/6 128/20 130/11 132/14 152/4 153/7 <b>America [2]</b> 131/16 132/20 <b>amongst [6]</b> 12/13 56/19 88/14 124/22 141/13 141/15 <b>amorphous [2]</b> 9/8 12/10 <b>amount [6]</b> 27/10 52/13 90/10 113/18 121/21 135/15 <b>amplified [1]</b> 101/19 <b>analyse [1]</b> 5/7 <b>analysis [9]</b> 2/14 3/1 45/23 48/14 65/21 70/23 71/1 71/15 147/24 <b>analysts [1]</b> 45/21 <b>angry [1]</b> 126/13 <b>animal [2]</b> 62/7 62/7 <b>annex [1]</b> 43/3 <b>announced [2]</b> 100/6 146/25 <b>announcement [1]</b> 144/7 <b>announcements [2]</b> 3/13 147/5 <b>another [13]</b> 21/25 25/1 28/11 34/20 58/3 61/5 82/24 99/24 111/17 111/17 112/18 127/5 134/21 <b>answer [6]</b> 15/9 79/5 98/10 113/3 113/12 132/23 <b>answers [2]</b> 2/16 32/2 <b>anxiety [4]</b> 135/10 141/9 141/21 141/23 <b>anxious [3]</b> 25/25 135/11 141/21 <b>any [38]</b> 13/9 15/11 18/21 28/8 33/2 35/1 40/20 51/6 58/1 58/1 66/23 81/4 82/11 86/6 86/13 86/14 86/24 91/13 94/23 112/16 113/13 114/5 116/2 116/25 117/12 122/17 128/5 132/21 134/4 138/15 142/16 143/2 144/10 145/12 148/13 149/24 150/17 150/25 <b>anybody [1]</b> 147/4 <b>anyone [4]</b> 23/20 82/23 116/6 116/7 <b>anything [13]</b> 25/6 41/4 49/25 51/5 53/3 73/17 74/24 85/19	71/5 71/18 71/25 73/3 73/11 74/8 75/22 76/5 79/6 80/6 82/1 82/2 82/7 82/25 83/4 83/13 84/21 84/25 85/9 85/12 85/13 87/2 87/3 87/7 87/20 88/15 89/5 89/8 92/19 95/22 97/23 101/12 108/23 109/6 109/7 110/9 113/6 113/8 114/25 115/1 115/17 116/11 116/11 116/12 116/14 117/4 117/5 117/5 117/6 117/12 117/14 117/15 117/23 118/8 118/21 119/5 119/11 126/14 126/14 126/15 126/17 127/17 128/4 129/8 129/21 130/2 130/13 130/13 130/14 130/17 136/12 138/5 142/8 144/10 144/12 149/24 150/7 150/14 150/17 150/17 150/23 151/2 151/6 151/8 151/24 152/19 <b>area [8]</b> 61/5 66/16 68/4 69/15 69/16 76/18 85/17 87/15 <b>areas [5]</b> 36/24 36/25 47/24 69/8 90/16 <b>aren't [2]</b> 128/5 144/10 <b>argue [2]</b> 12/17 13/1 <b>arising [1]</b> 124/17 <b>Arlene [1]</b> 31/13 <b>Arlene Foster [1]</b> 31/13 <b>arm [1]</b> 110/5 <b>around [29]</b> 7/11 7/14 10/14 17/10 24/14 32/8 36/21 37/4 37/5 53/9 62/7 65/1 73/25 74/2 76/8 80/9 81/9 82/7 86/1 93/10 94/15 102/13 104/16 106/9 107/12 117/6 136/9 146/12 151/8 <b>arrangement [1]</b> 13/10 <b>arthritis [1]</b> 117/17 <b>article [1]</b> 131/15 <b>articles [2]</b> 3/5 142/17 <b>as [236]</b> <b>As I said [1]</b> 51/18 <b>ASAP [1]</b> 55/5 <b>ascertain [1]</b> 30/17 <b>aside [1]</b> 63/16 <b>ask [20]</b> 41/24 84/7 88/18 90/6 100/2 102/17 104/18 110/17 114/17 115/23 119/17	120/13 122/24 123/17 123/25 125/3 126/1 129/19 137/9 146/5 <b>asked [7]</b> 35/14 82/21 97/4 120/25 138/17 140/24 152/11 <b>aspect [1]</b> 15/17 <b>aspects [9]</b> 3/6 3/20 11/19 37/1 63/1 67/8 69/7 76/10 135/20 <b>assert [1]</b> 13/6 <b>assess [1]</b> 149/22 <b>assessment [1]</b> 25/22 <b>assessments [1]</b> 105/13 <b>assigning [1]</b> 62/24 <b>assist [1]</b> 59/22 <b>assistance [1]</b> 1/13 <b>associate [1]</b> 84/25 <b>associate professor [1]</b> 84/25 <b>associated [3]</b> 89/23 95/14 120/7 <b>assume [4]</b> 22/18 22/20 24/4 56/15 <b>assumption [2]</b> 5/20 33/11 <b>assurance [1]</b> 63/22 <b>assured [1]</b> 69/5 <b>astonished [1]</b> 131/19 <b>at [170]</b> <b>atmosphere [2]</b> 21/12 60/16 <b>attached [1]</b> 19/2 <b>attack [1]</b> 57/9 <b>attempting [1]</b> 135/23 <b>attend [4]</b> 31/3 31/24 44/13 65/11 <b>attendance [2]</b> 30/19 32/4 <b>attended [6]</b> 30/24 31/12 31/12 31/14 31/19 38/6 <b>attending [3]</b> 128/23 152/24 153/1 <b>attention [5]</b> 30/13 48/15 69/6 74/5 142/12 <b>attracted [1]</b> 139/14 <b>attributes [2]</b> 73/16 81/3 <b>audience [1]</b> 25/13 <b>author [2]</b> 3/19 106/8 <b>authored [1]</b> 3/19 <b>authoritative [4]</b> 34/17 68/2 78/23 85/17 <b>authoritatively [1]</b> 16/9 <b>authorities [5]</b> 98/6 98/24 137/7 137/24	143/8 <b>authority [13]</b> 7/20 12/11 12/20 13/13 13/16 13/20 19/20 48/10 50/1 50/3 51/9 62/25 65/7 <b>authors [2]</b> 42/25 43/15 <b>authors' [1]</b> 73/15 <b>autoimmune [1]</b> 117/16 <b>autumn [3]</b> 14/3 17/4 103/1 <b>available [5]</b> 17/17 17/18 33/10 73/13 108/23 <b>avoid [3]</b> 85/10 85/20 150/13 <b>aware [6]</b> 61/10 78/15 91/8 91/21 101/12 110/12 <b>away [3]</b> 32/15 32/18 35/19 <b>awful [1]</b> 45/25
			<b>B</b>	
			<b>back [43]</b> 6/5 6/11 20/22 21/10 21/20 21/23 27/9 37/16 48/19 54/21 56/14 74/3 88/22 89/8 98/5 99/13 103/7 106/25 107/23 110/20 113/5 115/5 117/3 118/18 119/17 121/17 122/1 122/15 123/10 127/24 131/19 133/5 133/17 133/18 134/16 138/3 139/23 141/12 141/20 142/21 143/5 143/15 150/21 <b>bad [4]</b> 77/15 107/4 140/11 140/12 <b>badged [1]</b> 148/25 <b>ball [1]</b> 64/21 <b>bar [2]</b> 28/22 28/25 <b>Barr [1]</b> 89/3 <b>based [5]</b> 3/2 17/16 22/16 113/9 138/22 <b>basement [2]</b> 32/17 32/23 <b>basis [8]</b> 58/1 58/2 58/15 58/25 90/11 103/22 114/9 149/9 <b>battle [1]</b> 150/10 <b>be [219]</b> <b>bear [1]</b> 140/16 <b>became [12]</b> 27/19 32/21 33/15 36/3 36/4 38/4 39/10 92/3 97/12 135/22 137/17 145/2 <b>because [80]</b> 6/17 6/22 10/5 10/8 10/12 11/4 13/15 17/19	

<b>B</b>	105/21 107/1 111/7 114/10 123/5 123/21 125/3 125/9 130/4 130/14 <b>beforehand [1]</b> 56/3 <b>began [3]</b> 46/21 48/6 48/10 <b>begin [3]</b> 100/23 127/22 145/10 <b>beginning [6]</b> 94/18 97/16 121/19 127/1 139/15 139/19 <b>begun [1]</b> 97/5 <b>behalf [7]</b> 66/12 66/13 129/15 130/6 130/8 130/13 130/17 <b>behavioural [1]</b> 69/11 <b>behaviours [1]</b> 77/15 <b>behind [2]</b> 20/21 59/14 <b>being [36]</b> 11/18 26/4 33/20 34/23 35/12 36/7 43/14 52/2 59/5 60/18 64/5 73/12 73/21 73/21 73/22 77/19 80/8 82/15 95/25 96/1 98/21 101/11 110/9 116/14 122/6 124/22 128/8 133/23 133/25 135/13 135/19 141/8 148/10 148/11 149/6 149/12 <b>beliefs [1]</b> 151/8 <b>believe [8]</b> 39/8 40/8 77/1 82/11 82/25 91/14 125/19 129/20 <b>believed [4]</b> 24/7 92/18 114/3 135/19 <b>believing [1]</b> 127/19 <b>beloved [1]</b> 6/6 <b>Ben [1]</b> 23/1 <b>beneficial [4]</b> 30/7 30/15 68/24 72/14 <b>benefit [4]</b> 28/24 29/25 30/2 44/16 <b>bereaved [1]</b> 129/13 <b>best [13]</b> 2/18 5/17 5/23 10/24 10/25 12/6 39/19 71/7 71/21 80/7 80/11 80/13 89/14 <b>bet [1]</b> 125/20 <b>Bethell [5]</b> 103/11 103/21 124/21 126/6 145/18 <b>better [7]</b> 39/24 76/25 79/23 80/25 118/4 133/10 149/20 <b>between [26]</b> 5/13 12/12 19/22 26/1 26/11 26/18 26/20 29/14 39/12 52/7 60/19 63/7 65/2 65/4 65/8 66/7 66/16 66/21	70/18 83/16 85/10 103/15 119/18 140/3 145/5 149/19 <b>beyond [2]</b> 57/6 127/15 <b>bias [1]</b> 116/23 <b>big [3]</b> 47/2 92/25 93/3 <b>binary [1]</b> 92/19 <b>biomedical [1]</b> 105/25 <b>bit [12]</b> 77/3 82/22 88/19 93/21 103/10 118/9 125/17 131/8 139/24 143/17 151/2 152/4 <b>Black [1]</b> 152/17 <b>blame [1]</b> 55/6 <b>blaming [1]</b> 56/15 <b>block [1]</b> 42/6 <b>blocks [1]</b> 109/10 <b>blood [3]</b> 106/6 107/14 112/16 <b>bloody [1]</b> 55/5 <b>Bluntly [1]</b> 53/18 <b>blurred [1]</b> 5/12 <b>board [1]</b> 104/10 <b>bodies [1]</b> 6/1 <b>body [10]</b> 10/2 27/24 27/24 28/2 45/12 47/23 47/24 79/18 86/6 86/13 <b>bollocks [3]</b> 125/2 126/21 126/24 <b>Boris [6]</b> 22/19 22/20 57/22 124/3 125/14 147/5 <b>Boris Johnson [4]</b> 22/20 124/3 125/14 147/5 <b>Boris Johnson's [1]</b> 57/22 <b>both [26]</b> 5/7 11/17 19/18 41/3 41/6 45/15 46/25 56/23 59/17 61/10 64/20 74/25 83/25 83/25 84/17 89/1 89/8 94/7 102/9 108/21 109/21 114/1 120/7 124/2 128/7 137/19 <b>Bottle [1]</b> 134/1 <b>bottom [11]</b> 1/20 21/22 22/25 104/22 111/2 111/4 116/1 125/11 136/2 142/22 142/23 <b>boundaries [2]</b> 70/17 70/19 <b>box [3]</b> 27/15 56/2 124/14 <b>boy [2]</b> 59/3 59/4 <b>brain [2]</b> 86/11 114/23	<b>brain-fog [1]</b> 114/23 <b>breadth [1]</b> 3/16 <b>break [7]</b> 42/17 61/24 66/20 82/21 82/22 82/24 96/21 <b>breaking [2]</b> 20/2 62/13 <b>breaks [1]</b> 79/4 <b>breathing [4]</b> 94/2 95/21 106/5 152/2 <b>breathlessness [3]</b> 89/20 114/23 141/22 <b>Brexit [4]</b> 47/7 47/9 47/12 74/16 <b>Brexit-O [1]</b> 47/9 <b>brief [3]</b> 30/21 105/7 152/10 <b>briefing [2]</b> 27/16 27/18 <b>briefly [4]</b> 68/3 71/3 115/18 130/7 <b>BRIGHTLING [15]</b> 83/9 83/13 84/5 85/1 85/6 91/11 97/3 102/14 102/23 115/18 120/14 128/4 131/2 143/16 154/9 <b>brilliantly [1]</b> 37/19 <b>bring [12]</b> 11/10 11/12 12/5 63/11 79/19 84/7 106/25 116/13 122/15 142/12 150/3 150/7 <b>bringing [1]</b> 63/5 <b>brings [2]</b> 27/24 152/12 <b>British [3]</b> 12/10 78/24 78/25 <b>broad [3]</b> 3/16 8/16 79/16 <b>broking [1]</b> 63/6 <b>brought [7]</b> 45/7 47/21 47/24 70/13 78/4 100/9 109/13 <b>Brown [1]</b> 28/22 <b>build [2]</b> 48/10 108/13 <b>building [1]</b> 42/6 <b>built [1]</b> 18/10 <b>bunfight [1]</b> 77/20 <b>business [3]</b> 3/25 39/22 71/9 <b>but [222]</b> <b>bypassed [1]</b> 41/17	6/22 7/7 7/17 7/24 8/2 8/12 8/14 8/15 9/6 9/9 9/13 9/16 9/19 9/22 12/16 16/16 16/24 17/3 17/21 18/1 18/7 19/9 19/23 20/15 24/2 24/9 25/18 26/1 26/18 27/15 32/18 32/24 39/1 39/18 45/14 46/15 48/9 54/11 57/13 59/24 63/4 63/9 63/14 64/17 65/17 75/2 76/24 77/6 77/21 77/23 78/6 <b>Cabinet Office's [1]</b> 7/1 <b>Cabinet Secretaries</b> <b>[1]</b> 15/15 <b>Cabinet Secretary</b> <b>[29]</b> 7/9 10/16 10/22 11/13 12/2 12/3 12/11 12/20 13/6 13/13 14/2 14/3 14/9 14/12 14/23 15/3 15/8 15/11 16/22 19/20 20/6 22/3 24/23 25/5 32/11 38/25 43/7 48/23 54/9 <b>Cabinet Secretary's</b> <b>[3]</b> 12/14 13/11 37/10 <b>CabOff [3]</b> 22/5 23/13 23/20 <b>Cain [7]</b> 26/12 26/13 54/11 54/25 55/6 56/8 56/14 <b>Caino [1]</b> 54/11 <b>calibre [2]</b> 74/21 74/25 <b>call [13]</b> 1/6 3/22 21/4 66/15 75/18 87/8 101/23 110/21 130/7 132/24 136/23 142/21 143/5 <b>called [14]</b> 2/1 27/19 37/11 60/1 61/14 88/1 95/23 100/6 100/17 102/6 105/24 129/9 130/8 134/1 <b>calling [2]</b> 29/3 78/3 <b>calls [2]</b> 104/5 104/13 <b>calm [1]</b> 37/17 <b>Calum [2]</b> 120/25 121/12 <b>Calum Semple [1]</b> 121/12 <b>came [11]</b> 42/1 89/15 101/19 104/13 104/16 107/13 111/13 113/25 114/14 123/24 131/15 <b>Cameron [2]</b> 38/8 40/25 <b>campaign [1]</b> 131/7 <b>campaigning [6]</b>
----------	--	--	--	--

<b>C</b>	<b>Carrie [1]</b> 24/25	59/12 74/18	8/14 8/21 9/20 10/7	34/8 34/13 39/11 66/6
<b>campaigning... [6]</b>	<b>carried [1]</b> 33/17	<b>changed [5]</b> 8/22	10/9 10/11 10/23 11/6	66/18 132/24
136/16 136/21 139/12	<b>carries [1]</b> 60/23	35/2 58/16 72/16	11/19 13/24 15/1 15/2	<b>co-founders [1]</b>
150/4 150/8 151/15	<b>case [20]</b> 13/20 14/1	144/20	15/18 15/19 19/25	132/24
<b>campaigns [1]</b> 98/20	14/2 24/24 31/16	<b>changes [4]</b> 37/10	21/3 24/1 28/3 32/10	<b>co-ordinated [1]</b> 9/19
<b>can [102]</b> 1/19 2/17	38/12 42/23 43/5 43/6	60/24 79/17 146/1	36/19 38/24 43/6	<b>co-ordination [4]</b>
10/18 10/19 13/5	44/18 54/8 54/17 55/4	<b>changing [4]</b> 7/13	45/19 46/11 48/21	34-13 39/11 66/6
13/16 21/8 25/10	55/24 56/1 56/10 61/3	7/14 58/14 150/25	55/20 57/4 57/12 58/4	66/18
27/14 33/16 50/1	61/21 79/25 140/25	<b>channelling [1]</b> 68/25	58/19 58/20 58/25	<b>COBR [52]</b> 6/11
51/20 51/24 52/21	<b>cases [3]</b> 91/13	<b>chaos [3]</b> 24/21	59/3 59/4 63/15 71/24	21/20 27/9 27/12
54/5 59/3 59/19 60/13	102/4 136/8	77/17 78/17	78/10 80/17 80/18	27/16 27/22 28/4 28/7
62/5 64/14 65/18	<b>cast [2]</b> 7/14 41/3	<b>chaotic [3]</b> 16/5	80/19 81/9	28/14 28/15 28/18
67/16 68/3 69/5 73/3	<b>catch [2]</b> 82/22	25/25 79/10	<b>civil service [18]</b>	28/23 28/25 29/3 29/5
77/4 79/25 81/5 81/9	150/16	<b>chapter [1]</b> 119/22	2/11 3/10 10/7 10/9	29/14 29/17 29/20
82/5 82/22 85/16 86/6	<b>caught [2]</b> 25/4 42/19	<b>character [1]</b> 125/23	10/11 10/23 11/6	30/1 30/4 30/8 30/16
86/7 86/12 86/13	<b>cause [4]</b> 58/11	<b>characterised [1]</b>	11/19 13/24 15/2	30/19 30/24 30/25
86/14 86/15 86/21	58/23 88/10 91/15	114/22	15/18 15/19 36/19	31/3 31/6 31/17 32/15
86/24 87/7 87/11	<b>caused [2]</b> 88/20	<b>characters [2]</b> 7/14	38/24 45/19 58/20	32/16 32/23 33/8
87/17 88/4 88/10	89/2	78/12	59/4 81/9	33/16 33/25 34/7 34/8
88/19 89/3 90/6 93/21	<b>causing [4]</b> 77/17	<b>charities [1]</b> 97/21	<b>clarify [1]</b> 55/16	34/14 34/21 34/25
94/5 94/6 95/18 95/24	88/23 89/4 128/1	<b>chart [3]</b> 6/22 27/9	<b>clarity [4]</b> 12/19 13/8	35/1 35/2 35/4 35/6
96/2 100/11 101/13	<b>caution [6]</b> 25/8	119/24	78/25 90/2	35/20 36/1 36/10
101/23 105/7 105/10	59/22 60/8 60/13	<b>check [2]</b> 38/21	<b>classified [1]</b> 87/3	43/12 43/17 53/24
111/18 112/17 113/11	69/21 69/22	44/14	<b>clear [27]</b> 14/1 19/6	64/3 66/3 74/6
115/8 115/10 115/24	<b>caveats [1]</b> 50/21	<b>chesty [1]</b> 152/5	31/7 39/10 41/21 58/9	<b>COBRA [2]</b> 27/17
115/25 116/6 116/8	<b>CCS [4]</b> 8/22 23/25	<b>chew [1]</b> 40/22	58/9 62/19 68/1 70/7	27/19
117/11 117/11 117/25	24/1 63/18	<b>chief [13]</b> 7/16 7/16	75/10 77/25 78/2	<b>COBRs [2]</b> 29/11
123/6 123/16 124/15	<b>CDC [1]</b> 87/22	16/25 19/13 20/11	79/13 80/12 90/16	30/22
124/18 124/18 125/5	<b>central [4]</b> 66/22	52/14 52/15 68/19	91/11 94/16 101/24	<b>cognitive [1]</b> 88/5
128/17 128/22 130/6	67/24 68/8 76/15	68/20 123/9 137/5	108/19 113/16 114/1	<b>coherence [3]</b> 15/5
131/7 132/22 133/12	<b>centre [3]</b> 61/15	137/6 137/7	121/20 122/19 127/24	44/25 71/8
134/11 134/16 136/1	64/10 123/1	<b>Chilcot [1]</b> 73/24	146/25 148/9	<b>coherent [3]</b> 34/17
136/24 139/23 141/2	<b>certain [10]</b> 8/4 27/10	<b>children [15]</b> 115/23	<b>clearly [22]</b> 11/14	46/3 46/18
141/4 141/22 142/21	28/16 28/17 35/11	118/18 118/21 118/23	13/4 27/5 32/20 43/20	<b>cohort [4]</b> 94/23 95/6
146/8 146/19 147/4	107/13 113/17 115/17	118/24 119/2 119/5	52/13 56/18 57/5 67/1	96/11 97/4
147/12 149/10 149/16	121/16 142/17	119/5 119/8 119/9	67/18 73/5 74/1 75/9	<b>coined [1]</b> 98/2
150/3 150/7 151/1	<b>certainly [14]</b> 28/21	119/12 135/11 135/13	76/5 76/15 78/22 79/4	<b>collaboration [3]</b>
151/13	64/19 90/17 92/19	147/15 147/17	104/11 110/14 126/22	67/14 77/20 105/24
<b>can't [11]</b> 14/21	93/1 96/19 110/7	<b>children's [1]</b> 152/18	127/6 146/14	<b>colleagues [4]</b> 3/1
18/22 53/14 59/4 72/2	111/9 116/21 121/22	<b>China [4]</b> 90/9 91/4	<b>clinic [3]</b> 101/12	12/16 12/16 13/24
77/22 78/12 125/19	140/8 145/17 148/12	92/1 94/9	102/14 105/13	<b>collect [1]</b> 106/3
127/21 127/21 128/19	152/21	<b>choice [1]</b> 81/23	<b>clinical [7]</b> 48/1	<b>collection [2]</b> 2/23
<b>Canada [1]</b> 94/6	<b>cetera [1]</b> 56/14	<b>Chris [5]</b> 83/13 123/9	87/10 87/11 102/13	6/18
<b>cancelled [1]</b> 56/9	<b>chair [10]</b> 28/7 28/9	127/17 137/4 143/6	111/19 122/7 122/21	<b>collective [5]</b> 9/4
<b>cannot [1]</b> 54/14	28/14 29/20 30/8	<b>Chris Whitty [3]</b>	<b>clinically [1]</b> 150/20	49/16 49/17 51/14
<b>capabilities [2]</b> 11/1	30/16 31/17 47/1	123/9 137/4 143/6	<b>clinician [1]</b> 94/16	52/4
61/14	82/24 91/1	<b>CHRISTOPHER [2]</b>	<b>clinicians [5]</b> 99/9	<b>come [26]</b> 11/22
<b>capability [4]</b> 5/5	<b>chaired [15]</b> 29/10	83/9 154/9	100/1 102/11 127/19	13/18 21/20 21/23
9/13 57/15 57/18	29/17 30/25 37/1	<b>chronic [5]</b> 87/14	127/23	22/17 26/3 32/17 34/4
<b>capable [1]</b> 82/7	39/19 39/24 40/9 42/5	87/18 87/19 87/22	<b>clinics [7]</b> 98/25 99/2	48/12 48/19 85/25
<b>capacity [4]</b> 4/20 5/5	42/10 42/11 46/5 46/6	88/11	99/9 101/6 101/8	87/4 88/13 90/9 91/25
10/11 63/18	103/9 103/11 103/20	<b>chronology [5]</b> 100/4	106/14 145/13	92/9 96/10 99/12
<b>capture [1]</b> 141/12	<b>chairing [5]</b> 30/1 30/4	107/25 121/16 124/7	<b>close [3]</b> 33/21 57/2	100/2 103/7 118/18
<b>captures [1]</b> 141/25	30/22 39/21 45/2	131/1	103/3	119/17 129/14 134/16
<b>carbon [1]</b> 5/22	<b>challenge [1]</b> 64/10	<b>churn [1]</b> 80/16	<b>closely [4]</b> 16/24	138/3 148/5
<b>card [1]</b> 138/21	<b>challenges [1]</b> 94/14	<b>circumspection [1]</b>	102/13 108/12 137/16	<b>comes [4]</b> 22/14
<b>care [13]</b> 4/12 29/10	<b>challenging [3]</b> 94/22	59/15	<b>closest [4]</b> 26/21	67/15 74/3 78/9
57/10 61/7 62/16	99/8 121/7	<b>circumstance [1]</b>	34/25 52/24 56/19	<b>comfortable [2]</b>
95/19 95/23 99/3	<b>chance [1]</b> 81/21	59/8	<b>clues [3]</b> 107/8	59/19 74/8
101/10 105/5 114/11	<b>chancellor [5]</b> 7/18	<b>circumstances [4]</b>	107/11 107/12	<b>coming [13]</b> 6/11
143/12 144/23	39/22 40/5 42/11 45/1	62/3 62/4 73/25 133/1	<b>clusters [2]</b> 115/12	16/10 56/14 93/8
<b>career [2]</b> 4/13 84/6	<b>change [10]</b> 7/25	<b>civil [53]</b> 2/11 3/10	115/14	93/10 121/10 121/11
<b>carefully [1]</b> 119/23	8/10 36/21 40/16	4/2 4/4 4/7 4/8 4/13	<b>CMO [1]</b> 68/25	121/25 122/1 122/5
	40/17 44/8 58/13 59/8	7/10 7/10 8/6 8/9 8/12	<b>co [9]</b> 3/19 9/19 28/2	133/18 137/1 151/22

<b>C</b>	<b>compiled [1]</b> 70/3	107/2	24/1 28/3 63/15	<b>corrected [1]</b> 35/3
<b>commence [1]</b> 5/24	<b>complaining [1]</b> 145/13	<b>confidently [1]</b> 96/8	<b>contingency [1]</b> 80/19	<b>correctly [1]</b> 62/24
<b>commencement [1]</b> 39/7	<b>complaint [1]</b> 142/4	<b>confirm [2]</b> 4/1 113/8	<b>continue [8]</b> 8/5 17/3 34/21 35/23 68/5 112/6 133/9 152/6	<b>correspondence [1]</b> 49/24
<b>commend [2]</b> 58/18 68/15	<b>complete [2]</b> 75/18 125/20	<b>confirmed [1]</b> 94/17	<b>continued [4]</b> 33/16 42/2 103/21 127/3	<b>cough [1]</b> 132/9
<b>comment [4]</b> 3/22 5/5 65/15 125/3	<b>completely [5]</b> 60/22 76/2 78/20 114/6 147/8	<b>confusing [1]</b> 1/20	<b>continuing [4]</b> 95/11 95/14 133/6 138/10	<b>could [58]</b> 1/10 2/15 6/5 6/25 18/24 31/20 32/5 34/10 35/4 35/9 37/9 41/8 41/24 42/20 43/19 44/10 44/18 45/8 47/1 47/3 51/4 58/7 58/11 58/23 65/15 65/24 67/20 72/13 74/23 74/24 75/15 76/24 77/3 98/6 98/15 104/19 107/15 108/5 109/13 110/5 110/21 118/12 118/14 122/3 123/2 123/7 125/6 125/9 127/3 129/6 132/13 136/23 137/9 141/21 142/14 145/8 149/19 149/22
<b>commented [2]</b> 68/5 71/22	<b>completeness [1]</b> 20/25	<b>consensus [1]</b> 70/4	<b>convened [6]</b> 28/5 28/19 29/14 29/17 34/21 34/21	<b>couldn't [3]</b> 31/24 131/10 145/25
<b>comments [4]</b> 58/7 65/9 125/22 151/7	<b>complex [2]</b> 16/10 72/3	<b>consequence [1]</b> 122/12	<b>convenient [1]</b> 72/1	<b>Council [1]</b> 91/1
<b>commission [1]</b> 69/23	<b>complexities [1]</b> 74/16	<b>consequences [12]</b> 15/4 48/15 49/13 74/11 76/1 94/7 94/8 94/8 96/2 121/3 121/22 121/25	<b>convening [3]</b> 28/25 28/25 33/17	<b>COUNSEL [6]</b> 1/9 83/10 128/16 154/5 154/12 154/16
<b>commissioned [3]</b> 69/17 120/3 121/14	<b>complicated [2]</b> 27/5 67/6	<b>consider [4]</b> 76/18 92/25 108/4 117/18	<b>conversation [1]</b> 142/16	<b>counting [2]</b> 136/8 136/18
<b>Commissioner [1]</b> 15/19	<b>complied [1]</b> 83/24	<b>considerable [1]</b> 74/15	<b>conversations [3]</b> 24/13 43/23 91/3	<b>country [12]</b> 33/20 61/22 66/17 67/8 111/9 111/10 112/10 130/19 137/25 147/7 147/8 151/3
<b>committee [20]</b> 39/22 39/23 39/23 40/9 40/11 41/5 42/6 43/22 44/1 44/6 44/9 44/16 44/22 45/10 46/6 47/13 47/21 53/13 67/19 69/10	<b>comprehensive [1]</b> 123/18	<b>considerably [3]</b> 84/17 89/12 119/6	<b>convincing [1]</b> 24/16	<b>course [50]</b> 1/18 1/22 3/4 3/24 4/7 6/13 7/13 15/22 16/20 17/6 19/16 20/4 20/6 21/16 21/23 25/9 26/2 29/16 32/3 33/22 50/6 57/11 58/8 60/7 63/3 67/12 68/6 71/1 71/12 72/2 82/3 85/18 89/8 90/10 97/23 105/8 107/25 108/20 119/20 119/22 119/24 120/5 130/25 138/15 147/7 147/15 148/5 149/17 149/24 151/13
<b>committees [15]</b> 34/3 39/18 41/8 42/4 45/22 46/7 46/10 46/16 46/17 47/8 48/4 51/7 51/16 73/8 81/8	<b>comprise [1]</b> 80/4	<b>consideration [2]</b> 74/10 148/13	<b>convoluted [1]</b> 35/24	<b>couple [3]</b> 20/17 126/11 126/12
<b>common [10]</b> 21/15 53/7 65/18 115/1 117/12 118/23 119/1 135/4 135/5 135/5	<b>concept [1]</b> 117/6	<b>considerations [2]</b> 48/1 81/25	<b>copied [3]</b> 22/9 23/15 143/12	<b>couple [3]</b> 20/17 126/11 126/12
<b>Commons [1]</b> 82/4	<b>concern [8]</b> 58/2 58/12 58/24 72/22 140/18 146/17 147/18 149/10	<b>considered [8]</b> 41/1 59/11 68/13 76/11 122/4 140/11 148/12 149/11	<b>copy [1]</b> 22/10	<b>course [50]</b> 1/18 1/22 3/4 3/24 4/7 6/13 7/13 15/22 16/20 17/6 19/16 20/4 20/6 21/16 21/23 25/9 26/2 29/16 32/3 33/22 50/6 57/11 58/8 60/7 63/3 67/12 68/6 71/1 71/12 72/2 82/3 85/18 89/8 90/10 97/23 105/8 107/25 108/20 119/20 119/22 119/24 120/5 130/25 138/15 147/7 147/15 148/5 149/17 149/24 151/13
<b>comms [1]</b> 56/16	<b>concerned [5]</b> 24/3 31/22 107/10 147/7 150/13	<b>considering [3]</b> 85/24 90/16 148/10	<b>core [17]</b> 1/15 5/15 5/15 7/11 8/4 9/14 37/4 49/10 52/7 66/9 74/1 97/24 130/4 133/19 137/14 137/14 142/4	<b>court [1]</b> 21/7
<b>comms messaging [1]</b> 56/16	<b>concerning [3]</b> 25/21 29/5 72/6	<b>consistency [6]</b> 20/24 58/10 58/22 59/7 66/17 79/6	<b>core participant [1]</b> 130/4	<b>court-like [1]</b> 21/7
<b>CommsProblem [1]</b> 55/6	<b>concerns [8]</b> 57/14 60/18 69/16 81/11 97/13 146/23 148/16 149/9	<b>consistent [7]</b> 10/17 10/18 24/11 52/4 56/22 56/24 112/3	<b>core participants [2]</b> 49/10 97/24	<b>courtier [1]</b> 21/7
<b>communicated [1]</b> 60/3	<b>conclude [1]</b> 79/9	<b>consortium [2]</b> 108/12 111/11	<b>coronavirus [3]</b> 3/13 88/23 91/15	<b>courtier-like [1]</b> 21/7
<b>communication [6]</b> 66/19 66/21 67/11 71/23 72/1 72/14	<b>concluded [1]</b> 4/13	<b>constellation [2]</b> 86/12 106/21	<b>coronaviruses [1]</b> 89/9	<b>CoV [12]</b> 88/25 89/10 89/12 89/25 90/1 90/3 91/9 91/14 91/17 91/22 94/9 95/17
<b>community [12]</b> 94/21 97/11 97/16 98/9 102/2 104/12 104/13 104/17 108/3 108/10 134/9 138/10	<b>conclusion [3]</b> 20/16 92/1 105/9	<b>constitution [2]</b> 49/21 81/7	<b>corporate [1]</b> 8/8	<b>cover [3]</b> 65/20 71/3 86/4
<b>comorbidities [1]</b> 116/13	<b>conclusions [2]</b> 2/20 60/9	<b>constitutional [3]</b> 9/13 12/24 13/10	<b>correct [43]</b> 3/17 4/6 4/16 7/5 9/2 9/25 11/13 14/5 14/24 29/12 33/1 37/3 40/13 42/9 44/4 44/5 45/6 55/25 60/24 62/12 71/11 73/19 82/9 83/15 83/18 84/2 84/10 84/12 84/20 84/24 85/5 88/17 91/17 92/3 95/4 96/16 101/21 103/2 103/23 112/19 112/24 113/20 119/14	<b>covid [185]</b>
<b>compared [1]</b> 117/8	<b>condition [19]</b> 84/19 85/4 90/18 98/12 99/15 99/24 104/6 104/11 105/20 111/14 111/17 120/2 128/10 134/5 140/5 144/25 145/1 151/1 151/10	<b>constitutionally [2]</b> 11/17 50/8	<b>correct [43]</b> 3/17 4/6 4/16 7/5 9/2 9/25 11/13 14/5 14/24 29/12 33/1 37/3 40/13 42/9 44/4 44/5 45/6 55/25 60/24 62/12 71/11 73/19 82/9 83/15 83/18 84/2 84/10 84/12 84/20 84/24 85/5 88/17 91/17 92/3 95/4 96/16 101/21 103/2 103/23 112/19 112/24 113/20 119/14	
<b>compassionate [1]</b> 37/17	<b>conditions [10]</b> 86/5 86/21 86/22 87/7 94/3 106/24 113/7 117/17 117/24 121/8	<b>constraints [1]</b> 71/14		
<b>compelling [1]</b> 126/23	<b>condolences [1]</b> 129/13	<b>consultant [3]</b> 84/11 84/13 84/22		
<b>competence [10]</b> 57/15 57/25 58/3 59/1 60/20 60/21 60/25 61/1 73/15 82/6	<b>conducive [1]</b> 74/9	<b>consulting [1]</b> 77/23		
<b>competent [1]</b> 37/16	<b>conferences [1]</b> 33/11	<b>contact [2]</b> 91/3 143/11		
<b>competing [1]</b> 79/10	<b>confidence [14]</b> 14/8 14/12 14/17 14/22 14/25 15/12 17/19 17/21 19/21 19/25 56/21 56/23 57/7 57/18	<b>contain [1]</b> 24/20		
	<b>confident [2]</b> 92/21	<b>containable [2]</b> 33/12 33/13		
		<b>contains [1]</b> 23/18		
		<b>content [1]</b> 19/19		
		<b>contents [2]</b> 85/8 129/21		
		<b>context [7]</b> 20/17 24/18 38/9 60/4 72/23 75/4 131/23		
		<b>contingencies [7]</b> 8/6 8/21 9/20 19/25		

<p><b>C</b></p> <p><b>Covid-19 [11]</b> 32/20 37/11 42/7 90/6 90/14 95/2 101/25 110/2 112/3 138/9 141/7</p> <p><b>Covid-19 Taskforce [1]</b> 45/8</p> <p><b>Covid-O [17]</b> 42/4 42/11 42/20 43/15 44/3 44/6 44/16 45/10 50/18 51/3 52/3 52/17 52/25 53/5 64/4 66/3 80/3</p> <p><b>Covid-O's [1]</b> 44/18</p> <p><b>Covid-S [12]</b> 42/5 42/10 42/20 43/15 50/18 51/3 52/3 52/17 52/25 53/4 64/4 66/4</p> <p><b>CPs [1]</b> 128/5</p> <p><b>crack [1]</b> 76/2</p> <p><b>created [2]</b> 47/3 63/21</p> <p><b>creates [1]</b> 12/25</p> <p><b>crises [11]</b> 7/4 12/19 14/14 18/8 27/22 28/15 30/3 61/15 62/6 62/9 80/2</p> <p><b>crisis [49]</b> 9/18 9/21 9/24 10/1 10/15 12/6 13/2 14/10 16/4 17/25 18/5 18/6 18/22 18/22 20/2 24/3 25/17 26/6 28/1 28/13 28/15 28/23 29/24 30/14 31/22 32/22 33/4 34/8 36/3 37/14 51/17 61/14 61/20 61/20 61/23 62/2 62/14 62/15 63/2 64/14 65/7 69/13 71/1 73/10 75/7 75/11 79/7 79/22 81/2</p> <p><b>critical [3]</b> 21/2 60/2 118/11</p> <p><b>critically [1]</b> 13/25</p> <p><b>criticise [1]</b> 34/5</p> <p><b>criticised [2]</b> 58/11 58/23</p> <p><b>criticism [1]</b> 62/12</p> <p><b>criticisms [2]</b> 68/12 71/17</p> <p><b>critique [2]</b> 24/16 75/14</p> <p><b>critiques [1]</b> 74/1</p> <p><b>cross [1]</b> 71/21</p> <p><b>cross-government [1]</b> 71/21</p> <p><b>crucible [2]</b> 59/23 60/15</p> <p><b>CTF [3]</b> 50/13 51/12 51/15</p> <p><b>culturally [1]</b> 21/2</p> <p><b>culture [3]</b> 17/9 77/19 77/25</p>	<p><b>Cummings [21]</b> 11/23 14/21 17/1 19/2 19/3 19/11 20/18 22/1 22/22 22/25 23/10 24/6 25/2 26/12 26/13 48/24 51/14 54/12 55/14 56/4 65/9</p> <p><b>Cummings' [12]</b> 20/4 20/7 20/9 20/25 22/19 22/23 22/24 49/2 49/4 49/12 54/5 65/13</p> <p><b>current [3]</b> 14/2 23/20 105/6</p> <p><b>cusp [1]</b> 54/8</p> <p><b>cut [1]</b> 23/10</p> <hr/> <p><b>D</b></p> <p><b>daily [2]</b> 37/24 41/7</p> <p><b>dairies [1]</b> 11/24</p> <p><b>damaging [1]</b> 20/12</p> <p><b>damning [2]</b> 19/7 78/5</p> <p><b>danger [1]</b> 81/16</p> <p><b>DAs [3]</b> 21/22 43/19 43/23</p> <p><b>dashboards [1]</b> 41/1</p> <p><b>data [11]</b> 41/1 65/20 65/20 65/23 71/19 89/14 91/18 93/10 106/18 110/3 122/3</p> <p><b>date [5]</b> 123/19 125/12 129/21 130/25 150/7</p> <p><b>dated [9]</b> 19/4 21/25 23/11 37/12 61/16 83/25 123/9 124/15 136/25</p> <p><b>dates [2]</b> 32/4 38/21</p> <p><b>David [2]</b> 38/8 40/25</p> <p><b>David Cameron [1]</b> 38/8</p> <p><b>David Cameron-style [1]</b> 40/25</p> <p><b>dawn [1]</b> 76/20</p> <p><b>dawning [1]</b> 74/12</p> <p><b>day [10]</b> 6/24 25/12 25/12 38/9 45/15 45/15 53/25 133/12 149/1 149/15</p> <p><b>days [7]</b> 77/6 78/20 90/12 99/16 118/2 133/12 134/1</p> <p><b>dead [1]</b> 147/11</p> <p><b>deal [12]</b> 16/3 17/24 18/4 18/8 36/24 42/7 47/12 61/8 68/3 73/14 74/16 80/1</p> <p><b>dealing [3]</b> 8/24 27/22 47/11</p> <p><b>deaths [1]</b> 134/8</p> <p><b>debate [10]</b> 10/20 11/2 44/18 52/13 53/15 54/24 70/6 75/23 76/3 81/20</p>	<p><b>debated [1]</b> 53/21</p> <p><b>debilitating [1]</b> 132/11</p> <p><b>decades [2]</b> 7/13 113/5</p> <p><b>December [5]</b> 3/8 61/12 99/14 110/20 111/6</p> <p><b>December 2020 [2]</b> 110/20 111/6</p> <p><b>December 2021 [1]</b> 3/8</p> <p><b>December 2022 [1]</b> 61/12</p> <p><b>decided [3]</b> 34/25 44/19 53/22</p> <p><b>deciding [1]</b> 36/11</p> <p><b>decision [63]</b> 1/16 15/23 16/7 27/24 32/15 34/5 34/15 35/10 35/22 36/2 37/4 37/20 39/2 39/14 41/5 43/10 49/16 49/17 49/18 49/20 49/24 50/12 50/22 51/1 51/8 51/14 51/22 51/23 51/24 52/7 52/23 53/6 53/16 53/17 53/20 54/1 57/17 58/10 58/22 59/12 66/9 69/4 69/18 70/18 71/7 71/21 72/21 72/23 72/25 73/6 73/25 74/2 74/11 75/19 76/9 78/18 79/6 79/12 79/24 110/4 112/22 136/7 136/18</p> <p><b>decision-making [35]</b> 1/16 15/23 27/24 34/5 34/15 35/22 36/2 37/4 37/20 39/2 39/14 41/5 43/10 49/16 49/17 49/18 50/12 51/14 52/7 52/23 58/10 58/22 66/9 69/4 69/18 71/7 71/21 74/2 75/19 76/9 79/6 79/12 79/24 110/4 136/18</p> <p><b>decisions [48]</b> 5/11 5/15 8/18 14/15 18/20 33/8 33/19 33/21 33/24 34/22 35/1 35/13 36/6 41/8 41/15 45/24 49/15 50/17 51/2 51/2 51/5 51/10 51/13 52/1 52/2 52/17 53/4 56/22 56/25 57/15 60/2 60/5 66/11 66/13 72/15 73/3 73/21 74/7 74/8 74/9 74/21 75/17 75/21 76/11 77/22 80/13 136/9 145/3</p> <p><b>deep [1]</b> 78/24</p>	<p><b>deeper [1]</b> 67/5</p> <p><b>deeply [3]</b> 92/10 108/21 126/13</p> <p><b>deference [2]</b> 60/12 81/5</p> <p><b>deficiencies [1]</b> 67/18</p> <p><b>defined [5]</b> 87/22 95/6 97/20 111/5 112/1</p> <p><b>definitely [3]</b> 32/22 113/15 139/8</p> <p><b>definition [17]</b> 86/2 87/20 88/7 99/15 99/18 110/19 111/6 111/8 111/13 111/20 111/21 112/9 112/23 114/9 114/12 114/13 115/8</p> <p><b>definitions [3]</b> 87/5 87/21 99/22</p> <p><b>definitively [1]</b> 113/2</p> <p><b>DEFRA [2]</b> 62/6 66/15</p> <p><b>degree [9]</b> 14/7 23/6 33/4 41/15 60/8 60/25 66/6 70/24 135/2</p> <p><b>delay [1]</b> 68/14</p> <p><b>delayed [1]</b> 1/3</p> <p><b>delegate [1]</b> 28/11</p> <p><b>delegated [1]</b> 50/1</p> <p><b>deliberately [1]</b> 9/23</p> <p><b>Delphi [1]</b> 111/11</p> <p><b>Delta [1]</b> 148/6</p> <p><b>demands [3]</b> 8/3 53/24 74/15</p> <p><b>democracy [1]</b> 81/14</p> <p><b>democratically [1]</b> 82/2</p> <p><b>demographics [2]</b> 117/14 117/15</p> <p><b>demonstrate [1]</b> 14/17</p> <p><b>demonstrated [2]</b> 33/14 106/19</p> <p><b>denigrate [1]</b> 151/10</p> <p><b>departing [1]</b> 26/13</p> <p><b>department [28]</b> 4/10 4/11 4/14 29/9 29/10 40/1 61/6 61/7 61/10 61/17 61/25 62/4 62/7 62/13 62/16 62/17 62/20 62/23 62/25 63/1 63/8 64/5 64/24 65/4 65/7 124/10 143/11 143/19</p> <p><b>departmental [2]</b> 44/25 45/3</p> <p><b>departments [22]</b> 4/9 6/1 7/3 9/15 16/12 25/16 30/12 39/25 40/7 40/10 40/11 61/5 61/23 62/10 63/5 63/7 63/12 63/20 63/24</p>	<p>64/9 64/12 75/3</p> <p><b>depend [2]</b> 28/13 75/7</p> <p><b>dependency [1]</b> 35/17</p> <p><b>depending [2]</b> 8/1 29/1</p> <p><b>depends [2]</b> 67/17 73/12</p> <p><b>deploy [1]</b> 19/11</p> <p><b>deputy [3]</b> 31/3 32/11 48/23</p> <p><b>derived [1]</b> 112/13</p> <p><b>describe [11]</b> 7/5 45/9 69/16 93/17 98/18 131/6 135/22 138/9 141/7 142/24 150/4</p> <p><b>described [14]</b> 16/18 50/14 63/3 63/10 65/12 76/20 91/23 103/12 104/13 105/21 108/8 131/17 132/6 133/20</p> <p><b>describes [2]</b> 77/9 78/16</p> <p><b>describing [2]</b> 87/16 123/13</p> <p><b>description [3]</b> 13/21 126/9 126/10</p> <p><b>descriptions [1]</b> 127/24</p> <p><b>deserved [1]</b> 126/25</p> <p><b>desiccated [1]</b> 81/18</p> <p><b>design [1]</b> 108/13</p> <p><b>designated [1]</b> 101/8</p> <p><b>designed [2]</b> 36/10 69/20</p> <p><b>desired [1]</b> 53/10</p> <p><b>desk [1]</b> 15/21</p> <p><b>despite [1]</b> 153/1</p> <p><b>detail [7]</b> 61/13 71/3 86/1 88/13 93/21 103/25 142/25</p> <p><b>detailed [1]</b> 110/18</p> <p><b>details [1]</b> 138/25</p> <p><b>determine [2]</b> 104/24 112/17</p> <p><b>determines [1]</b> 51/22</p> <p><b>detrimentally [1]</b> 21/8</p> <p><b>devastating [1]</b> 106/24</p> <p><b>develop [6]</b> 89/6 112/2 116/6 116/15 116/22 122/7</p> <p><b>developed [4]</b> 85/3 90/23 111/11 131/10</p> <p><b>developing [9]</b> 16/9 91/25 98/7 107/18 110/14 116/3 117/1 120/1 149/14</p> <p><b>development [2]</b> 101/6 102/20</p>
---	--	---	--	--

<b>D</b>	42/13 44/25 46/8 53/16 62/9 66/17 67/7 67/25 76/10 78/20 80/1 86/16 86/16 87/21 95/13 96/11 96/17 97/21 101/14 102/10 102/10 105/18 105/22 106/2 107/12 116/17 117/15 117/24 117/24 118/16 118/17 146/22 147/24	<b>dismissively [1]</b> 141/8 <b>disparate [2]</b> 11/10 66/1 <b>dissonance [1]</b> 140/3 <b>distinct [6]</b> 11/9 14/7 17/9 48/13 60/13 61/17 <b>distinction [2]</b> 9/1 70/21 <b>distorting [1]</b> 48/15 <b>distress [1]</b> 94/4 <b>distressing [1]</b> 78/11 <b>distribution [1]</b> 136/10 <b>distrust [1]</b> 127/18 <b>divergence [2]</b> 17/22 19/22 <b>diversity [2]</b> 68/13 69/12 <b>divided [2]</b> 8/15 26/1 <b>do [60]</b> 2/8 2/8 2/13 2/14 2/14 2/18 4/1 4/20 5/4 5/5 5/5 5/7 5/23 10/19 15/3 39/5 41/12 41/21 43/2 44/21 46/25 48/10 48/12 51/11 59/22 66/5 68/5 70/15 73/1 79/9 79/16 80/9 80/25 84/3 91/12 98/5 100/1 101/9 106/4 107/11 108/21 109/17 110/25 111/4 113/7 114/25 121/23 122/7 125/12 125/19 126/18 128/8 133/9 137/20 137/21 138/25 141/20 142/10 144/11 152/2 <b>doctor [2]</b> 112/20 113/1 <b>doctors [7]</b> 99/3 113/18 134/5 135/5 141/15 141/17 144/25 <b>document [13]</b> 21/24 43/8 49/10 76/22 76/23 76/25 83/20 123/15 123/25 125/4 125/5 126/3 126/11 <b>documentation [1]</b> 72/17 <b>documented [1]</b> 95/25 <b>documents [4]</b> 39/9 51/20 123/2 124/2 <b>does [38]</b> 2/25 4/18 4/22 6/15 6/16 9/17 9/21 13/8 17/15 19/12 19/13 19/16 19/18 19/25 28/3 28/4 28/6 41/3 53/5 55/19 57/6 61/24 62/24 63/12 65/15 71/2 75/7 75/21 80/15 80/18 106/25	109/5 115/5 115/16 122/14 124/20 126/21 152/6 <b>doesn't [7]</b> 23/20 31/18 47/23 53/12 113/12 149/18 151/4 <b>doing [8]</b> 29/21 77/15 78/1 78/1 80/23 80/25 92/7 106/2 <b>dom [1]</b> 54/11 <b>domain [1]</b> 91/18 <b>domestic [1]</b> 8/20 <b>Dominic [5]</b> 14/21 26/12 54/12 55/14 56/4 <b>Dominic Cummings</b> <b>[5]</b> 14/21 26/12 54/12 55/14 56/4 <b>don't [33]</b> 13/16 31/19 32/6 34/6 40/20 50/18 50/21 50/22 50/22 51/18 53/15 82/11 82/12 84/6 88/11 88/15 108/22 109/18 111/1 111/3 127/6 127/6 129/19 132/15 138/3 140/5 141/18 141/19 141/19 141/25 149/19 150/16 151/6 <b>done [16]</b> 2/21 2/24 5/6 5/8 32/14 47/6 82/5 85/18 92/6 98/6 98/15 112/17 113/12 120/17 128/11 132/25 <b>door [2]</b> 17/10 17/12 <b>doubt [3]</b> 8/7 98/20 130/17 <b>down [24]</b> 22/9 22/18 22/19 61/24 62/13 66/20 67/15 69/18 74/17 76/2 79/4 112/10 115/11 125/17 132/13 132/16 136/22 139/23 139/24 139/24 141/3 142/3 146/19 148/17 <b>Downing [2]</b> 26/14 32/25 <b>Downing Street [2]</b> 26/14 32/25 <b>DR [24]</b> 83/8 83/14 84/21 85/7 86/18 87/12 88/18 91/23 97/3 103/12 104/3 104/13 105/21 106/8 106/8 107/18 111/2 115/6 122/24 127/13 128/3 131/2 143/16 154/7 <b>Dr Evans [21]</b> 84/21 85/7 86/18 87/12 88/18 91/23 97/3 103/12 104/3 104/13	105/21 106/8 106/8 107/18 111/2 115/6 122/24 127/13 128/3 131/2 143/16 <b>Dr Rachael Evans [1]</b> 83/14 <b>drafted [1]</b> 25/13 <b>Drakeford [4]</b> 31/5 31/12 31/19 31/24 <b>dramatic [2]</b> 8/11 8/13 <b>draw [2]</b> 6/21 22/8 <b>drawing [2]</b> 53/2 60/9 <b>drawn [1]</b> 2/21 <b>dreadful [2]</b> 127/18 128/10 <b>drew [2]</b> 74/5 92/1 <b>drift [1]</b> 35/25 <b>drive [1]</b> 67/13 <b>drivers [1]</b> 118/9 <b>driving [3]</b> 62/1 118/6 118/15 <b>drugs [1]</b> 95/22 <b>Duchy [4]</b> 7/18 40/6 42/11 45/2 <b>due [7]</b> 6/13 15/22 21/23 25/8 29/15 60/12 119/22 <b>duration [1]</b> 120/21 <b>during [11]</b> 3/4 4/3 14/10 68/5 93/13 112/2 119/25 120/9 120/17 140/17 152/16 <b>duties [3]</b> 83/22 83/23 83/24 <b>duty [1]</b> 1/22 <b>dynamic [1]</b> 7/7 <b>dysfunction [1]</b> 14/8 <b>dysfunctionality [3]</b> 24/9 26/24 27/2
			<b>E</b>	
			<b>each [8]</b> 7/19 21/14 37/1 39/13 46/19 77/14 85/13 85/21 <b>earlier [19]</b> 18/3 30/8 31/6 31/19 32/14 34/7 35/20 55/14 60/1 74/6 81/1 99/25 109/17 115/19 118/9 119/16 122/3 122/4 138/18 <b>early [39]</b> 17/4 25/23 26/23 26/23 33/8 33/10 42/2 65/21 71/6 88/22 90/8 90/12 90/15 90/23 91/6 91/9 92/21 93/10 93/17 93/17 94/10 97/5 97/22 98/7 99/16 100/19 106/7 109/11 110/4 113/17 118/1 120/20 120/21 121/10 121/10 122/5 129/2 134/1 140/17	

<b>E</b>	<b>emerging [3]</b> 16/4 20/2 33/5	25/11 78/15	78/3	75/1 85/14 95/10 99/5 99/19 102/12 103/13
<b>earth [1]</b> 131/13	<b>emissions [1]</b> 5/22	<b>entry [1]</b> 25/7	<b>everything [4]</b> 41/9	108/13 111/13 113/23
<b>easier [1]</b> 109/12	<b>emoji [1]</b> 55/1	<b>environment [7]</b> 4/10 4/14 17/12 20/20 21/8	59/11 114/13 152/22	126/6 135/4 135/20
<b>easing [1]</b> 136/10	<b>emotional [1]</b> 59/17	56/19 62/7	<b>evidence [38]</b> 1/23	141/1 141/25
<b>easy [1]</b> 59/16	<b>emotive [1]</b> 127/15	<b>environmental [1]</b>	2/15 5/2 5/25 6/23	<b>experienced [2]</b> 78/8 111/16
<b>economic [13]</b> 8/20 16/11 36/25 39/22	<b>empathetic [1]</b> 78/9	34/12	18/3 27/10 27/11 41/2	<b>experiences [2]</b>
47/22 47/25 48/14	<b>emphasis [1]</b> 134/7	<b>epidemic [2]</b> 89/11	43/25 47/17 49/2	150/1 151/23
70/12 70/23 70/25	<b>emphasise [1]</b> 81/14	91/25	51/22 51/25 52/9	<b>experiencing [2]</b>
71/7 71/15 79/20	<b>employees [1]</b> 18/9	<b>epidemiological [1]</b>	52/11 53/18 58/6 61/1	131/21 132/18
<b>economy [3]</b> 55/5	<b>enable [2]</b> 12/6 80/12	66/15	61/8 61/13 68/6 69/3	<b>expert [4]</b> 1/15 47/21 48/13 83/23
56/14 76/12	<b>encapsulates [1]</b>	69/10	70/7 70/11 73/24 74/5	<b>expertise [2]</b> 48/10 69/12
<b>education [3]</b> 62/17	138/14	<b>episode [1]</b> 122/11	74/10 75/12 82/18	<b>experts [10]</b> 44/17 47/4 48/17 68/23
62/20 76/12	<b>encourage [1]</b>	<b>Epstein [1]</b> 89/3	85/9 97/25 114/19	68/24 69/13 80/4 80/6
<b>effect [8]</b> 13/3 20/12	150/12	<b>Epstein-Barr [1]</b> 89/3	148/13 152/12 152/13	106/1 111/12
33/23 47/18 65/10	<b>encouraged [1]</b>	<b>equals [1]</b> 12/13	152/16 152/20	<b>explain [3]</b> 118/19 146/18 146/22
79/9 93/2 117/9	144/6	<b>equipped [2]</b> 17/24	<b>evident [4]</b> 11/4 19/5	<b>explained [8]</b> 29/19 91/24 92/18 96/7
<b>effective [9]</b> 2/7 5/2	<b>encouraging [1]</b>	18/4	33/15 71/25	103/19 112/8 117/25
26/6 44/23 62/5 66/24	144/23	<b>equivalent [1]</b> 47/20	<b>evidently [1]</b> 16/17	133/6
66/25 109/15 144/19	<b>encroachment [1]</b>	<b>equivalents [1]</b> 30/24	<b>evolution [1]</b> 103/2	<b>explanation [1]</b>
<b>effectively [3]</b> 15/3	64/7	<b>essentially [3]</b> 51/16	<b>evolved [1]</b> 76/21	111/17
39/3 41/16	<b>end [18]</b> 4/3 10/7	142/4 149/7	<b>exacerbation [1]</b>	<b>explore [1]</b> 50/24
<b>effects [4]</b> 89/15	42/1 95/19 99/13	<b>established [4]</b> 26/4	88/2	<b>explosions [1]</b> 77/16
90/21 104/25 106/9	100/5 103/8 104/3	38/14 130/25 145/12	<b>exactly [7]</b> 12/11	<b>express [5]</b> 20/21 57/14 115/9 141/18
<b>efficacy [2]</b> 44/21	104/14 114/14 116/8	<b>establishment [2]</b>	12/20 20/24 86/25	149/18
72/6	120/23 124/11 129/18	36/23 42/3	92/23 126/12 127/25	<b>expressed [8]</b> 19/18 20/18 55/10 58/2
<b>efficient [1]</b> 4/19	131/10 142/25 147/11	<b>estimate [1]</b> 138/16	<b>examined [1]</b> 73/4	60/19 81/11 120/12
<b>efficiently [1]</b> 14/13	152/13	<b>estimates [2]</b> 119/2	<b>examining [3]</b> 5/25	125/25
<b>either [11]</b> 3/9 16/8	<b>endeavour [1]</b> 82/18	119/3	75/20 134/8	<b>expressing [1]</b> 20/11
31/21 49/6 49/23	<b>ending [1]</b> 94/1	<b>et [1]</b> 56/14	<b>example [17]</b> 5/18	<b>extend [1]</b> 57/6
51/15 94/3 102/7	<b>endorse [1]</b> 27/7	<b>et cetera [1]</b> 56/14	8/18 9/9 9/21 21/17	<b>extension [1]</b> 81/22
117/11 126/15 143/25	<b>endorsed [1]</b> 121/6	<b>Europe [1]</b> 91/4	33/20 33/21 34/9	<b>extent [23]</b> 12/24
<b>elaborate [1]</b> 6/25	<b>enemy [1]</b> 64/17	<b>European [1]</b> 91/2	40/19 62/5 62/17	13/22 14/11 17/2
<b>elderly [2]</b> 147/1	<b>enforcement [1]</b> 67/7	<b>EVANS [24]</b> 83/8	67/19 76/14 90/1	19/13 36/3 40/12
147/6	<b>engage [1]</b> 47/2	83/14 84/21 85/7	109/9 112/16 143/19	45/11 48/2 50/12
<b>elect [1]</b> 81/21	<b>engaged [9]</b> 23/15	86/18 87/12 88/18	<b>examples [2]</b> 28/21	52/14 55/19 57/19
<b>elected [2]</b> 67/17	28/15 30/12 43/19	91/23 97/3 103/12	88/20	66/18 67/9 70/15
82/3	44/3 52/6 67/25	104/3 104/13 105/21	<b>exception [1]</b> 40/8	74/20 74/24 75/7 75/9
<b>election [1]</b> 74/19	105/23 124/21	106/8 106/8 107/18	<b>excessive [1]</b> 17/22	75/21 132/5 135/9
<b>element [1]</b> 94/12	<b>engagement [3]</b>	111/2 115/6 122/24	<b>exciting [1]</b> 145/16	<b>external [2]</b> 7/4 16/9
<b>elevated [1]</b> 15/17	98/23 102/21 129/3	127/13 128/3 131/2	<b>excluded [1]</b> 111/18	<b>extra [1]</b> 46/10
<b>eligible [1]</b> 140/12	<b>engaging [2]</b> 104/4	143/16 154/7	<b>excluding [1]</b> 66/14	<b>extract [2]</b> 23/9 32/12
<b>eloquent [1]</b> 152/2	135/23	<b>eve [1]</b> 53/19	<b>executive [5]</b> 7/17	<b>extracts [1]</b> 55/15
<b>else [3]</b> 31/25 49/25	<b>engendered [1]</b>	<b>even [20]</b> 9/8 13/5	31/10 46/12 137/5	<b>extraordinary [2]</b>
56/3	79/10	13/12 25/12 46/19	137/8	27/5 132/22
<b>else's [1]</b> 20/22	<b>England [16]</b> 65/2	54/15 87/8 91/9 91/13	<b>executives [1]</b> 137/6	<b>extrapolate [1]</b>
<b>elsewhere [7]</b> 33/25	65/3 65/5 66/12 100/6	94/16 96/13 106/13	<b>exercise [3]</b> 12/7	113/24
34/2 36/7 39/10 52/10	102/6 137/6 137/8	113/18 116/5 126/20	50/2 109/15	<b>extreme [2]</b> 48/16 72/18
53/4 57/13	137/13 137/15 137/16	127/25 135/6 140/11	<b>exerted [1]</b> 133/14	<b>extremely [11]</b> 16/6
<b>email [3]</b> 23/11 23/13	137/22 143/10 143/11	146/1 150/15	<b>exertional [2]</b> 88/1	16/7 19/7 20/13 55/11
23/17	144/6 144/11	<b>evening [2]</b> 11/24	88/2	73/1 75/17 78/8 96/6
<b>embarrassing [1]</b>	<b>English [1]</b> 137/12	24/20	<b>exist [6]</b> 35/23 36/12	118/5 126/13
54/18	<b>enlarged [1]</b> 104/23	<b>event [1]</b> 88/4	46/21 51/7 97/21	<b>eye [1]</b> 140/24
<b>embodying [1]</b> 10/24	<b>enough [6]</b> 62/24	<b>events [5]</b> 3/23 16/9	151/4	
<b>emerge [1]</b> 80/2	64/9 75/18 78/2 80/1	67/2 100/4 146/6	<b>existed [2]</b> 34/16	
<b>emerged [1]</b> 3/23	140/11	<b>eventually [1]</b> 143/9	46/3	
<b>emergence [2]</b> 31/22	<b>ensure [1]</b> 80/10	<b>ever [2]</b> 67/6 67/6	<b>existence [1]</b> 113/14	
93/13	<b>entire [1]</b> 93/2	<b>every [4]</b> 37/7 50/22	<b>existing [4]</b> 20/13	
<b>Emergencies [1]</b>	<b>entirely [9]</b> 28/10	82/21 140/24	67/10 105/5 116/13	
47/19	50/19 56/21 57/16	<b>everybody [5]</b> 21/13	<b>expanding [1]</b> 108/4	
<b>emergency [2]</b> 28/16	58/5 66/10 75/13	54/21 59/13 153/2	<b>expect [3]</b> 53/2 87/25	
28/18	76/13 105/2	153/2	127/8	
<b>emergent [1]</b> 105/4	<b>entities [1]</b> 6/1	<b>everyone [2]</b> 42/19	<b>expectation [1]</b> 62/1	
	<b>entries [3]</b> 11/23		<b>experience [19]</b> 3/2	
			32/19 34/14 68/14	

<b>F</b>	29/12 29/14 29/24 31/13 33/4 61/16 109/1 109/3 124/6 125/12 125/23 <b>February 2021 [3]</b> 109/1 124/6 125/23 <b>February 2022 [1]</b> 61/16 <b>February/March 2020 [1]</b> 109/3 <b>feeding [2]</b> 110/3 127/24 <b>feeds [1]</b> 139/4 <b>feel [11]</b> 39/17 70/15 81/17 85/19 126/12 126/25 127/11 127/15 127/22 140/19 144/19 <b>feeling [2]</b> 133/13 138/11 <b>feelings [1]</b> 138/14 <b>feels [1]</b> 85/16 <b>felt [13]</b> 32/20 64/20 70/9 93/7 132/25 133/23 133/25 134/2 135/17 138/13 145/24 145/25 150/9 <b>female [1]</b> 116/12 <b>ferocious [1]</b> 53/21 <b>fever [3]</b> 89/4 89/7 132/8 <b>few [21]</b> 10/3 14/10 15/24 15/25 43/2 65/25 100/2 106/13 106/13 110/17 113/5 119/17 122/25 123/2 123/21 131/24 133/12 138/5 142/18 144/18 146/18 <b>fewer [3]</b> 89/13 118/24 119/6 <b>field [2]</b> 72/5 76/7 <b>fields [2]</b> 47/22 48/18 <b>Fifthly [1]</b> 70/7 <b>fighting [1]</b> 25/18 <b>fight [1]</b> 77/13 <b>filed [1]</b> 130/5 <b>fill [1]</b> 70/9 <b>film [1]</b> 133/25 <b>finally [4]</b> 63/24 105/3 146/5 150/3 <b>financial [1]</b> 67/7 <b>find [4]</b> 24/15 72/20 115/22 150/21 <b>finding [2]</b> 91/6 114/3 <b>findings [2]</b> 106/7 111/19 <b>finds [1]</b> 26/25 <b>fine [1]</b> 129/5 <b>finished [1]</b> 97/8 <b>firm [1]</b> 94/18 <b>first [55]</b> 1/20 12/13 14/10 15/18 15/24 15/25 22/14 27/23 29/5 29/17 31/2 31/2	31/3 31/5 31/12 31/14 32/3 35/7 37/20 54/10 67/12 69/14 75/25 83/20 86/1 90/7 93/2 100/12 103/8 104/24 106/8 106/12 106/13 108/8 108/20 109/2 109/3 109/19 115/25 117/22 122/15 123/2 123/11 124/4 124/13 126/1 126/3 128/17 130/7 138/7 138/7 142/5 146/24 147/1 152/14 <b>First Minister [1]</b> 31/5 <b>First Ministers [2]</b> 31/3 67/12 <b>firstly [4]</b> 18/6 57/24 69/9 71/6 <b>fit [1]</b> 132/12 <b>fits [1]</b> 130/25 <b>five [9]</b> 75/6 100/7 102/20 103/16 103/16 105/14 106/17 126/4 144/8 <b>five years [1]</b> 75/6 <b>five-point [5]</b> 102/20 103/16 103/16 126/4 144/8 <b>flaw [2]</b> 62/14 78/24 <b>flexible [1]</b> 80/1 <b>flip [1]</b> 78/17 <b>flip-flopping [1]</b> 78/17 <b>flopping [1]</b> 78/17 <b>flowing [1]</b> 65/23 <b>flows [1]</b> 65/20 <b>fluctuated [1]</b> 29/1 <b>fluid [2]</b> 6/23 7/24 <b>focus [17]</b> 1/17 4/18 48/16 69/9 104/9 104/16 105/12 107/24 121/18 122/10 122/11 130/21 137/13 137/17 137/23 142/6 147/18 <b>focused [15]</b> 1/15 3/19 7/8 17/9 69/6 88/19 93/19 94/24 96/5 100/22 108/9 108/19 136/4 144/22 145/9 <b>focusing [3]</b> 95/5 100/3 105/2 <b>fog [2]</b> 86/11 114/23 <b>follow [2]</b> 9/21 94/19 <b>followed [1]</b> 89/17 <b>following [10]</b> 14/4 53/25 69/8 70/16 79/17 86/19 93/23 99/4 103/23 139/1 <b>Food [2]</b> 4/10 4/14 <b>fora [4]</b> 34/3 50/23 53/6 74/7	<b>forceful [2]</b> 20/18 20/21 <b>foreign [2]</b> 39/21 39/21 <b>Foreign Secretary [1]</b> 39/21 <b>foreseeability [1]</b> 90/5 <b>foreseeable [3]</b> 90/12 91/7 92/19 <b>forever [1]</b> 6/20 <b>forget [1]</b> 55/5 <b>forgotten [1]</b> 138/8 <b>form [7]</b> 41/23 49/18 49/20 52/5 72/1 92/23 137/18 <b>formal [17]</b> 13/15 40/19 40/22 41/4 41/12 42/3 44/7 45/15 50/7 53/4 53/13 55/16 57/3 72/15 102/25 136/5 136/16 <b>formalised [2]</b> 80/10 110/13 <b>formality [2]</b> 41/16 72/24 <b>formally [3]</b> 40/14 54/1 92/14 <b>formed [1]</b> 133/20 <b>former [1]</b> 9/2 <b>formerly [1]</b> 8/21 <b>forming [1]</b> 82/4 <b>forms [2]</b> 69/3 85/23 <b>formulated [1]</b> 52/18 <b>forth [1]</b> 131/20 <b>fortunate [1]</b> 113/6 <b>fortunately [1]</b> 133/16 <b>forum [10]</b> 34/15 34/17 35/4 35/10 36/2 36/11 36/11 47/3 144/24 145/4 <b>forward [3]</b> 42/7 51/22 150/4 <b>Foster [1]</b> 31/13 <b>found [10]</b> 7/21 89/19 89/21 106/11 107/4 107/13 115/1 122/6 130/3 131/3 <b>founded [1]</b> 2/6 <b>founders [1]</b> 132/24 <b>founding [2]</b> 129/8 129/10 <b>four [8]</b> 36/24 36/24 39/6 39/12 43/1 43/13 46/18 75/6 <b>fourth [1]</b> 101/16 <b>Fourthly [1]</b> 70/2 <b>framed [1]</b> 53/6 <b>framework [3]</b> 61/12 75/15 75/16 <b>free [1]</b> 85/20 <b>freedom [2]</b> 149/1 149/15	<b>Freeman [1]</b> 31/10 <b>frequently [1]</b> 114/22 <b>friction [1]</b> 23/21 <b>Friday [1]</b> 1/1 <b>frightening [2]</b> 98/12 132/11 <b>front [3]</b> 21/3 53/21 112/21 <b>frustrated [1]</b> 65/17 <b>frustrating [2]</b> 47/11 146/3 <b>frustration [2]</b> 65/24 145/14 <b>fulfil [3]</b> 48/4 48/6 129/3 <b>fulfilling [1]</b> 36/8 <b>full [6]</b> 1/10 24/12 55/2 56/6 81/25 151/21 <b>fully [5]</b> 48/8 63/19 85/14 106/15 106/17 <b>function [11]</b> 8/6 8/7 12/24 19/8 34/9 46/21 48/5 48/6 89/21 89/22 151/15 <b>functional [2]</b> 8/23 47/12 <b>functions [7]</b> 8/4 9/7 18/2 18/16 27/13 34/9 39/14 <b>funded [3]</b> 101/2 108/16 108/17 <b>funding [6]</b> 101/16 104/15 104/15 108/8 108/23 109/1 <b>further [9]</b> 22/9 43/4 88/18 91/14 115/11 120/3 128/13 139/24 148/17 <b>future [10]</b> 5/11 105/4 105/6 109/6 110/7 110/11 122/8 122/14 122/17 123/24
			<b>G</b>	
			<b>gain [1]</b> 80/21 <b>gap [6]</b> 48/13 63/13 63/22 63/23 67/24 69/2 <b>gaps [1]</b> 34/15 <b>gaslighting [1]</b> 135/15 <b>gather [1]</b> 104/4 <b>gave [5]</b> 90/1 91/14 107/8 107/11 146/17 <b>GCSA [1]</b> 68/25 <b>gear [1]</b> 37/13 <b>general [14]</b> 9/17 14/6 15/25 17/2 19/7 39/5 39/23 52/5 58/3 71/5 74/19 78/16 85/22 120/11 <b>general election [1]</b> 74/19	

<b>G</b>	85/22 87/18 92/20 96/9 100/2 101/7 106/7 107/23 108/1 108/18 115/23 121/17 124/2 131/19 138/18 139/23 140/18 141/12 143/5 144/10 145/3 145/16 146/10 146/14 150/10	127/10 134/4 135/24 136/18 138/11 142/6 142/12 142/18 143/3 143/4 143/15 145/17 145/18 148/10 149/11 150/11	<b>guess [1]</b> 57/20 <b>guidance [2]</b> 99/14 100/13 <b>guidelines [1]</b> 124/9 <b>gulf [2]</b> 125/2 125/20 <b>gulf war [2]</b> 125/2 125/20 <b>Gus [1]</b> 75/13 <b>Gus O'Donnell [1]</b> 75/13	<b>hard [7]</b> 13/5 16/7 72/20 74/23 118/8 136/6 137/22 <b>harder [1]</b> 13/5 <b>harsh [1]</b> 59/5 <b>has [70]</b> 3/3 3/3 5/6 5/7 6/17 6/20 7/14 8/10 10/14 11/5 11/14 12/12 12/15 12/20 13/20 15/7 18/8 18/12 19/14 19/21 20/12 20/18 23/2 23/10 25/4 25/5 28/5 28/16 28/17 28/20 29/1 37/16 43/25 47/17 52/11 53/23 55/7 57/17 58/15 60/8 61/17 63/21 65/3 67/21 68/13 69/6 72/16 73/20 77/21 77/21 77/23 85/18 85/19 88/14 91/23 103/12 104/22 107/19 111/8 111/17 112/18 112/21 117/17 126/18 127/17 127/20 128/18 133/15 135/18 137/13 <b>hash [1]</b> 47/5 <b>hashing [1]</b> 80/8 <b>hat [1]</b> 65/13 <b>have [205]</b> <b>haven't [10]</b> 22/6 39/16 49/1 49/4 51/18 51/25 53/3 55/16 87/14 123/4 <b>having [16]</b> 34/21 46/18 75/8 95/20 96/3 113/1 120/15 121/23 125/24 131/9 142/1 144/5 145/1 145/11 145/16 151/25 <b>hazy [1]</b> 41/19 <b>he [35]</b> 11/6 13/13 14/2 22/3 22/11 23/4 23/10 23/12 23/15 24/7 24/22 25/4 31/21 32/19 33/10 33/11 37/18 37/21 37/23 47/1 53/22 53/23 56/16 78/16 80/10 112/20 125/16 125/18 126/20 126/21 126/24 128/23 128/24 128/25 129/3 <b>he'll [1]</b> 54/20 <b>head [5]</b> 7/9 10/9 10/23 48/22 78/4 <b>headed [2]</b> 6/17 124/19 <b>headlines [1]</b> 40/24 <b>headquarters [1]</b> 8/8 <b>health [38]</b> 4/11 29/10 30/24 31/7 31/11 36/25 37/14
<b>generally [5]</b> 28/19 28/20 38/5 59/2 76/19 <b>generations [1]</b> 38/15 <b>genuine [1]</b> 58/2 <b>get [26]</b> 16/12 35/25 40/20 47/6 48/8 53/1 54/21 82/14 82/24 86/24 95/18 103/20 114/3 133/17 137/24 138/9 138/15 143/15 145/25 147/2 147/10 147/12 148/7 149/19 150/24 151/7 <b>Gething [2]</b> 31/9 31/24 <b>gets [3]</b> 88/3 113/22 115/22 <b>getting [12]</b> 91/2 99/8 108/1 111/12 128/9 132/21 134/4 144/8 144/10 145/12 149/13 150/13 <b>give [17]</b> 1/10 2/15 30/13 62/24 72/3 82/18 87/8 87/11 88/19 93/21 105/7 120/18 125/6 129/6 134/23 138/25 151/1 <b>given [9]</b> 11/21 29/23 30/5 30/9 31/16 66/16 80/11 81/5 111/14 <b>giving [4]</b> 18/17 48/16 48/17 85/9 <b>glandular [2]</b> 89/4 89/7 <b>Glenfield [1]</b> 84/22 <b>Glenfield Hospital [1]</b> 84/22 <b>go [47]</b> 7/18 13/23 17/11 21/4 22/7 23/17 27/9 37/23 42/23 51/6 53/24 55/7 73/25 78/19 79/15 88/8 89/6 104/18 104/19 109/10 112/21 113/5 114/19 115/3 115/25 116/10 117/3 123/10 124/18 125/5 125/9 125/15 125/17 129/19 133/5 136/20 138/4 139/23 140/2 140/10 142/21 146/8 147/10 149/16 150/16 150/21 151/8 <b>goes [7]</b> 13/3 19/18 19/19 51/22 74/4 89/23 145/15 <b>going [40]</b> 6/3 15/22 19/4 21/10 25/23 42/7 42/13 48/3 49/15 51/13 53/15 69/4 79/15 85/6 85/14	261/10 261/11 261/12 261/13 261/14 261/15 261/16 261/17 261/18 261/19 261/20 261/21 261/22 261/23 261/24 261/25 261/26 261/27 261/28 261/29 261/30 261/31 261/32 261/33 261/34 261/35 261/36 261/37 261/38 261/39 261/40 261/41 261/42 261/43 261/44 261/45 261/46 261/47 261/48 261/49 261/50 261/51 261/52 261/53 261/54 261/55 261/56 261/57 261/58 261/59 261/60 261/61 261/62 261/63 261/64 261/65 261/66 261/67 261/68 261/69 261/70 261/71 261/72 261/73 261/74 261/75 261/76 261/77 261/78 261/79 261/80 261/81 261/82 261/83 261/84 261/85 261/86 261/87 261/88 261/89 261/90 261/91 261/92 261/93 261/94 261/95 261/96 261/97 261/98 261/99 261/100	<b>government's [14]</b> 3/6 3/11 3/16 4/25 5/16 6/2 14/13 21/18 57/21 67/4 70/8 70/14 70/16 76/15 <b>government-produce d [1]</b> 61/11 <b>governments [2]</b> 5/21 81/15 <b>GPs [1]</b> 101/7 <b>gram [1]</b> 6/6 <b>grapple [1]</b> 75/17 <b>grateful [6]</b> 82/14 97/2 151/12 151/18 151/22 152/22 <b>gratitude [1]</b> 82/14 <b>great [5]</b> 61/8 73/14 74/24 80/5 140/18 <b>greater [2]</b> 13/12 116/11 <b>greatest [1]</b> 6/2 <b>greatly [1]</b> 147/8 <b>grew [1]</b> 139/13 <b>gripping [1]</b> 64/21 <b>ground [3]</b> 35/8 36/13 109/14 <b>grounds [1]</b> 113/13 <b>group [50]</b> 22/1 37/1 38/1 39/6 39/24 46/9 46/15 47/18 54/7 54/23 86/4 93/24 94/22 97/9 97/11 99/4 100/23 105/12 107/7 107/15 107/21 115/16 115/17 117/20 120/25 129/9 130/1 130/2 130/24 131/7 131/18 131/18 131/20 132/12 133/4 133/18 133/19 134/25 135/17 137/11 137/11 137/12 139/11 139/12 139/18 141/13 142/8 142/9 146/17 149/25 <b>grouping [3]</b> 9/2 9/8 45/14 <b>groups [29]</b> 36/24 37/24 43/11 45/25 46/2 46/19 46/19 97/23 98/3 98/22 100/24 105/22 107/12 114/2 116/14 118/10 129/11 129/15 130/4 130/6 130/14 130/18 137/18 137/18 143/21 143/22 146/25 151/14 152/18 <b>grown [1]</b> 18/12	<b>habitually [1]</b> 19/11 <b>had [81]</b> 9/6 14/15 24/13 28/22 32/16 36/18 36/21 41/15 43/10 43/12 46/2 46/12 46/19 56/20 57/19 70/7 70/25 74/14 74/17 75/4 75/5 77/25 81/13 90/22 91/3 91/8 91/19 93/2 93/9 93/24 94/16 94/18 96/12 97/3 97/5 99/3 101/20 101/24 102/9 103/4 104/12 104/16 105/12 105/16 105/17 107/12 108/9 108/10 109/3 109/11 110/4 110/5 122/2 122/5 126/16 126/19 127/9 128/18 128/25 129/3 131/14 131/17 132/12 132/25 133/6 134/3 136/6 139/17 139/25 140/1 140/2 141/1 141/25 143/8 143/9 143/10 143/12 143/13 146/16 146/23 147/4 <b>hadn't [1]</b> 131/14 <b>half [1]</b> 143/18 <b>halfway [1]</b> 139/24 <b>Hancock [6]</b> 29/8 30/22 55/7 56/17 143/6 145/19 <b>hand [5]</b> 56/1 65/5 111/4 140/4 140/6 <b>handful [3]</b> 18/15 65/25 116/19 <b>Hang [1]</b> 53/14 <b>happen [5]</b> 9/15 32/1 90/2 133/13 146/2 <b>happened [8]</b> 31/25 91/8 109/19 121/13 127/5 143/17 145/5 148/4 <b>happening [10]</b> 35/8 36/17 58/7 98/13 103/3 144/9 144/9 144/13 148/23 150/19 <b>happens [2]</b> 1/25 28/10 <b>happy [1]</b> 27/7	

<b>H</b>	15/8 32/12 35/19 49/23	<b>hospitalisation [2]</b> 95/2 120/24	<b>I can't [2]</b> 14/21 78/12	<b>I mean [11]</b> 13/20 14/16 19/19 22/16 33/6 51/8 104/7 104/8 126/20 127/4 151/6
<b>health... [31]</b> 48/1 57/9 61/6 61/20 62/16 65/2 70/12 76/13 79/20 90/20 94/7 98/6 98/23 98/24 106/22 106/23 116/4 124/10 137/4 137/6 137/8 137/23 140/4 142/7 142/19 143/8 143/10 143/11 143/20 149/6 150/10	<b>herd [1]</b> 75/25 <b>here [8]</b> 57/5 57/24 82/25 109/25 127/16 129/10 130/2 153/2	<b>hospitalisations [1]</b> 134/7	<b>I caught [1]</b> 42/19 <b>I completely [1]</b> 60/22	<b>I mentioned [2]</b> 97/8 118/9
<b>Health Secretary [2]</b> 30/24 137/4	<b>hibernating [10]</b> 109/7 109/11 109/21 110/2 110/5 110/10 122/1 122/16 122/20 122/20	<b>hospitalised [8]</b> 92/11 93/16 93/20 95/7 101/25 104/10 105/3 107/25	<b>I copied [1]</b> 143/12 <b>I could [1]</b> 65/15 <b>I deliberately [1]</b> 9/23 <b>I describe [1]</b> 7/5 <b>I developed [1]</b> 131/10	<b>I might [1]</b> 119/16 <b>I must [1]</b> 58/18 <b>I myself [1]</b> 60/8 <b>I needn't [1]</b> 6/10 <b>I not [1]</b> 131/13 <b>I occasionally [1]</b> 47/9
<b>health-related [1]</b> 106/23	<b>high [6]</b> 12/1 21/12 21/12 21/13 23/20 60/16	<b>hours [2]</b> 16/7 78/20	<b>I did [1]</b> 1/24 <b>I do [4]</b> 2/14 41/21 46/25 84/3	<b>I overdo [1]</b> 133/11 <b>I perhaps [1]</b> 30/1 <b>I personally [1]</b> 68/10 <b>I please [2]</b> 1/6 2/15 <b>I put [2]</b> 6/23 60/11 <b>I read [1]</b> 78/10 <b>I realised [1]</b> 131/23 <b>I really [1]</b> 131/10 <b>I remember [1]</b> 143/14
<b>healthcare [6]</b> 98/13 99/6 101/10 107/7 114/4 134/5	<b>highlighted [1]</b> 120/23	<b>House [1]</b> 82/4	<b>I don't [18]</b> 13/16 31/19 32/6 34/6 40/20 50/18 50/21 50/22 50/22 51/18 53/15 82/11 84/6 111/1 127/6 129/19 138/3 141/25	<b>I said [5]</b> 15/11 18/2 55/14 55/16 118/18 <b>I saw [1]</b> 75/12 <b>I say [7]</b> 13/15 31/16 50/19 51/25 55/22 103/25 123/15 <b>I see [2]</b> 124/13 129/18
<b>healthy [4]</b> 58/14 81/19 81/20 81/24	<b>him [5]</b> 19/21 24/10 78/19 108/12 128/22	<b>how [54]</b> 4/18 4/19 4/19 4/23 5/1 5/8 5/17 5/23 10/1 12/7 16/1 29/19 34/5 38/20 39/18 41/21 45/9 54/1 67/24 74/23 74/23 75/10 76/21 76/24 79/2 80/21 92/21 92/25 93/1 93/3 93/17 94/25 100/10 105/16 107/3 113/5 113/24 119/24 122/7 122/20 123/23 127/6 127/22 131/8 131/20 134/2 138/12 139/1 139/9 139/16 139/22 142/14 149/22 150/24	<b>I entirely [1]</b> 76/13 <b>I feel [2]</b> 39/17 126/12 <b>I felt [1]</b> 132/25 <b>I find [1]</b> 24/15 <b>I first [1]</b> 128/17 <b>I found [1]</b> 7/21 <b>I go [1]</b> 117/3 <b>I guess [1]</b> 57/20 <b>I had [2]</b> 97/3 141/25 <b>I hadn't [1]</b> 131/14 <b>I have [16]</b> 30/5 40/2 49/2 49/7 50/16 52/11 55/15 72/16 72/21 85/11 128/24 129/17 133/10 133/17 135/18 151/24	<b>I see [2]</b> 124/13 129/18 <b>I sent [1]</b> 23/13 <b>I shall [1]</b> 96/19 <b>I should [4]</b> 11/13 41/19 55/13 138/17 <b>I simply [1]</b> 123/16 <b>I spoke [1]</b> 99/24 <b>I still [1]</b> 127/15 <b>I suppose [6]</b> 7/1 7/5 30/5 33/6 50/21 140/16
<b>hear [7]</b> 27/8 51/11 85/2 92/9 98/21 128/19 152/2	<b>himself [2]</b> 13/20 24/23	<b>however [3]</b> 10/19 121/9 145/24	<b>I haven't [4]</b> 39/16 49/1 51/18 51/25 <b>I heard [1]</b> 78/13 <b>I hope [4]</b> 32/2 35/25 96/20 152/6	<b>I take [1]</b> 131/3 <b>I thank [1]</b> 30/20 <b>I think [106]</b> 4/13 5/12 7/5 8/4 10/18 13/17 20/16 20/17 20/23 25/20 27/20 30/14 33/9 34/4 36/22 38/21 39/23 41/23 42/9 42/24 44/23 46/1 46/7 46/25 47/13 48/6 48/7 48/8 50/25 51/20 53/1 54/9 55/24 55/25 56/18 56/22 57/1 57/4 58/13 58/15 59/5 59/14 62/15 62/23 63/13 64/11 64/13 64/18 65/6 66/10 66/10 66/14 66/25 67/3 67/15 67/17 68/11 68/19 68/23 68/24 70/20 71/17 71/19 74/3 74/3 74/4 74/23 75/12 76/13
<b>heard [15]</b> 43/25 61/8 78/13 90/8 91/13 113/20 114/19 118/1 119/10 120/6 127/19 143/16 147/5 150/18 152/13	<b>hinders [1]</b> 12/17 <b>hindsight [1]</b> 98/10 <b>his [32]</b> 12/13 12/15 12/15 13/11 14/21 15/1 15/8 16/25 19/12 20/4 23/12 24/6 25/4 26/20 29/17 32/17 32/18 32/18 32/20 33/7 33/7 34/24 49/5 49/23 52/24 56/9 56/21 56/24 57/18 75/14 123/13 124/4	<b>huge [5]</b> 51/21 75/9 90/10 93/1 135/15	<b>I identified [1]</b> 44/24 <b>I imagine [2]</b> 46/11 130/9 <b>I initially [1]</b> 131/12 <b>I invite [1]</b> 152/14 <b>I joined [1]</b> 131/18 <b>I just [8]</b> 101/23 123/1 127/21 134/22 137/9 138/4 149/10 150/3 <b>I know [9]</b> 40/21 65/1 68/12 68/21 85/11 109/6 111/1 123/16 127/11 <b>I lead [1]</b> 2/11 <b>I make [1]</b> 73/24 <b>I may [12]</b> 6/3 58/18 89/10 93/12 109/24 114/17 115/21 119/15 133/16 136/20 137/15 139/18	
<b>hearing [4]</b> 32/3 91/5 97/25 153/7	<b>historical [1]</b> 23/11 <b>historical [1]</b> 23/11 <b>history [2]</b> 58/19 87/11	<b>hugely [1]</b> 70/5	<b>I</b>	
<b>hearings [1]</b> 119/11	<b>hit [1]</b> 109/14	<b>human [1]</b> 8/25	<b>I agree [6]</b> 14/16 23/8 36/9 36/15 62/3 67/23	
<b>heart [8]</b> 6/14 20/14 25/16 39/2 63/4 73/23 76/9 110/25	<b>hm [2]</b> 133/22 135/25	<b>humanly [1]</b> 2/16	<b>I also [3]</b> 65/19 68/18 80/23	
<b>heavy [2]</b> 2/9 2/13	<b>hoarders [1]</b> 71/18	<b>Humphrey [1]</b> 59/16	<b>I am [5]</b> 2/3 80/21 83/6 130/11 152/4	
<b>hedge [1]</b> 125/20	<b>hoards [1]</b> 64/16	<b>hundreds [1]</b> 142/7	<b>I and [1]</b> 24/13	
<b>held [7]</b> 10/19 24/10 24/10 29/6 37/7 40/4 55/20	<b>hoc [3]</b> 34/3 40/15 58/17	<b>hydra [1]</b> 6/17	<b>I apologise [1]</b> 35/24 <b>I ask [1]</b> 125/3	
<b>Helen [10]</b> 32/10 35/5 42/23 43/5 48/23 49/2 74/5 76/23 77/5 78/8	<b>hold [2]</b> 38/2 39/25	<b>hyperinflammatory [1]</b> 117/9	<b>I assume [4]</b> 22/18 22/20 24/4 56/15	
<b>Helen MacNamara [8]</b> 32/10 35/5 42/23 43/5 48/23 76/23 77/5 78/8	<b>holding [3]</b> 40/7 62/17 82/3		<b>I believe [3]</b> 39/8 40/8 82/25	
<b>Helen MacNamara's [1]</b> 49/2	<b>home [4]</b> 134/10 134/20 135/11 140/2		<b>I bet [1]</b> 125/20	
<b>help [12]</b> 82/16 94/2 100/21 101/14 128/11 132/21 132/22 138/10 138/15 144/10 150/24 152/8	<b>homework [1]</b> 40/12		<b>I blame [1]</b> 55/6	
<b>helped [2]</b> 130/3 131/3	<b>Hong [1]</b> 89/15		<b>I break [1]</b> 82/22	
<b>helpful [1]</b> 88/9	<b>Hong Kong [1]</b> 89/15		<b>I came [1]</b> 131/15	
<b>helpfully [2]</b> 100/9 129/18	<b>honorary [1]</b> 84/21		<b>I can [7]</b> 59/19 68/3 79/25 85/16 90/6 115/24 133/12	
<b>helps [1]</b> 113/7	<b>hope [5]</b> 32/2 35/25 96/20 141/23 152/6			
<b>hence [1]</b> 27/16	<b>hopefully [1]</b> 67/22			
<b>her [6]</b> 12/14 13/11	<b>hopes [1]</b> 81/11			
	<b>hospital [23]</b> 84/22 90/19 94/1 94/13 94/16 95/13 95/17 96/1 96/5 96/6 97/5 99/1 100/23 108/6 110/2 118/25 132/7 140/9 140/10 140/12 140/22 147/11 150/17			

<b>I</b>	<b>I've [22]</b> 3/18 5/2 14/16 14/19 16/5 17/15 23/23 24/19 33/7 34/1 34/23 39/9 58/6 64/18 68/18 93/15 102/16 126/11 128/22 133/14 151/19 152/11 <b>I've said [1]</b> 151/19 <b>ICU [2]</b> 95/11 95/23 <b>idea [2]</b> 122/1 128/24 <b>identification [2]</b> 75/10 75/22 <b>identified [4]</b> 44/24 63/23 77/9 78/19 <b>identify [1]</b> 107/15 <b>if [102]</b> 6/3 8/9 9/15 10/6 14/23 14/23 15/17 22/23 23/17 24/6 24/6 24/7 25/13 26/24 27/9 29/2 34/9 34/11 34/22 35/20 36/1 36/3 36/11 37/23 39/24 42/23 42/24 43/13 43/16 44/1 48/13 51/8 51/25 52/18 55/14 58/18 59/7 59/14 59/19 60/6 62/21 63/6 65/22 73/4 73/16 74/17 77/3 80/3 85/19 85/23 88/22 89/10 90/6 93/12 94/16 95/10 100/11 104/19 109/18 109/24 110/4 110/20 112/20 113/5 114/17 114/19 115/21 115/24 115/25 117/3 119/15 122/2 123/6 123/10 124/18 125/5 125/6 125/14 125/17 126/17 127/8 127/25 128/23 130/6 130/23 133/11 133/13 133/14 134/11 134/16 136/20 136/22 139/23 140/11 140/19 141/2 142/3 142/21 142/25 146/18 150/16 152/25 <b>IFG [5]</b> 2/22 2/24 3/17 68/10 71/3 <b>ignored [2]</b> 77/19 127/3 <b>ill [3]</b> 95/6 96/6 140/13 <b>illegitimate [1]</b> 35/22 <b>illness [9]</b> 86/7 94/10 95/22 113/13 113/14 116/9 127/18 127/25 132/7 <b>illustrate [1]</b> 134/2 <b>imagine [4]</b> 46/11 59/19 78/7 130/9 <b>immediate [4]</b> 32/21 34/8 61/20 79/17	<b>immune [2]</b> 117/7 117/19 <b>immunity [1]</b> 75/25 <b>impact [9]</b> 14/12 74/18 74/20 105/11 106/22 106/23 119/10 136/9 152/13 <b>impacts [1]</b> 59/12 <b>impaired [1]</b> 89/22 <b>impairment [1]</b> 106/20 <b>imperative [1]</b> 142/8 <b>implementation [4]</b> 36/24 37/24 39/6 43/11 <b>implicit [2]</b> 19/16 79/5 <b>imply [1]</b> 17/8 <b>import [1]</b> 51/6 <b>importance [2]</b> 51/21 72/12 <b>important [33]</b> 10/1 10/5 10/22 11/17 12/7 12/9 14/20 20/3 21/17 40/10 44/9 46/8 51/15 61/21 63/3 70/5 70/21 73/1 75/10 75/12 76/18 79/17 82/18 84/16 85/10 92/24 99/15 99/18 101/25 116/4 117/10 119/9 136/7 <b>importantly [2]</b> 111/17 118/16 <b>impose [2]</b> 33/21 53/20 <b>imposed [1]</b> 71/13 <b>imposition [3]</b> 3/14 21/19 33/22 <b>impossible [3]</b> 6/21 109/20 142/14 <b>impression [2]</b> 40/20 144/18 <b>imprimatur [1]</b> 50/15 <b>improve [5]</b> 5/8 5/10 67/23 90/18 105/5 <b>improved [3]</b> 26/6 34/10 136/19 <b>improving [1]</b> 82/6 <b>inactive [1]</b> 96/1 <b>incentive [2]</b> 21/1 21/2 <b>inchoate [1]</b> 64/25 <b>incidence [3]</b> 92/22 115/22 147/13 <b>incident [2]</b> 34/11 34/12 <b>include [3]</b> 25/2 88/16 108/5 <b>included [6]</b> 21/21 45/20 99/22 103/12 121/7 145/19 <b>including [7]</b> 4/9 23/25 48/21 72/11	126/7 135/11 150/6 <b>incorporation [1]</b> 136/17 <b>increased [1]</b> 117/7 <b>increases [1]</b> 8/13 <b>incredible [2]</b> 25/15 25/20 <b>incredibly [1]</b> 99/7 <b>incumbent [1]</b> 14/2 <b>indeed [14]</b> 6/17 11/16 15/7 25/12 27/3 48/19 49/25 82/13 82/16 97/20 113/5 128/7 152/7 152/8 <b>independent [1]</b> 1/23 <b>INDEX [1]</b> 153/9 <b>indicated [1]</b> 130/1 <b>indictment [1]</b> 78/5 <b>individual [1]</b> 74/21 <b>individuals [7]</b> 7/19 14/18 14/20 16/6 17/23 74/25 89/17 <b>inevitably [1]</b> 5/12 <b>inexperienced [1]</b> 74/13 <b>inextricably [1]</b> 46/16 <b>infected [2]</b> 141/7 148/7 <b>infecting [2]</b> 148/2 148/4 <b>infection [7]</b> 91/7 93/5 95/15 109/19 112/2 116/7 131/14 <b>infer [1]</b> 88/3 <b>infighting [2]</b> 24/22 25/14 <b>inflammation [2]</b> 107/15 118/11 <b>inflammatory [2]</b> 117/8 117/19 <b>influence [4]</b> 36/14 57/20 127/10 150/11 <b>influenced [2]</b> 127/7 135/13 <b>inform [5]</b> 35/10 122/21 122/22 150/23 150/24 <b>informal [4]</b> 40/15 71/23 72/14 72/19 <b>informality [1]</b> 74/2 <b>information [12]</b> 11/11 18/18 33/10 35/8 47/25 63/6 64/16 65/23 71/19 90/9 93/24 149/21 <b>informed [3]</b> 35/1 52/14 70/20 <b>informs [1]</b> 51/23 <b>infrastructure [1]</b> 11/8 <b>inherently [2]</b> 34/6 35/22 <b>initial [4]</b> 3/11 89/18 95/15 104/15	<b>initially [3]</b> 104/8 131/12 136/4 <b>initiative [1]</b> 145/7 <b>initiatives [3]</b> 104/1 143/23 144/19 <b>injury [6]</b> 88/24 94/1 94/3 94/11 95/7 117/10 <b>innovations [1]</b> 124/11 <b>input [5]</b> 35/21 36/14 66/8 66/20 68/13 <b>INQ000048313 [2]</b> 18/24 54/5 <b>INQ000136755 [1]</b> 76/22 <b>INQ000137215 [1]</b> 42/21 <b>INQ000182338 [1]</b> 37/9 <b>INQ000204014 [1]</b> 6/6 <b>INQ0002041014 [1]</b> 27/10 <b>INQ000214216 [1]</b> 125/5 <b>INQ000238582 [1]</b> 136/24 <b>INQ000251910 [1]</b> 124/15 <b>INQ000251916 [1]</b> 123/3 <b>INQ000273841 [1]</b> 32/5 <b>INQUIRY [42]</b> 1/9 1/10 1/14 17/18 19/3 23/10 23/14 24/13 30/20 31/4 39/9 39/17 41/24 47/9 48/25 52/11 59/23 61/8 61/12 68/13 69/6 72/18 74/22 75/20 76/6 76/18 81/4 83/10 97/24 119/21 123/4 123/16 128/16 129/16 130/5 130/15 137/10 151/14 152/19 154/5 154/12 154/16 <b>Inquiry's [1]</b> 69/9 <b>inside [5]</b> 30/2 40/1 48/8 48/9 68/16 <b>insists [1]</b> 82/23 <b>insofar [1]</b> 37/5 <b>instance [3]</b> 27/23 40/6 139/17 <b>institute [9]</b> 2/1 2/4 2/5 3/3 4/22 5/19 40/18 72/11 81/17 <b>instituted [1]</b> 45/8 <b>institution [1]</b> 49/14 <b>institutional [8]</b> 12/4 12/8 34/15 35/16 63/10 64/15 64/16 81/19
----------	---	--	---	--

<b>I</b>	131/4 134/25 139/9 139/21 143/22 143/25	146/9 148/22 148/23 149/17 151/8 151/17	22/7 24/9 42/23 45/8 49/9 50/24 55/13 55/15 55/25 65/25 70/11 77/2 82/24 85/24 86/2 87/16 89/7 90/11 91/11 92/17 93/1 93/13 95/12 97/8 98/19 100/4 100/11 100/14 101/23 101/23 103/19 107/23 108/19 110/17 111/25 115/21 122/25 123/1 123/7 124/7 124/24 125/6 125/6 125/9 127/4 127/14 127/21 130/7 131/1 131/25 132/2 134/11 134/22 137/9 138/4 139/23 141/9 141/13 142/3 142/19 142/21 142/24 146/5 148/5 148/10 149/10 149/15 149/16 150/3 150/3 151/5	41/19 41/20 45/18 46/9 46/12 47/4 47/8 47/11 50/17 50/18 50/21 50/22 50/22 51/18 52/18 53/3 53/10 55/22 57/2 57/5 57/14 57/20 58/6 58/9 60/20 64/19 65/1 65/6 67/20 68/12 68/15 68/21 73/7 73/9 73/13 76/7 78/10 85/11 89/23 93/1 93/5 93/8 94/5 96/11 97/17 97/19 98/12 98/18 99/17 107/3 107/20 108/21 109/6 110/25 111/1 116/19 116/21 121/18 123/16 126/18 127/6 127/6 127/11 127/25 128/25 133/13 134/10 139/16 140/8 141/19 141/21 145/10 149/14 149/18 151/7
<b>institutionally [2]</b> 7/21 63/8	<b>involvement [4]</b> 35/12 102/9 151/13 151/14	<b>Italy [1]</b> 91/5	<b>knowing [1]</b> 113/24	
<b>instructions [1]</b> 36/8	<b>involves [2]</b> 2/12 49/22	<b>its [30]</b> 4/20 4/20 6/22 16/3 27/12 27/13 35/17 36/8 36/18 39/7 44/22 46/9 46/19 48/4 49/22 50/13 60/17 61/17 62/18 64/5 64/24 68/11 69/6 69/21 71/16 71/16 77/23 88/14 105/8 148/6	<b>knowledge [3]</b> 1/22 110/9 123/18	
<b>insult [1]</b> 86/5	<b>involving [3]</b> 15/18 61/23 87/13	<b>itself [13]</b> 9/3 20/12 23/7 24/25 35/20 41/20 51/4 55/11 102/22 110/18 114/2 116/21 136/23	<b>known [8]</b> 36/23 90/8 90/11 93/6 94/4 96/13 97/12 135/7	
<b>integrity [1]</b> 73/16	<b>Iraq [1]</b> 74/1	<b>J</b>	<b>knows [2]</b> 78/3 78/12	
<b>intemperate [5]</b> 19/10 23/6 24/16 25/10 60/14	<b>Ireland [4]</b> 31/2 31/10 66/14 137/21	<b>January [8]</b> 29/6 29/11 29/11 31/12 90/12 146/10 148/16 148/21	<b>Kong [1]</b> 89/15	
<b>intensity [1]</b> 95/12	<b>is [406]</b>	<b>January 2020 [1]</b> 90/12	<b>K</b>	
<b>intensive [2]</b> 95/19 95/23	<b>ISARIC [4]</b> 109/24 110/6 121/2 121/3	<b>January 2021 [2]</b> 146/10 148/16	<b>keep [6]</b> 2/16 134/12 134/16 134/18 140/24 146/19	
<b>inter [1]</b> 12/13	<b>ish [1]</b> 38/10	<b>Janus [1]</b> 11/5	<b>keeping [1]</b> 73/2	
<b>interaction [1]</b> 119/18	<b>isn't [10]</b> 20/3 20/8 21/6 53/17 78/2 96/9 97/12 100/14 113/11 114/16	<b>Janus-faced [1]</b> 11/5	<b>Keith [3]</b> 1/5 22/7 59/5	
<b>interactions [1]</b> 103/4	<b>issue [16]</b> 28/20 29/15 38/25 56/9 57/6 57/7 57/25 63/24 69/11 70/2 72/4 73/20 73/22 85/23 86/1 92/19	<b>Javid [2]</b> 145/19 149/6	<b>kept [3]</b> 64/6 112/14 119/25	
<b>interest [1]</b> 137/10	<b>issued [1]</b> 99/14	<b>Jeane [1]</b> 31/10	<b>key [6]</b> 36/24 38/2 73/10 136/7 136/12 136/13	
<b>interested [4]</b> 105/15 105/16 145/21 150/25	<b>issues [9]</b> 3/11 21/17 74/20 76/5 79/20 85/18 89/2 119/18 136/7	<b>Jeane Freeman [1]</b> 31/10	<b>Khunti [1]</b> 120/7	
<b>interests [2]</b> 4/1 24/12	<b>it [422]</b>	<b>JMC [2]</b> 43/22 66/4	<b>kidneys [1]</b> 95/21	
<b>interlinkages [1]</b> 66/16	<b>it's [108]</b> 1/21 8/22 15/10 15/13 17/6 18/7 19/2 19/5 20/3 22/10 23/12 23/20 27/7 27/14 28/2 29/4 29/15 32/24 35/22 37/12 39/17 43/1 46/7 49/10 49/20 50/25 54/5 55/22 56/4 58/14 59/16 76/9 76/25 78/2 78/10 78/23 81/3 83/19 85/9 87/23 93/2 93/3 93/3 95/2 96/9 97/11 100/5 100/9 101/24 104/20 107/21 109/19 110/13 110/21 110/23 111/2 112/13 113/23 113/23 114/18 116/1 116/24 117/10 117/21 117/22 118/1 118/5 118/23 119/1 119/4 119/8 119/20 121/20 123/8 123/8 123/9 123/11 124/13 124/16 125/13 125/16 125/17 126/13 127/4 127/5 127/14 128/21 129/18 130/2 133/19 136/24 136/24 137/3 138/19 138/19 140/4 141/16 141/21 142/8 142/22 142/23 143/21	<b>job [7]</b> 4/7 12/2 13/19 13/21 15/3 18/1 68/12	<b>Kids [2]</b> 129/11 130/13	<b>labour [2]</b> 62/5 69/2
<b>interlocutor [1]</b> 56/3	<b>it's [108]</b> 1/21 8/22 15/10 15/13 17/6 18/7 19/2 19/5 20/3 22/10 23/12 23/20 27/7 27/14 28/2 29/4 29/15 32/24 35/22 37/12 39/17 43/1 46/7 49/10 49/20 50/25 54/5 55/22 56/4 58/14 59/16 76/9 76/25 78/2 78/10 78/23 81/3 83/19 85/9 87/23 93/2 93/3 93/3 95/2 96/9 97/11 100/5 100/9 101/24 104/20 107/21 109/19 110/13 110/21 110/23 111/2 112/13 113/23 113/23 114/18 116/1 116/24 117/10 117/21 117/22 118/1 118/5 118/23 119/1 119/4 119/8 119/20 121/20 123/8 123/8 123/9 123/11 124/13 124/16 125/13 125/16 125/17 126/13 127/4 127/5 127/14 128/21 129/18 130/2 133/19 136/24 136/24 137/3 138/19 138/19 140/4 141/16 141/21 142/8 142/22 142/23 143/21	<b>Johnson [10]</b> 19/2 22/19 22/20 23/4 29/17 32/16 74/12 124/3 125/14 147/5	<b>kind [6]</b> 15/17 24/15 38/14 62/19 62/21 141/15	<b>lack [13]</b> 12/19 13/8 13/9 13/15 24/18 25/10 59/1 61/1 65/22 69/12 72/2 75/14 94/21
<b>internal [2]</b> 7/6 26/16	<b>issued [1]</b> 99/14	<b>Johnson's [3]</b> 33/3 57/22 79/9	<b>lacking [1]</b> 16/14	
<b>international [1]</b> 37/1	<b>issues [9]</b> 3/11 21/17 74/20 76/5 79/20 85/18 89/2 119/18 136/7	<b>join [1]</b> 138/21	<b>lacks [1]</b> 63/10	
<b>interpreted [1]</b> 135/9	<b>it [422]</b>	<b>joined [1]</b> 131/18	<b>lacuna [1]</b> 35/11	
<b>interrogate [1]</b> 63/19	<b>it's [108]</b> 1/21 8/22 15/10 15/13 17/6 18/7 19/2 19/5 20/3 22/10 23/12 23/20 27/7 27/14 28/2 29/4 29/15 32/24 35/22 37/12 39/17 43/1 46/7 49/10 49/20 50/25 54/5 55/22 56/4 58/14 59/16 76/9 76/25 78/2 78/10 78/23 81/3 83/19 85/9 87/23 93/2 93/3 93/3 95/2 96/9 97/11 100/5 100/9 101/24 104/20 107/21 109/19 110/13 110/21 110/23 111/2 112/13 113/23 113/23 114/18 116/1 116/24 117/10 117/21 117/22 118/1 118/5 118/23 119/1 119/4 119/8 119/20 121/20 123/8 123/8 123/9 123/11 124/13 124/16 125/13 125/16 125/17 126/13 127/4 127/5 127/14 128/21 129/18 130/2 133/19 136/24 136/24 137/3 138/19 138/19 140/4 141/16 141/21 142/8 142/22 142/23 143/21	<b>joint [4]</b> 43/22 43/25 67/18 114/23	<b>Lady [18]</b> 1/6 21/16 26/24 32/2 43/25 46/1 59/14 60/6 82/11 82/17 82/25 83/6 83/12 96/17 97/2 128/13 152/10 152/22	
<b>interrupt [1]</b> 49/1	<b>it's [108]</b> 1/21 8/22 15/10 15/13 17/6 18/7 19/2 19/5 20/3 22/10 23/12 23/20 27/7 27/14 28/2 29/4 29/15 32/24 35/22 37/12 39/17 43/1 46/7 49/10 49/20 50/25 54/5 55/22 56/4 58/14 59/16 76/9 76/25 78/2 78/10 78/23 81/3 83/19 85/9 87/23 93/2 93/3 93/3 95/2 96/9 97/11 100/5 100/9 101/24 104/20 107/21 109/19 110/13 110/21 110/23 111/2 112/13 113/23 113/23 114/18 116/1 116/24 117/10 117/21 117/22 118/1 118/5 118/23 119/1 119/4 119/8 119/20 121/20 123/8 123/8 123/9 123/11 124/13 124/16 125/13 125/16 125/17 126/13 127/4 127/5 127/14 128/21 129/18 130/2 133/19 136/24 136/24 137/3 138/19 138/19 140/4 141/16 141/21 142/8 142/22 142/23 143/21	<b>Joker [1]</b> 55/7	<b>Lancaster [4]</b> 7/18 40/6 42/12 45/2	
<b>interrupting [1]</b> 85/21	<b>it's [108]</b> 1/21 8/22 15/10 15/13 17/6 18/7 19/2 19/5 20/3 22/10 23/12 23/20 27/7 27/14 28/2 29/4 29/15 32/24 35/22 37/12 39/17 43/1 46/7 49/10 49/20 50/25 54/5 55/22 56/4 58/14 59/16 76/9 76/25 78/2 78/10 78/23 81/3 83/19 85/9 87/23 93/2 93/3 93/3 95/2 96/9 97/11 100/5 100/9 101/24 104/20 107/21 109/19 110/13 110/21 110/23 111/2 112/13 113/23 113/23 114/18 116/1 116/24 117/10 117/21 117/22 118/1 118/5 118/23 119/1 119/4 119/8 119/20 121/20 123/8 123/8 123/9 123/11 124/13 124/16 125/13 125/16 125/17 126/13 127/4 127/5 127/14 128/21 129/18 130/2 133/19 136/24 136/24 137/3 138/19 138/19 140/4 141/16 141/21 142/8 142/22 142/23 143/21	<b>journey [1]</b> 153/1	<b>lands [1]</b> 15/21	
<b>intervention [2]</b> 107/17 107/18	<b>it's [108]</b> 1/21 8/22 15/10 15/13 17/6 18/7 19/2 19/5 20/3 22/10 23/12 23/20 27/7 27/14 28/2 29/4 29/15 32/24 35/22 37/12 39/17 43/1 46/7 49/10 49/20 50/25 54/5 55/22 56/4 58/14 59/16 76/9 76/25 78/2 78/10 78/23 81/3 83/19 85/9 87/23 93/2 93/3 93/3 95/2 96/9 97/11 100/5 100/9 101/24 104/20 107/21 109/19 110/13 110/21 110/23 111/2 112/13 113/23 113/23 114/18 116/1 116/24 117/10 117/21 117/22 118/1 118/5 118/23 119/1 119/4 119/8 119/20 121/20 123/8 123/8 123/9 123/11 124/13 124/16 125/13 125/16 125/17 126/13 127/4 127/5 127/14 128/21 129/18 130/2 133/19 136/24 136/24 137/3 138/19 138/19 140/4 141/16 141/21 142/8 142/22 142/23 143/21	<b>judged [1]</b> 33/7	<b>language [8]</b> 19/10 19/12 23/6 55/23 57/4 59/15 111/25 112/12	
<b>interviews [2]</b> 113/22 113/25	<b>it's [108]</b> 1/21 8/22 15/10 15/13 17/6 18/7 19/2 19/5 20/3 22/10 23/12 23/20 27/7 27/14 28/2 29/4 29/15 32/24 35/22 37/12 39/17 43/1 46/7 49/10 49/20 50/25 54/5 55/22 56/4 58/14 59/16 76/9 76/25 78/2 78/10 78/23 81/3 83/19 85/9 87/23 93/2 93/3 93/3 95/2 96/9 97/11 100/5 100/9 101/24 104/20 107/21 109/19 110/13 110/21 110/23 111/2 112/13 113/23 113/23 114/18 116/1 116/24 117/10 117/21 117/22 118/1 118/5 118/23 119/1 119/4 119/8 119/20 121/20 123/8 123/8 123/9 123/11 124/13 124/16 125/13 125/16 125/17 126/13 127/4 127/5 127/14 128/21 129/18 130/2 133/19 136/24 136/24 137/3 138/19 138/19 140/4 141/16 141/21 142/8 142/22 142/23 143/21	<b>judgement [1]</b> 3/2	<b>last [18]</b> 15/12 38/20 42/24 43/2 43/2 75/5 86/16 93/23 95/24	
<b>into [29]</b> 8/15 11/23 21/4 23/12 45/4 60/13 66/8 67/5 69/4 71/14 73/25 75/15 78/19 93/14 99/9 103/23 110/2 110/3 117/5 118/25 121/10 121/25 122/5 131/22 146/11 147/3 150/16 150/21 152/20	<b>it's [108]</b> 1/21 8/22 15/10 15/13 17/6 18/7 19/2 19/5 20/3 22/10 23/12 23/20 27/7 27/14 28/2 29/4 29/15 32/24 35/22 37/12 39/17 43/1 46/7 49/10 49/20 50/25 54/5 55/22 56/4 58/14 59/16 76/9 76/25 78/2 78/10 78/23 81/3 83/19 85/9 87/23 93/2 93/3 93/3 95/2 96/9 97/11 100/5 100/9 101/24 104/20 107/21 109/19 110/13 110/21 110/23 111/2 112/13 113/23 113/23 114/18 116/1 116/24 117/10 117/21 117/22 118/1 118/5 118/23 119/1 119/4 119/8 119/20 121/20 123/8 123/8 123/9 123/11 124/13 124/16 125/13 125/16 125/17 126/13 127/4 127/5 127/14 128/21 129/18 130/2 133/19 136/24 136/24 137/3 138/19 138/19 140/4 141/16 141/21 142/8 142/22 142/23 143/21	<b>July [11]</b> 23/11 23/14 23/18 100/20 103/8 121/6 121/15 136/25 148/19 148/21 148/25	<b>largely [7]</b> 1/15 18/7 69/10 97/12 113/21 135/22 138/22	
<b>investigate [1]</b> 104/25	<b>it's [108]</b> 1/21 8/22 15/10 15/13 17/6 18/7 19/2 19/5 20/3 22/10 23/12 23/20 27/7 27/14 28/2 29/4 29/15 32/24 35/22 37/12 39/17 43/1 46/7 49/10 49/20 50/25 54/5 55/22 56/4 58/14 59/16 76/9 76/25 78/2 78/10 78/23 81/3 83/19 85/9 87/23 93/2 93/3 93/3 95/2 96/9 97/11 100/5 100/9 101/24 104/20 107/21 109/19 110/13 110/21 110/23 111/2 112/13 113/23 113/23 114/18 116/1 116/24 117/10 117/21 117/22 118/1 118/5 118/23 119/1 119/4 119/8 119/20 121/20 123/8 123/8 123/9 123/11 124/13 124/16 125/13 125/16 125/17 126/13 127/4 127/5 127/14 128/21 129/18 130/2 133/19 136/24 136/24 137/3 138/19 138/19 140/4 141/16 141/21 142/8 142/22 142/23 143/21	<b>June [5]</b> 42/2 45/5 97/22 98/19 130/25	<b>larger [1]</b> 97/10	
<b>investigations [1]</b> 113/10	<b>it's [108]</b> 1/21 8/22 15/10 15/13 17/6 18/7 19/2 19/5 20/3 22/10 23/12 23/20 27/7 27/14 28/2 29/4 29/15 32/24 35/22 37/12 39/17 43/1 46/7 49/10 49/20 50/25 54/5 55/22 56/4 58/14 59/16 76/9 76/25 78/2 78/10 78/23 81/3 83/19 85/9 87/23 93/2 93/3 93/3 95/2 96/9 97/11 100/5 100/9 101/24 104/20 107/21 109/19 110/13 110/21 110/23 111/2 112/13 113/23 113/23 114/18 116/1 116/24 117/10 117/21 117/22 118/1 118/5 118/23 119/1 119/4 119/8 119/20 121/20 123/8 123/8 123/9 123/11 124/13 124/16 125/13 125/16 125/17 126/13 127/4 127/5 127/14 128/21 129/18 130/2 133/19 136/24 136/24 137/3 138/19 138/19 140/4 141/16 141/21 142/8 142/22 142/23 143/21	<b>June 2020 [2]</b> 45/5 130/25	<b>last [18]</b> 15/12 38/20 42/24 43/2 43/2 75/5 86/16 93/23 95/24	
<b>investigators [1]</b> 121/2	<b>it's [108]</b> 1/21 8/22 15/10 15/13 17/6 18/7 19/2 19/5 20/3 22/10 23/12 23/20 27/7 27/14 28/2 29/4 29/15 32/24 35/22 37/12 39/17 43/1 46/7 49/10 49/20 50/25 54/5 55/22 56/4 58/14 59/16 76/9 76/25 78/2 78/10 78/23 81/3 83/19 85/9 87/23 93/2 93/3 93/3 95/2 96/9 97/11 100/5 100/9 101/24 104/20 107/21 109/19 110/13 110/21 110/23 111/2 112/13 113/23 113/23 114/18 116/1 116/24 117/10 117/21 117/22 118/1 118/5 118/23 119/1 119/4 119/8 119/20 121/20 123/8 123/8 123/9 123/11 124/13 124/16 125/13 125/16 125/17 126/13 127/4 127/5 127/14 128/21 129/18 130/2 133/19 136/24 136/24 137/3 138/19 138/19 140/4 141/16 141/21 142/8 142/22 142/23 143/21	<b></b>		

<b>L</b>	<b>legitimately [3]</b> 35/9 58/11 58/23	107/20 116/15 117/4 118/5	119/25 120/10 120/11 120/18 121/18 121/21 121/25 122/13 122/17 122/25 123/8 123/13 123/19 124/4 124/19 125/19 125/25 126/16 126/17 126/19 129/1 129/9 129/10 129/11 129/12 129/15 130/1 130/3 130/9 130/13 130/17 130/18 130/22 136/5 136/8 136/16 136/17 136/18 137/18 139/17 143/20 145/13 147/4 147/12 147/14 147/25 148/3 148/10 148/13 149/11 149/12 149/14 149/21 150/20 150/24 151/3 152/18 153/1	37/14 97/9 104/25 <b>longer-term [1]</b> 104/25 <b>look [25]</b> 15/22 22/17 32/5 65/1 68/6 70/23 86/16 99/1 100/11 111/3 111/7 111/25 114/13 115/16 120/24 121/2 123/5 123/7 123/15 124/13 125/3 128/23 130/23 141/2 142/3 <b>looked [7]</b> 61/6 61/12 65/1 68/11 89/16 99/3 127/25 <b>looking [11]</b> 3/10 59/17 72/19 74/22 94/12 98/5 122/14 134/9 142/5 142/24 148/15 <b>looks [1]</b> 86/25 <b>Lord [10]</b> 14/4 22/2 36/22 42/3 75/13 103/11 103/21 124/21 126/6 145/18 <b>Lord Bethell [5]</b> 103/11 103/21 124/21 126/6 145/18 <b>Lord O'Donnell [1]</b> 75/13 <b>Lord Sedwill [4]</b> 14/4 22/2 36/22 42/3 <b>loses [1]</b> 15/12 <b>losing [1]</b> 36/17 <b>loss [8]</b> 14/8 14/11 14/17 14/22 17/19 17/21 56/23 57/7 <b>lost [3]</b> 56/21 77/23 150/9 <b>lot [14]</b> 2/13 27/11 45/25 68/19 103/25 105/11 132/4 132/19 133/15 135/16 139/14 139/21 140/21 148/4 <b>lots [2]</b> 77/18 111/12 <b>loud [1]</b> 114/1 <b>loved [2]</b> 126/16 140/24 <b>low [5]</b> 23/21 23/22 28/22 51/4 55/20 <b>lower [3]</b> 23/23 116/12 136/22 <b>lunch [7]</b> 92/9 96/10 96/18 96/21 97/3 105/21 107/1 <b>lung [10]</b> 88/24 89/2 89/20 89/22 89/23 93/25 94/3 94/11 95/7 117/10
<b>last... [9]</b> 101/22 102/5 109/15 116/1 123/6 123/7 125/18 126/12 148/18 <b>lasted [1]</b> 38/22 <b>lasting [1]</b> 87/13 <b>lastly [2]</b> 70/14 122/24 <b>late [6]</b> 17/4 29/24 32/8 33/18 108/24 124/8 <b>later [12]</b> 25/7 25/8 25/19 97/25 101/19 103/10 124/5 137/16 143/17 146/6 146/7 146/11 <b>latter [3]</b> 9/5 28/2 67/15 <b>latter's [1]</b> 66/8 <b>latterly [1]</b> 27/1 <b>lay [1]</b> 27/2 <b>lead [25]</b> 1/9 2/11 29/9 61/5 61/7 61/9 61/16 61/25 62/4 62/13 62/23 62/25 62/25 63/7 63/19 63/19 63/24 64/5 65/7 71/21 87/18 117/10 118/12 118/16 154/5 <b>leader [1]</b> 61/3 <b>leaders [3]</b> 67/3 77/16 77/22 <b>leadership [5]</b> 46/9 64/25 77/12 79/5 79/9 <b>leading [3]</b> 2/12 26/13 145/11 <b>leads [2]</b> 107/19 117/4 <b>learning [2]</b> 3/5 90/25 <b>learnt [1]</b> 90/10 <b>least [12]</b> 22/21 25/18 36/3 55/23 56/21 90/7 101/14 113/17 115/6 119/10 126/18 130/21 <b>leave [2]</b> 63/12 92/17 <b>leaves [2]</b> 35/11 63/13 <b>led [9]</b> 17/21 69/22 89/11 101/3 103/7 103/10 108/10 117/17 121/13 <b>Lee [6]</b> 26/12 54/11 54/25 55/6 56/8 56/14 <b>Lee Cain [3]</b> 26/12 54/11 56/14 <b>left [2]</b> 56/1 98/11 <b>left-hand [1]</b> 56/1 <b>legal [1]</b> 33/23 <b>legislate [1]</b> 67/16 <b>legitimate [2]</b> 66/11 68/12	<b>Leicester [4]</b> 84/8 84/23 85/1 101/3 <b>length [1]</b> 141/17 <b>lengths [1]</b> 86/16 <b>lengthy [2]</b> 83/19 84/5 <b>less [13]</b> 8/5 15/16 21/16 24/15 57/3 64/24 66/23 69/22 85/8 89/12 89/12 113/13 118/23 <b>lesser [1]</b> 147/13 <b>lesson [1]</b> 109/5 <b>lessons [1]</b> 22/8 <b>Let [4]</b> 88/18 90/4 104/18 114/17 <b>let's [8]</b> 75/18 110/17 111/25 124/13 125/3 130/21 141/2 141/23 <b>letter [20]</b> 19/2 23/9 23/12 48/24 49/4 49/7 49/12 54/6 55/14 55/17 136/20 136/23 138/4 139/23 142/4 142/24 143/3 148/15 148/21 149/4 <b>Letwin [1]</b> 61/13 <b>level [12]</b> 12/1 28/16 28/18 28/18 29/4 51/4 53/8 53/9 60/13 64/1 75/20 76/3 <b>level 2 [1]</b> 29/4 <b>levelled [1]</b> 71/18 <b>levels [3]</b> 57/24 70/25 78/17 <b>levers [4]</b> 12/4 12/8 12/21 63/10 <b>liable [2]</b> 35/2 147/11 <b>liar [1]</b> 55/9 <b>lies [1]</b> 15/9 <b>life [3]</b> 106/23 109/13 133/17 <b>lifting [3]</b> 2/9 2/14 146/15 <b>light [1]</b> 23/25 <b>like [43]</b> 5/19 5/24 6/19 7/6 8/9 8/24 9/14 9/15 10/6 12/9 21/7 21/7 22/17 22/21 25/6 28/1 36/12 37/15 38/22 41/4 52/19 53/15 63/6 64/14 69/14 73/16 74/18 80/3 85/23 86/25 95/10 95/18 99/9 115/17 117/16 119/15 120/13 127/21 127/25 129/12 140/17 141/18 143/22 <b>likelihood [2]</b> 90/2 90/20 <b>likely [6]</b> 93/7 105/20	<b>limit [2]</b> 81/4 82/5 <b>limitations [1]</b> 61/18 <b>limited [1]</b> 76/16 <b>limiting [1]</b> 120/8 <b>limits [1]</b> 13/10 <b>line [6]</b> 5/12 9/14 93/23 138/4 138/4 143/1 <b>lines [3]</b> 79/11 111/3 116/2 <b>link [3]</b> 17/10 17/12 65/8 <b>linked [1]</b> 46/16 <b>list [5]</b> 41/3 124/19 124/23 124/23 136/12 <b>listed [1]</b> 125/16 <b>listen [2]</b> 22/6 145/21 <b>little [21]</b> 35/24 72/17 77/3 88/19 93/14 93/21 100/3 100/18 101/19 103/10 106/18 108/11 118/9 120/10 121/9 121/24 123/23 131/8 142/6 143/17 151/1 <b>live [1]</b> 137/14 <b>lived [6]</b> 99/5 99/19 102/12 103/13 111/13 126/6 <b>living [2]</b> 127/17 127/22 <b>lobby [1]</b> 135/23 <b>local [2]</b> 66/23 67/2 <b>located [1]</b> 9/15 <b>lockdown [4]</b> 33/23 53/19 53/21 53/23 <b>lockdowns [1]</b> 3/13 <b>lockstep [2]</b> 16/16 17/3 <b>logistical [1]</b> 94/14 <b>London [1]</b> 31/25 <b>long [122]</b> 6/20 15/13 16/7 38/20 73/22 79/25 80/6 83/17 84/18 85/3 85/24 87/4 88/14 88/20 89/15 90/6 90/14 90/21 91/15 92/2 92/18 92/20 93/5 93/13 93/18 96/12 97/7 97/17 97/19 97/20 98/2 98/8 98/24 99/17 100/7 101/8 102/6 102/11 104/24 106/24 107/3 110/18 112/13 112/18 112/20 113/19 114/18 114/22 115/13 115/23 116/3 116/7 116/15 117/2 117/14 117/23 118/2 118/7 118/15 118/20 119/1 119/13 119/13 119/19	119/25 120/10 120/11 120/18 121/18 121/21 121/25 122/13 122/17 122/25 123/8 123/13 123/19 124/4 124/19 125/19 125/25 126/16 126/17 126/19 129/1 129/9 129/10 129/11 129/12 129/15 130/1 130/3 130/9 130/13 130/17 130/18 130/22 136/5 136/8 136/16 136/17 136/18 137/18 139/17 143/20 145/13 147/4 147/12 147/14 147/25 148/3 148/10 148/13 149/11 149/12 149/14 149/21 150/20 150/24 151/3 152/18 153/1 <b>long covid [82]</b> 83/17 84/18 85/3 85/24 87/4 88/14 93/5 93/13 96/12 97/17 97/19 97/20 98/2 98/8 98/24 99/17 100/7 101/8 102/6 110/18 112/13 112/18 112/20 113/19 114/18 114/22 115/13 115/23 116/3 116/7 116/15 117/2 117/14 117/23 118/2 118/7 118/15 118/20 119/1 119/13 119/19 119/25 120/10 120/11 120/18 121/18 122/13 122/25 123/13 123/19 124/4 124/19 125/19 125/25 126/16 126/17 126/19 130/3 130/17 130/18 136/5 136/8 136/16 136/17 136/18 137/18 143/20 145/13 147/4 147/12 147/14 147/25 148/3 148/10 148/13 149/11 149/12 149/14 150/20 150/24 151/3 152/18 <b>Long Covid Kids [2]</b> 129/11 130/13 <b>Long Covid SOS [5]</b> 129/9 129/10 129/15 130/1 130/22 <b>Long Covid Support</b> <b>[3]</b> 129/12 130/9 139/17 <b>long-term [18]</b> 88/20 89/15 90/6 90/14 90/21 91/15 92/2 92/18 92/20 93/18 97/7 104/24 106/24 107/3 119/13 121/21 121/25 122/17 <b>longer [4]</b> 22/22	
			<b>M</b> <b>machine [3]</b> 18/22 23/3 77/24 <b>machinery [6]</b> 9/18	

<b>M</b>	<b>management [14]</b> 2/9 3/12 8/25 48/1 69/13 69/13 75/7 75/11 79/21 80/19 90/18 100/16 100/22 101/15	56/17 143/6 145/19	107/14	140/4 142/19 149/12 150/6
<b>machinery... [5]</b> 18/6 24/17 27/22 37/11 40/17	<b>managements [1]</b> 70/13	<b>Matt Hancock MP [2]</b> 29/8 30/22	<b>mechanism [4]</b> 43/12 76/10 107/20 118/6	<b>met [3]</b> 44/1 126/6 135/1
<b>machines [1]</b> 94/2	<b>mandates [1]</b> 150/14	<b>matter [8]</b> 19/12 19/13 19/16 19/18 53/24 55/19 75/22 152/11	<b>media [5]</b> 17/17 52/9 139/13 151/7 151/9	<b>methods [1]</b> 71/23
<b>MacNamara [11]</b> 32/10 35/5 35/18 42/23 43/5 48/23 51/12 74/5 76/23 77/5 78/8	<b>manifested [1]</b> 8/10	<b>matters [6]</b> 43/18 44/19 79/21 118/3 124/17 136/19	<b>mediated [1]</b> 117/19	<b>Metzer [2]</b> 128/19 152/25
<b>MacNamara's [2]</b> 49/2 49/12	<b>manifests [1]</b> 118/20	<b>maximum [1]</b> 30/13	<b>medical [7]</b> 52/14 68/20 103/5 113/18 121/4 123/9 138/10	<b>Michael [5]</b> 40/9 42/12 45/1 46/6 47/3
<b>made [27]</b> 10/3 17/16 51/2 51/3 51/3 52/2 52/17 53/4 53/17 60/3 60/5 63/15 65/9 67/22 72/22 73/6 73/22 76/12 110/9 110/10 134/1 138/5 144/7 145/3 146/25 147/3 151/3	<b>manner [4]</b> 19/6 19/12 74/7 145/2	<b>may [61]</b> 1/6 4/21 6/3 7/2 8/15 11/4 13/14 16/1 16/12 20/12 25/11 25/12 26/3 26/22 28/7 29/21 33/17 34/4 38/24 42/24 48/12 50/22 50/23 58/18 65/20 65/20 69/21 70/4 77/1 78/24 79/21 86/24 86/25 89/10 93/12 95/11 96/12 96/13 97/22 98/19 109/24 109/24 114/17 115/21 117/18 118/2 119/15 123/10 123/10 123/14 127/9 128/25 133/16 136/20 137/15 139/18 142/17 147/10 148/24 152/4 152/14	<b>Medley [1]</b> 120/8	<b>Michael Gove [4]</b> 40/9 45/1 46/6 47/3
<b>main [4]</b> 68/18 69/2 104/14 106/7	<b>mantra [1]</b> 70/16	<b>May 2020 [1]</b> 77/1	<b>meet [3]</b> 28/16 38/3 44/1	<b>Michael Gove MP [1]</b> 42/12
<b>mainly [3]</b> 88/23 113/9 137/13	<b>many [43]</b> 12/9 16/6 20/18 23/21 25/20 58/6 62/3 62/9 72/19 77/10 77/11 77/22 78/12 87/20 94/7 94/7 95/24 95/24 99/1 99/5 99/23 105/16 113/6 115/7 130/17 131/20 132/10 132/11 133/17 134/2 135/10 135/18 139/1 139/9 139/16 139/22 140/8 140/8 140/25 141/18 142/14 144/8 151/2	<b>May 2021 [1]</b> 123/14	<b>meeting [36]</b> 28/5 28/7 28/25 29/4 29/5 31/6 31/20 35/6 36/17 37/6 37/25 38/1 38/4 38/5 38/10 38/13 40/14 40/14 40/15 40/18 40/23 40/25 41/1 41/10 41/10 41/13 41/14 43/17 46/4 46/5 49/23 53/10 53/11 54/16 102/24 103/8	<b>Michelle [1]</b> 31/14
<b>major [2]</b> 34/11 81/11	<b>many weeks [1]</b> 99/23	<b>maybe [4]</b> 22/21 43/3 142/17 151/8	<b>meetings [37]</b> 31/3 33/8 34/2 35/16 37/7 38/15 41/7 41/7 41/22 41/25 42/2 42/7 45/16 52/20 52/24 53/7 53/8 64/2 64/3 64/3 64/4 65/12 77/10 77/13 91/20 102/22 102/25 103/18 120/21 121/23 124/10 143/19 144/1 144/5 145/6 145/17 145/20	<b>Michelle O'Neill [1]</b> 31/14
<b>majority [1]</b> 82/4	<b>Marc [1]</b> 23/2	<b>McFarland [2]</b> 130/12 151/20	<b>meets [1]</b> 112/23	<b>middle [5]</b> 25/4 33/18 92/15 116/12 141/3
<b>make [34]</b> 5/1 5/22 12/4 13/5 13/16 14/15 15/2 16/15 20/16 24/4 41/15 49/13 51/10 51/13 58/7 59/10 59/12 65/14 69/9 71/6 73/24 74/6 74/9 79/14 79/22 80/12 81/5 95/8 96/8 100/25 111/18 112/22 113/1 113/12	<b>Marc Warner [1]</b> 23/2	<b>me [33]</b> 16/5 16/14 17/15 23/2 26/5 26/6 26/16 31/18 34/16 38/13 41/4 48/13 51/25 52/9 56/4 58/9 62/19 65/3 65/16 76/9 76/16 87/19 88/18 90/4 104/18 114/17 125/7 131/13 131/23 132/22 132/23 134/6 151/25	<b>member [1]</b> 129/10	<b>mildly [1]</b> 80/21
<b>make-up [1]</b> 69/9	<b>march [27]</b> 3/8 16/1 17/4 19/4 21/25 25/24 29/15 29/18 30/25 31/15 31/17 33/16 33/18 33/18 33/23 34/22 36/21 37/12 52/8 53/19 90/24 92/5 92/15 109/3 121/13 131/10 132/24	<b>mean [24]</b> 13/11 13/20 14/16 19/19 22/6 22/16 33/6 40/18 41/7 41/12 51/8 53/5 53/12 53/17 73/1 91/12 104/7 104/8 108/16 126/20 126/21 127/4 127/14 151/6	<b>members [7]</b> 2/21 44/12 61/2 119/8 129/8 137/14 149/25	<b>MIG [3]</b> 39/5 39/12 44/22
<b>makers [1]</b> 136/7	<b>March 2020 [2]</b> 3/8 17/4	<b>meaning [1]</b> 86/13	<b>memberships [2]</b> 138/20 138/21	<b>might [28]</b> 5/22 13/18 13/19 21/4 34/5 48/2 53/1 53/16 53/17 54/2 57/2 65/12 86/15 87/9 90/2 90/14 92/2 95/18 98/17 103/6 107/16 107/16 116/5 117/9 118/15 119/16 120/17 148/2
<b>makes [5]</b> 35/5 51/1 60/6 125/16 125/18	<b>Mark [6]</b> 14/4 20/5 20/5 31/5 36/20 36/22	<b>means [6]</b> 18/21 19/23 73/2 83/1 111/12 126/21	<b>men [4]</b> 116/24 117/4 117/8 117/13	<b>MIGs [7]</b> 39/15 40/3 41/8 41/10 41/12 42/1 43/13
<b>making [51]</b> 1/16 2/7 2/11 5/8 8/3 13/22 15/23 16/7 27/24 32/15 34/5 34/15 34/17 35/22 36/2 37/4 37/20 39/2 39/14 41/5 43/10 49/16 49/17 49/18 50/12 51/1 51/14 52/7 52/23 58/10 58/22 65/15 66/9 67/5 69/4 69/18 71/7 71/21 72/7 72/25 73/18 74/2 75/19 76/9 77/24 79/6 79/12 79/24 110/4 115/5 136/18	<b>Mark Drakeford [1]</b> 31/5	<b>meant [4]</b> 36/2 41/16 110/3 128/18	<b>mentioned [12]</b> 8/20 77/18 81/1 87/14 97/8 98/19 102/16 107/24 115/18 118/9 119/16 142/18	<b>mind [8]</b> 31/1 41/21 46/3 58/13 58/15 76/4 105/7 140/16
<b>malaise [1]</b> 88/2	<b>Mark Sedwill [3]</b> 14/4 20/5 36/20	<b>measure [1]</b> 90/20	<b>merged [1]</b> 11/3	<b>minds [1]</b> 73/10
<b>manage [1]</b> 43/23	<b>marked [1]</b> 40/12	<b>measurements [1]</b>	<b>MERS [2]</b> 89/1 89/8	<b>minister [92]</b> 6/8 7/3 7/8 7/17 9/3 9/5 9/10 10/6 10/8 10/24 11/6 11/12 13/25 14/20 14/24 15/10 15/12 15/13 16/22 16/25 17/10 18/17 18/19 19/14 19/24 21/5 23/15 26/12 26/20 28/8 28/9 28/11 28/11 29/2 29/16 29/16 29/20 29/23 29/25 30/3 30/8 30/11 30/16 30/25 31/5 31/17 34/24 35/1 35/3 37/2 37/6 37/18 38/13 39/25 42/10 42/22 43/21 46/5 47/1 47/14 49/22 51/17 52/24 53/9 53/13 53/22 56/13 57/20 58/13 60/21 61/4 67/13 74/3 74/18 76/25 78/17
<b>manageable [1]</b> 62/10	<b>marker [1]</b> 109/19		<b>message [10]</b> 19/1 19/19 21/5 22/10 56/17 70/16 116/5 125/13 134/1 149/16	
<b>managed [2]</b> 37/19 133/17	<b>masks [1]</b> 150/18		<b>messages [12]</b> 11/25 14/7 22/8 24/18 59/17 60/4 60/5 60/14 60/18 71/25 72/19 131/19	

<b>M</b>	71/1	<b>moronic [1]</b> 54/14	59/5	46/1 46/3 52/16 59/14
<b>minister... [16]</b> 79/1	<b>models [1]</b> 22/6	<b>most [20]</b> 2/23 14/21	<b>Mr Metzger [2]</b> 128/19	59/15 59/15 59/22
79/23 80/9 81/3 81/6	<b>moderate [1]</b> 30/6	15/1 18/14 34/1 35/11	152/25	60/6 71/2 72/16 72/22
81/10 81/23 123/12	<b>modern [1]</b> 77/19	54/16 56/20 56/22	<b>Mr O'Connor [5]</b> 83/2	73/24 82/11 82/17
124/3 124/16 124/25	<b>module [7]</b> 1/17 1/19	57/21 74/8 85/16	83/4 83/11 97/1 128/6	82/25 83/6 83/12
126/1 127/20 137/4	6/6 27/11 60/7 61/8	115/1 118/16 119/2	<b>Mr Thomas [19]</b> 1/13	85/15 86/1 90/4 96/17
143/6 145/17	61/14	132/20 138/14 140/14	2/15 6/7 11/4 15/25	97/2 128/13 129/7
<b>minister's [12]</b> 3/12	<b>Module 1 [4]</b> 6/6	150/17 152/21	19/1 21/11 22/13	132/24 133/17 135/1
12/12 15/21 18/20	27/11 61/8 61/14	<b>mostly [1]</b> 143/14	27/12 34/20 42/20	152/10 152/22
20/11 21/4 38/9 54/23	<b>Module 2 [1]</b> 1/19	<b>motivated [1]</b> 132/23	47/17 57/24 59/6 60/7	<b>my Lady [16]</b> 1/6
56/19 57/16 57/17	<b>moment [15]</b> 6/11	<b>mounted [1]</b> 98/21	69/5 77/3 81/4 82/13	21/16 26/24 32/2
127/9	9/10 11/22 50/25 53/2	<b>move [9]</b> 32/15 93/12	<b>Ms [16]</b> 35/18 49/12	43/25 46/1 59/14 60/6
<b>ministerial [20]</b>	108/18 115/24 125/7	101/8 108/18 110/17	51/12 128/15 128/17	82/11 82/17 82/25
27/23 35/10 35/21	129/15 130/21 134/11	119/15 121/19 146/5	129/8 130/21 131/25	83/12 96/17 97/2
36/23 37/24 38/15	145/16 146/11 150/8	146/11	136/24 146/12 150/3	128/13 152/22
39/6 40/23 42/6 43/11	150/13	<b>moved [2]</b> 35/19	151/12 151/20 152/1	<b>myself [4]</b> 2/14 60/8
43/22 43/25 44/6 44/9	<b>momentous [3]</b>	107/17	152/12 154/14	99/9 133/14
45/10 48/4 52/19 53/8	33/19 34/22 73/20	<b>moving [3]</b> 6/18	<b>Ms MacNamara [2]</b>	
67/19 102/22	<b>moments [2]</b> 10/3	92/12 115/21	35/18 51/12	<b>N</b>
<b>ministers [42]</b> 9/6	64/19	<b>MP [3]</b> 29/8 30/22	<b>Ms MacNamara's [1]</b>	<b>name [4]</b> 1/11 129/6
27/25 31/3 31/7 32/19	<b>Monday [4]</b> 29/18	42/12	49/12	129/7 143/21
36/14 38/2 38/16 42/5	53/19 153/3 153/8	<b>MPs [4]</b> 82/3 143/13	<b>Ms Rogers [1]</b>	<b>names [2]</b> 42/25
44/17 54/13 55/10	<b>monitoring [1]</b> 51/16	143/13 143/14	151/20	83/25
55/19 57/3 57/8 57/14	<b>month [1]</b> 136/25	<b>Mr [71]</b> 1/5 1/8 1/13	<b>Ms Sherwood [9]</b>	<b>nasty [1]</b> 151/6
57/16 57/18 58/3	<b>months [24]</b> 14/10	2/15 6/7 11/4 11/23	128/17 129/8 130/21	<b>Natalie [1]</b> 130/8
58/12 58/14 59/2	15/24 16/1 25/8 25/19	14/2 15/25 17/1 19/1	131/25 136/24 146/12	<b>Natalie Rogers [1]</b>
60/20 67/12 68/21	26/24 38/22 48/7 88/8	19/2 19/2 19/3 19/11	150/3 151/12 152/1	130/8
72/8 74/4 74/6 75/1	95/24 97/6 97/22 98/7	20/4 20/7 20/9 20/18	<b>Ms Sherwood's [1]</b>	<b>nation [1]</b> 43/13
75/16 80/4 80/5 80/16	99/6 103/21 105/14	20/25 21/11 22/1 22/7	152/12	<b>national [9]</b> 7/14 8/19
80/20 80/22 80/24	106/13 106/17 106/19	22/13 22/19 22/22	<b>much [45]</b> 6/6 9/17	10/13 10/15 11/7
81/15 81/15 82/1 82/6	118/3 123/21 124/5	22/23 22/24 22/25	22/22 24/15 32/9	33/23 53/20 67/4
145/18 146/2	140/17 146/7	23/4 23/10 24/6 25/2	47/10 51/15 61/25	98/23
<b>ministers' [1]</b> 57/25	<b>more [89]</b> 2/7 3/21	26/13 26/13 27/12	63/25 64/6 77/16	<b>nations [4]</b> 66/13
<b>minor [1]</b> 86/8	4/23 5/1 7/6 8/5 8/23	29/17 31/12 31/19	82/13 82/16 87/15	137/7 137/9 137/20
<b>minute [1]</b> 53/14	9/8 9/14 10/8 12/10	31/24 32/16 33/3	92/4 94/11 96/4 96/19	<b>natural [1]</b> 64/11
<b>minutes [6]</b> 45/18	15/16 15/22 21/15	34/20 42/20 47/17	97/10 102/20 104/10	<b>naturally [3]</b> 31/1
70/3 119/23 120/15	24/15 24/16 26/6 27/2	48/24 49/2 49/4 49/12	104/16 108/2 109/12	60/9 99/4
121/22 121/23	27/20 31/23 32/21	51/14 54/5 57/24 59/5	109/14 109/17 110/23	<b>nature [7]</b> 6/22 28/13
<b>mirror [1]</b> 85/8	33/9 40/18 40/22	59/6 60/7 65/9 65/13	122/12 127/7 128/3	50/24 60/14 75/20
<b>misleading [1]</b>	44/23 46/18 48/7	69/5 77/3 79/9 81/4	128/7 131/1 133/10	76/8 112/17
140/14	51/15 59/2 63/25	82/13 83/2 83/4 83/11	133/10 133/14 134/18	<b>necessarily [2]</b> 87/18
<b>misplaced [1]</b> 114/6	65/10 66/23 66/25	97/1 128/6 128/19	144/22 145/9 147/19	87/25
<b>missed [2]</b> 29/23	67/6 67/6 68/22 71/3	149/6 152/25 154/3	148/18 151/25 152/1	<b>need [23]</b> 17/11 22/8
122/9	72/22 73/9 77/3 85/7	<b>Mr Cain [1]</b> 26/13	152/7 152/8 152/24	23/4 37/13 37/15
<b>misunderstood [1]</b>	85/13 85/13 86/21	<b>Mr Case [1]</b> 14/2	<b>multi [1]</b> 6/17	44/14 51/6 77/19 80/9
134/22	88/19 91/9 92/9 92/14	<b>Mr Cummings [16]</b>	<b>multiple [4]</b> 16/20	80/15 80/18 81/14
<b>mitigation [1]</b> 75/24	93/21 98/6 98/15	11/23 17/1 19/2 19/3	95/21 105/20 116/16	82/24 105/22 107/6
<b>mix [2]</b> 3/18 150/22	98/21 98/23 99/10	19/11 20/18 22/1	<b>multisystem [2]</b>	109/20 109/21 111/3
<b>mixing [1]</b> 147/9	100/2 100/25 101/1	22/22 22/25 23/10	86/12 106/20	120/23 122/15 123/2
<b>Mm [3]</b> 133/22	101/18 102/13 102/25	24/6 25/2 26/13 48/24	<b>multitude [2]</b> 24/21	136/4 145/25
135/25 141/6	103/25 104/18 107/24	51/14 65/9	61/23	<b>needed [8]</b> 30/13
<b>Mm-hm [2]</b> 133/22	109/15 110/17 112/6	<b>Mr Cummings' [12]</b>	<b>muscle [2]</b> 86/11	43/17 45/24 90/17
135/25	116/6 116/14 116/18	20/4 20/7 20/9 20/25	114/23	92/6 109/16 140/19
<b>mobile [1]</b> 22/19	116/24 117/1 117/4	22/19 22/23 22/24	<b>must [5]</b> 25/9 58/18	148/11
<b>mobilising [1]</b> 10/11	117/5 117/6 117/12	49/2 49/4 49/12 54/5	87/23 131/12 151/5	<b>needing [2]</b> 95/7
<b>mode [2]</b> 55/2 56/6	117/15 118/6 118/12	65/13	<b>my [60]</b> 1/6 2/18 2/24	95/20
<b>model [10]</b> 47/15	119/1 119/17 120/17	<b>Mr Drakeford [3]</b>	2/25 3/2 5/15 6/23	<b>needn't [1]</b> 6/10
61/17 61/24 62/5	123/23 125/20 137/20	31/12 31/19 31/24	7/21 21/16 22/16	<b>needs [2]</b> 7/25 142/8
62/11 62/13 62/23	144/22 145/9 147/21	<b>Mr Javid [1]</b> 149/6	25/21 26/8 26/24 29/7	<b>negotiating [1]</b> 77/14
68/19 69/1 115/15	150/12 151/2	<b>Mr Johnson [4]</b> 19/2	29/13 30/20 31/1 31/4	<b>neither [2]</b> 93/6
<b>modelled [1]</b> 47/7	<b>Moreover [1]</b> 47/23	23/4 29/17 32/16	31/20 32/2 32/19	120/5
<b>modellers [1]</b> 69/11	<b>morning [9]</b> 1/6 37/7	<b>Mr Johnson's [2]</b>	33/11 34/14 35/25	<b>net [1]</b> 5/19
<b>modelling [2]</b> 70/23	40/25 41/13 76/8 79/4	33/3 79/9	37/8 38/7 39/17 41/18	<b>network [2]</b> 105/24
	81/13 129/2 129/3	<b>Mr Keith [3]</b> 1/5 22/7	41/21 43/25 45/13	105/25

<b>N</b>	134/8 139/22 142/15	18/10 18/12 18/23	<b>office [73]</b> 4/11 4/12	87/16 88/7 92/25
<b>networking [1]</b>	<b>nod [1]</b> 19/10	19/23 20/14 24/21	6/4 6/9 6/14 6/22 7/7	94/12 95/8 97/18
138/23	<b>nodes [1]</b> 7/11	24/22 25/17 26/2	7/12 7/16 7/17 7/21	105/14 106/18 106/19
<b>neutral [1]</b> 109/9	<b>non [3]</b> 2/1 2/6 63/19	26/16 26/18 34/2	7/24 8/2 8/2 8/12 8/14	108/14 112/4 112/17
<b>never [2]</b> 23/15 32/16	<b>non-lead [1]</b> 63/19	34/24 37/7 38/12 39/1	8/15 8/17 8/24 9/6 9/9	113/2 118/6 118/7
<b>nevertheless [4]</b>	<b>nonetheless [1]</b> 87/2	57/13 59/24 60/15	9/12 9/13 9/16 9/19	118/10 120/2 120/8
37/21 44/13 50/11	<b>normal [2]</b> 12/18	64/17 65/4 65/10	9/22 12/16 16/3 16/16	121/1 124/20 125/9
60/17	41/4	65/17 76/24 77/6	16/19 16/24 17/2 17/3	125/22 128/13 129/8
<b>new [10]</b> 13/18 38/18	<b>normally [2]</b> 87/5	77/17 77/24 78/6	17/7 17/21 18/1 18/7	132/21 132/24 134/9
42/3 74/13 77/17	89/4	<b>numbers [5]</b> 8/13	19/9 19/15 19/23	134/9 134/21 134/23
90/10 100/13 104/6	<b>Northern [4]</b> 31/2	18/13 91/21 147/10	20/15 21/5 22/5 24/2	140/3 140/19 140/19
131/16 132/8	31/10 66/14 137/21		24/9 25/18 26/1 26/18	143/4 150/9 151/13
<b>New York Times [1]</b>	<b>Northern Ireland [4]</b>	<b>O</b>	27/15 27/18 32/18	151/17 152/10
131/16	31/2 31/10 66/14	<b>o'clock [3]</b> 38/10	32/24 39/1 39/18	<b>one year [1]</b> 106/19
<b>news [2]</b> 91/25	137/21	38/12 96/20	45/14 46/15 48/9	<b>one-year [1]</b> 106/18
142/17	<b>not [156]</b>	<b>O'Connor [5]</b> 83/2	54/11 57/13 59/24	<b>ones [3]</b> 92/7 126/16
<b>next [10]</b> 37/12 68/6	<b>note [10]</b> 20/3 24/15	83/4 83/11 97/1 128/6	63/4 63/9 63/14 64/17	140/24
90/4 93/12 102/19	37/10 55/22 123/4	<b>O'Donnell [2]</b> 75/13	65/17 75/2 76/24 77/6	<b>ongoing [15]</b> 11/2
107/11 112/15 125/15	123/8 123/13 123/24	75/13	77/21 77/23 78/6	86/9 89/2 89/6 94/7
139/24 142/3	124/14 124/16	<b>O'Neill [1]</b> 31/14	80/22 80/24	99/5 99/23 101/1
<b>next week [1]</b> 68/6	<b>notes [2]</b> 11/24 24/20	<b>O's [1]</b> 44/18	<b>Office's [1]</b> 7/1	108/24 111/16 117/18
<b>NHS [15]</b> 65/3 65/5	<b>nothing [2]</b> 22/21	<b>obese [1]</b> 116/12	<b>officer [4]</b> 7/16 52/14	131/17 135/1 140/6
76/14 84/23 98/5 99/9	113/4	<b>objective [4]</b> 2/7	68/20 123/9	142/6
100/6 102/6 137/6	<b>notice [1]</b> 30/21	57/25 76/15 76/17	<b>official [3]</b> 28/8 28/14	142/6
137/16 137/22 143/10	<b>November [4]</b> 24/24	5/13 5/16 70/8 150/8	53/8	<b>online [2]</b> 100/16
144/6 144/11 144/22	25/7 25/15 26/9	<b>objectives [5]</b> 4/25	<b>officials [11]</b> 27/25	152/24
<b>NHS England [9]</b>	<b>November 2020 [2]</b>	5/13 5/16 70/8 150/8	38/6 44/17 47/14	<b>only [15]</b> 11/8 14/19
65/3 65/5 100/6 137/6	24/24 26/9	<b>obligated [1]</b> 25/17	55/11 64/6 65/10 72/9	20/4 20/6 51/1 59/19
137/16 137/22 143/10	<b>now [27]</b> 8/22 9/12	<b>obligation [1]</b> 29/20	75/16 80/4 80/6	78/19 114/12 114/13
144/6 144/11	14/4 30/9 65/25 72/22	<b>obliged [1]</b> 12/3	<b>often [10]</b> 10/8 28/10	122/19 128/7 140/1
<b>NHS-England [1]</b>	85/6 92/9 93/1 93/5	<b>observation [3]</b>	32/1 50/1 52/17 53/11	142/16 149/10 149/13
102/6	96/11 97/17 97/19	21/21 54/22 65/8	65/3 71/17 95/23	<b>ONS [1]</b> 121/11
<b>NHSE [1]</b> 101/2	97/21 112/15 113/6	<b>observational [1]</b>	135/1	<b>onwards [1]</b> 38/8
<b>NICE [6]</b> 99/12	121/17 123/4 123/7	110/1	<b>oh [3]</b> 132/14 134/13	<b>opaque [1]</b> 15/20
100/13 110/19 111/6	125/5 125/14 126/11	<b>observed [1]</b> 60/8	151/5	<b>open [9]</b> 15/16 49/9
111/21 124/9	139/6 143/16 146/10	<b>observes [2]</b> 51/12	<b>okay [4]</b> 128/21	55/4 56/11 56/13
<b>Nicola [1]</b> 31/13	148/15 150/17	51/14	132/16 134/19 146/24	58/14 64/8 107/16
<b>Nicola Sturgeon [1]</b>	<b>nuance [2]</b> 25/10	<b>obvious [3]</b> 15/4	<b>old [1]</b> 138/20	147/7
31/13	72/2	35/11 145/2	<b>old-fashioned [1]</b>	<b>opened [1]</b> 147/9
<b>night [1]</b> 140/25	<b>nuanced [1]</b> 70/20	<b>obviously [15]</b> 6/12	138/20	<b>opening [3]</b> 60/7
<b>NIHR [1]</b> 105/25	<b>nuances [1]</b> 70/6	11/21 19/19 23/21	<b>older [3]</b> 23/11 117/5	68/23 147/21
<b>no [35]</b> 8/7 13/21	<b>number [62]</b> 3/4 3/9	28/23 35/11 38/9	117/13	<b>operate [5]</b> 12/4 19/9
17/3 21/16 23/13	4/8 6/18 8/12 10/16	51/11 78/15 91/5	<b>Oliver [1]</b> 61/13	21/8 67/20 81/24
24/25 25/5 29/14	16/16 16/23 16/25	106/21 114/12 127/16	<b>Oliver Letwin [1]</b>	<b>operated [1]</b> 67/21
29/19 32/24 37/14	17/1 17/6 17/9 17/20	128/10 144/23	61/13	<b>operates [1]</b> 7/12
46/10 47/12 47/20	17/23 17/23 18/4 18/8	<b>occasion [3]</b> 59/1	<b>on [253]</b>	<b>operating [3]</b> 7/16
52/12 70/7 74/16	18/9 18/10 18/12	120/2 120/14	<b>once [8]</b> 17/11 27/17	24/17 75/5
77/25 82/12 98/20	18/23 19/23 20/14	<b>occasionally [1]</b> 47/9	80/22 85/18 107/2	<b>operation [5]</b> 21/19
112/15 113/4 113/13	24/21 24/22 25/17	<b>occupation [2]</b> 94/8	107/24 146/16 147/5	36/13 42/4 45/20 67/8
128/24 130/17 132/21	26/2 26/16 26/18 32/6	106/22	<b>Ondine [4]</b> 128/14	<b>operational [10]</b>
134/9 134/9 143/4	34/2 34/24 37/7 38/12	<b>occupies [1]</b> 87/15	128/15 129/7 154/14	18/14 30/2 34/13
143/4 143/14 147/16	39/1 39/19 46/2 48/21	<b>octane [2]</b> 21/12	<b>Ondine Sherwood [2]</b>	39/14 42/4 44/19
149/12 150/14 150/14	57/13 59/24 60/15	60/16	128/14 129/7	45/11 47/5 48/8 50/16
<b>No 10 [3]</b> 17/3 24/25	62/6 64/17 65/4 65/10	<b>October [9]</b> 1/1 99/14	<b>one [77]</b> 5/25 9/5	<b>operations [4]</b> 45/16
32/24	65/17 72/7 76/24 77/6	100/5 100/6 124/5	10/19 10/21 12/17	46/5 46/24 47/8
<b>No 10/CabOff [1]</b>	77/17 77/24 78/6	124/16 125/22 144/7	19/17 20/17 22/15	<b>opinion [1]</b> 14/11
23/13	79/14 89/16 90/16	153/8	25/5 27/18 31/6 32/10	<b>opinions [1]</b> 2/20
<b>no one [6]</b> 25/5 77/25	91/3 97/20 106/1	<b>October 2020 [2]</b>	32/14 34/15 39/8 40/2	<b>opportunity [3]</b> 29/23
132/21 134/9 134/9	119/5 125/16 125/17	124/5 125/22	43/3 49/13 50/21 58/7	36/5 122/9
143/4	132/18	<b>odd [1]</b> 131/11	62/8 63/14 65/5 65/24	<b>opposed [4]</b> 4/20
<b>no-deal Brexit [1]</b>	<b>Number 10 [39]</b>	<b>off [6]</b> 21/14 22/3	68/21 71/17 72/11	48/17 67/11 69/23
74/16	16/16 16/23 16/25	22/12 23/3 110/25	72/16 74/1 74/14	<b>Opposition [1]</b>
<b>nobody [4]</b> 23/23	17/1 17/6 17/9 17/20	131/13	77/25 78/22 79/18	143/14
	17/23 17/23 18/4 18/8	<b>offer [1]</b> 129/12	81/10 85/15 85/19	<b>option [1]</b> 101/11

<p><b>O</b></p> <p><b>or</b> [156]</p> <p><b>order</b> [9] 28/1 45/23 53/25 80/10 81/10 109/17 150/11 151/1 152/14</p> <p><b>ordained</b> [1] 9/19</p> <p><b>ordination</b> [6] 28/2 34/8 34/13 39/11 66/6 66/18</p> <p><b>organ</b> [2] 95/20 106/20</p> <p><b>organically</b> [1] 99/1</p> <p><b>organisation</b> [14] 6/21 15/5 17/8 130/8 130/22 131/3 131/6 135/21 137/1 138/19 138/20 139/6 139/12 144/15</p> <p><b>organisational</b> [1] 8/5</p> <p><b>organisations</b> [2] 137/19 152/18</p> <p><b>organise</b> [2] 13/6 38/8</p> <p><b>organised</b> [1] 77/20</p> <p><b>organism</b> [1] 7/24</p> <p><b>organogram</b> [1] 6/21</p> <p><b>organs</b> [1] 105/21</p> <p><b>origin</b> [1] 22/14</p> <p><b>original</b> [2] 86/5 88/25</p> <p><b>other</b> [64] 5/25 7/3 11/25 12/21 16/11 21/14 21/16 21/20 34/3 41/2 48/17 48/17 50/23 52/19 63/16 64/9 65/5 67/8 69/3 71/3 74/24 77/15 85/15 85/19 85/21 86/22 88/15 88/24 91/22 93/24 94/5 96/2 97/9 98/24 106/24 108/3 108/24 112/16 113/3 115/22 116/23 118/1 119/8 124/2 124/11 124/22 125/4 125/22 127/10 129/11 129/14 130/3 130/18 131/4 132/3 132/4 136/19 137/18 140/6 141/10 149/4 149/10 150/22 151/14</p> <p><b>others</b> [15] 3/20 11/25 21/3 24/13 25/3 33/8 38/11 77/23 90/25 91/4 128/25 133/2 133/23 134/22 150/5</p> <p><b>others'</b> [1] 39/13</p> <p><b>otherwise</b> [2] 18/2 51/7</p> <p><b>our</b> [29] 2/11 5/15 6/6</p>	<p>17/16 49/21 52/10 63/14 71/19 74/5 81/6 82/15 104/15 105/11 106/7 106/16 106/18 119/11 129/12 136/4 137/13 137/13 137/17 137/23 139/13 144/15 145/7 148/12 150/23 151/21</p> <p><b>ourselves</b> [4] 27/14 110/14 124/7 126/7</p> <p><b>out</b> [32] 13/10 18/1 18/20 19/5 26/11 26/17 47/6 53/2 59/3 59/4 60/1 65/13 73/5 77/21 78/3 78/9 79/16 80/8 90/9 97/10 103/20 104/14 107/4 113/12 113/25 127/4 140/22 146/13 146/24 148/5 149/16 149/22</p> <p><b>outbreaks</b> [1] 62/8</p> <p><b>outcome</b> [4] 53/10 53/11 63/11 78/21</p> <p><b>outcomes</b> [2] 105/18 106/4</p> <p><b>outlasted</b> [1] 36/18</p> <p><b>outlive</b> [1] 35/17</p> <p><b>outset</b> [1] 105/19</p> <p><b>outside</b> [6] 8/2 26/16 40/1 52/2 68/16 106/22</p> <p><b>over</b> [33] 3/13 3/24 7/13 8/13 12/19 12/20 13/19 23/17 26/2 37/23 40/25 41/14 46/21 48/6 57/20 58/8 74/14 76/21 77/5 77/5 77/14 77/19 88/8 96/21 106/16 108/25 115/4 126/11 132/19 136/13 141/2 144/20 149/17</p> <p><b>overall</b> [1] 23/22</p> <p><b>overarching</b> [3] 47/24 75/23 79/18</p> <p><b>overdo</b> [1] 133/11</p> <p><b>overlapping</b> [1] 39/11</p> <p><b>overspeaking</b> [1] 85/10</p> <p><b>overview</b> [1] 93/13</p> <p><b>overwhelming</b> [1] 79/2</p> <p><b>own</b> [21] 1/21 2/20 2/24 3/2 12/22 13/23 20/4 31/4 40/12 41/21 46/9 46/12 46/20 67/4 68/11 69/21 97/13 119/8 127/20 134/3 140/2</p> <p><b>owned</b> [1] 40/3</p> <p><b>ownership</b> [1] 77/14</p> <p><b>oxygen</b> [2] 94/1 95/8</p>	<p><b>P</b></p> <p><b>pace</b> [5] 22/3 22/12 71/10 104/4 146/19</p> <p><b>pace'</b> [1] 23/3</p> <p><b>paced</b> [2] 82/15 104/8</p> <p><b>page</b> [48] 1/20 6/7 18/25 21/22 21/24 22/25 23/9 23/17 23/18 27/10 27/15 32/6 37/23 37/23 42/24 43/2 43/3 43/8 54/6 77/4 83/20 84/6 104/20 104/20 110/24 111/1 111/25 114/20 115/11 115/25 123/6 123/7 123/11 124/18 125/9 125/11 125/15 125/15 130/23 136/1 136/22 139/24 141/2 142/22 142/23 146/8 148/17 154/2</p> <p><b>page 10</b> [1] 104/20</p> <p><b>page 12</b> [1] 114/20</p> <p><b>page 13</b> [1] 146/8</p> <p><b>page 19</b> [1] 115/25</p> <p><b>page 2</b> [2] 37/23 130/23</p> <p><b>page 22</b> [1] 18/25</p> <p><b>page 3</b> [2] 43/3 43/8</p> <p><b>page 4</b> [1] 27/10</p> <p><b>page 54</b> [1] 54/6</p> <p><b>Page 56</b> [1] 23/9</p> <p><b>page 6</b> [2] 110/24 136/1</p> <p><b>page 7</b> [2] 21/24 142/22</p> <p><b>page 9</b> [1] 124/18</p> <p><b>pages</b> [3] 43/1 43/3 123/8</p> <p><b>paid</b> [1] 81/6</p> <p><b>pain</b> [2] 86/11 114/24</p> <p><b>painful</b> [1] 47/11</p> <p><b>pandemic</b> [49] 3/4 3/20 3/21 3/24 6/3 9/22 15/24 25/24 26/23 37/13 42/8 47/25 62/18 62/21 63/18 65/22 67/1 69/13 70/12 71/6 71/13 74/12 76/20 79/20 88/23 89/1 91/8 91/10 91/12 92/1 92/25 93/3 93/9 97/6 98/16 100/20 108/25 109/9 109/15 110/8 110/11 119/25 120/9 120/17 122/18 136/15 140/18 141/22 146/7</p> <p><b>pandemics</b> [1] 109/6</p> <p><b>paper</b> [4] 42/22 43/14 43/16 67/20</p> <p><b>papers</b> [4] 39/17</p>	<p>45/17 61/11 106/9</p> <p><b>paragraph</b> [19] 23/18 32/6 32/13 37/18 41/6 43/8 104/22 110/24 111/2 114/21 130/24 136/2 138/7 139/25 141/3 141/4 142/3 142/23 148/19</p> <p><b>paragraph 1.14</b> [1] 114/21</p> <p><b>paragraph 1.6</b> [1] 110/24</p> <p><b>paragraph 23</b> [1] 136/2</p> <p><b>paragraph 27</b> [1] 142/23</p> <p><b>paragraph 3</b> [2] 37/18 130/24</p> <p><b>paragraph 43</b> [1] 32/13</p> <p><b>paragraph 6</b> [1] 43/8</p> <p><b>paragraph 70</b> [1] 41/6</p> <p><b>paragraphs</b> [1] 146/9</p> <p><b>paragraphs 50</b> [1] 146/9</p> <p><b>parallel</b> [2] 12/12 110/5</p> <p><b>parents</b> [1] 135/13</p> <p><b>parents.Yes</b> [1] 119/9</p> <p><b>pares</b> [1] 12/13</p> <p><b>Parliament</b> [2] 81/16 132/25</p> <p><b>part</b> [36] 4/3 5/24 8/21 16/18 17/6 21/7 25/18 26/23 35/6 36/6 39/9 41/24 44/8 44/10 52/7 59/2 61/1 65/11 65/22 68/10 69/21 71/6 81/25 84/23 86/6 86/13 88/22 90/19 105/25 108/10 110/13 121/5 142/6 144/16 145/19 151/14</p> <p><b>participant</b> [1] 130/4</p> <p><b>participants</b> [3] 49/10 68/4 97/24</p> <p><b>participate</b> [1] 31/6</p> <p><b>participation</b> [1] 66/2</p> <p><b>particular</b> [23] 7/19 10/14 12/2 14/10 14/18 14/24 25/21 30/3 30/21 36/19 44/3 48/14 49/24 58/8 60/21 63/16 65/9 70/25 75/2 85/17 86/14 86/15 89/22</p> <p><b>particularly</b> [20] 15/23 16/1 31/21 35/4 37/5 52/10 57/1 59/25 72/3 75/1 78/13 91/4 94/5 95/10 99/18 107/14 112/25 120/24</p>	<p>131/14 133/14</p> <p><b>partisan</b> [2] 2/1 2/6</p> <p><b>partly</b> [7] 10/5 10/8 10/12 27/20 56/16 67/3 98/20</p> <p><b>parts</b> [9] 6/18 8/16 8/16 11/10 16/20 23/21 23/25 66/17 85/12</p> <p><b>party</b> [2] 81/22 149/16</p> <p><b>pass</b> [1] 17/11</p> <p><b>passage</b> [1] 148/14</p> <p><b>passed</b> [2] 50/13 50/17</p> <p><b>pasted</b> [1] 23/10</p> <p><b>path</b> [1] 35/17</p> <p><b>pathogens</b> [1] 88/25</p> <p><b>patient</b> [11] 98/3 98/22 100/24 104/5 105/18 106/3 112/13 112/23 114/1 131/7 133/21</p> <p><b>patient-reported</b> [2] 105/18 106/3</p> <p><b>patients</b> [21] 92/11 93/16 93/25 94/6 97/4 97/18 105/3 105/6 105/12 106/11 107/15 107/25 108/3 108/5 110/1 112/11 114/10 126/24 135/10 141/18 150/19</p> <p><b>Patrick</b> [8] 11/23 23/2 24/20 26/8 68/16 78/16 137/5 143/7</p> <p><b>Patrick Vallance</b> [2] 137/5 143/7</p> <p><b>pattern</b> [1] 31/18</p> <p><b>Paul</b> [1] 108/11</p> <p><b>pause</b> [6] 32/7 55/25 83/3 125/8 131/25 134/11</p> <p><b>pausing</b> [2] 50/5 114/25</p> <p><b>pay</b> [1] 46/13</p> <p><b>paying</b> [1] 60/12</p> <p><b>penultimate</b> [1] 143/1</p> <p><b>people</b> [127] 2/13 11/25 17/20 17/20 27/3 37/15 47/4 60/19 65/16 75/8 77/5 77/12 77/14 77/17 77/18 78/14 80/6 88/15 89/13 89/14 89/24 91/6 93/19 94/2 94/12 94/15 95/6 95/9 95/18 96/5 96/7 96/11 97/9 99/1 99/3 99/4 99/8 99/19 100/22 101/6 101/9 101/12 101/24 102/12 103/12 104/12 106/15 106/16 108/9</p>
---	--	---	--	---

<b>P</b>	<b>permanent secretary</b> [2] 12/15 54/10	<b>plainly</b> [1] 79/16	72/20 73/3 73/18	135/7 141/10 141/24
<b>people...</b> [78] 109/2	<b>persistent</b> [1] 118/10	<b>plan</b> [11] 100/7	77/11 146/1 150/25	<b>Potemkin</b> [1] 36/4
110/15 111/12 111/15	<b>person</b> [9] 10/2 10/3	100/12 101/7 102/18	<b>policymakers</b> [1]	<b>potential</b> [6] 91/10
113/22 115/9 116/5	10/10 10/19 10/23	102/20 103/16 103/17	120/18	93/10 96/3 107/17
116/11 116/12 116/21	22/18 22/18 88/3	108/22 122/19 126/4	<b>political</b> [14] 1/16 7/8	122/22 148/6
118/17 119/21 120/6	128/20	144/8	17/20 19/21 19/24	<b>potentially</b> [1] 142/7
126/6 126/14 126/15	<b>person's</b> [3] 19/17	<b>plane</b> [1] 47/20	21/13 26/21 28/24	<b>power</b> [8] 6/24 8/1
126/17 127/10 127/16	78/22 78/23	<b>planet</b> [1] 93/2	32/18 55/21 57/2	12/4 12/8 41/15 63/11
127/22 131/4 131/20	<b>personal</b> [17] 10/20	<b>planning</b> [3] 47/12	57/19 72/5 75/4	74/14 79/11
132/3 132/4 132/9	13/12 13/16 18/17	74/16 92/12	<b>politically</b> [1] 7/24	<b>powerful</b> [1] 51/24
132/11 132/18 132/19	20/9 29/1 40/2 46/25	<b>plans</b> [5] 62/20 63/19	<b>politicians</b> [2] 71/24	<b>powers</b> [2] 13/11
134/2 134/8 134/25	57/8 59/18 63/25	110/9 122/7 147/16	79/22	13/15
135/11 135/17 135/19	64/23 68/22 72/9	<b>platform</b> [1] 105/4	<b>politics</b> [1] 77/16	<b>Powis</b> [1] 143/9
137/3 137/25 138/15	73/16 81/2 82/6	<b>played</b> [2] 6/1 68/8	<b>poor</b> [3] 21/2 79/12	<b>practical</b> [1] 152/10
138/21 139/1 139/7	<b>personalities</b> [4]	<b>playing</b> [1] 64/21	142/7	<b>practically</b> [1] 11/18
139/9 139/11 139/14	26/19 27/2 67/11	<b>plays</b> [3] 9/22 61/21	<b>poorly</b> [1] 77/10	<b>practice</b> [3] 63/25
139/16 139/20 139/21	67/12	63/4	<b>population</b> [5] 81/21	67/21 122/21
139/25 140/7 140/8	<b>personally</b> [4] 30/12	<b>please</b> [33] 1/6 1/10	82/2 115/24 118/19	<b>pre</b> [6] 20/13 38/3
140/14 140/21 141/1	68/10 102/7 143/25	2/4 2/15 6/5 18/24	121/3	53/7 67/10 102/24
141/7 142/1 142/8	<b>personnel</b> [2] 18/9	21/10 21/24 23/17	<b>posed</b> [2] 32/2	105/5
142/14 144/9 145/13	60/24	27/9 32/5 37/9 42/15	120/19	<b>pre-existing</b> [2]
146/16 147/2 147/9	<b>persons</b> [1] 73/17	42/21 43/8 45/9 54/5	<b>position</b> [11] 25/12	67/10 105/5
147/14 148/2 148/4	<b>perspective</b> [3]	76/22 77/2 83/7 85/19	26/22 27/12 30/17	<b>pre-meeting</b> [1]
148/7 149/13 149/19	78/22 78/23 90/7	93/22 114/20 123/3	60/19 63/7 68/7 70/4	102/24
149/24 150/12 150/16	<b>phase</b> [3] 37/12	124/18 125/6 125/10	75/8 118/22 120/16	<b>pre-meetings</b> [1]
150/17 150/20 150/22	37/20 134/6	129/6 132/13 136/23	<b>positive</b> [3] 87/8	53/7
150/23 150/24 151/2	<b>phenomenon</b> [1]	142/22 146/9 146/22	99/25 111/19	<b>precautionary</b> [1]
151/4 151/10	128/2	<b>pleased</b> [1] 27/8	<b>possible</b> [9] 28/14	69/24
<b>people's</b> [1] 113/9	<b>phone</b> [2] 22/19	<b>plenty</b> [2] 27/16 34/4	30/13 35/7 35/9 66/18	<b>precautions</b> [3]
<b>perceived</b> [1] 17/19	22/24	<b>pm</b> [4] 25/4 96/23	78/7 80/7 80/11 80/13	150/11 150/12 150/14
<b>percolated</b> [1] 60/17	<b>phones</b> [1] 72/9	96/25 153/6	<b>possibly</b> [4] 48/7	<b>precise</b> [1] 87/20
<b>perfect</b> [2] 26/4 26/5	<b>PHOSP</b> [4] 94/25	<b>point</b> [45] 16/15	72/2 104/2 117/19	<b>precisely</b> [1] 19/22
<b>perfectly</b> [1] 31/1	104/21 108/14 121/12	17/16 19/22 20/8	<b>post</b> [34] 85/25 86/3	<b>precision</b> [1] 118/13
<b>perform</b> [2] 11/9 18/2	<b>PHOSP-Covid</b> [3]	25/21 28/8 34/20 35/5	86/4 86/10 86/20	<b>precursor</b> [1] 85/23
<b>performance</b> [4]	94/25 104/21 121/12	36/9 36/10 36/16	86/24 87/3 87/17 88/1	<b>predecessors</b> [1]
14/25 16/2 20/22	<b>phraseology</b> [1]	41/20 53/1 60/11	88/2 88/10 88/21	25/5
23/22	58/20	60/12 60/23 63/14	91/18 91/22 95/2	<b>predict</b> [1] 86/24
<b>performing</b> [1] 39/3	<b>physicians</b> [1] 112/9	81/14 92/14 94/11	95/14 95/23 96/3	<b>predominant</b> [1]
<b>performs</b> [1] 10/16	<b>physician</b> [3] 84/14	94/18 100/7 100/15	98/17 99/1 99/22	94/10
<b>perhaps</b> [43] 6/20	84/22 87/5	101/5 101/16 101/22	100/23 105/1 110/11	<b>predominantly</b> [1]
10/17 25/3 30/1 31/24	<b>physicians</b> [1] 114/8	102/5 102/19 102/20	111/5 111/14 112/1	113/9
58/18 59/2 59/22	<b>physiological</b> [1]	103/16 103/16 106/25	115/7 120/24 121/8	<b>preface</b> [2] 15/25
59/24 60/25 61/21	106/5	107/23 108/22 115/5	135/6 135/7 141/10	17/13
63/25 64/24 71/13	<b>pick</b> [3] 118/14 138/5	124/19 125/16 125/17	141/24	<b>preferences</b> [1] 29/1
81/2 85/16 86/2 90/6	142/25	125/18 126/4 141/13	<b>post SARS-Cov-1</b> [1]	<b>premium</b> [1] 13/12
93/14 95/14 98/14	<b>picking</b> [2] 50/5 77/2	144/8 148/12 150/6	91/22	<b>preparation</b> [1] 62/15
102/19 105/1 109/5	<b>picks</b> [1] 134/20	150/9	<b>post-Covid</b> [4] 99/22	<b>prepare</b> [2] 80/25
110/20 114/25 115/6	<b>picture</b> [4] 47/2	<b>point 25</b> [1] 124/19	111/14 112/1 121/8	98/16
116/10 117/21 120/8	77/25 87/10 98/8	<b>Point 3</b> [1] 101/5	<b>Post-Covid-19</b> [1]	<b>prepared</b> [9] 1/18
120/13 123/6 126/1	<b>piece</b> [2] 53/13 113/1	<b>points</b> [10] 20/17	111/5	42/22 76/23 77/11
130/6 134/22 136/1	<b>pieces</b> [2] 3/5 3/22	63/14 66/1 71/5 95/8	<b>post-discharge</b> [1]	109/8 124/22 135/6
138/17 140/18 144/20	<b>pinnacle</b> [2] 11/18	100/12 105/14 121/16	105/1	135/8 135/8
146/5 146/8 146/18	49/22	125/16 138/5	<b>post-exertional</b> [2]	<b>preparedness</b> [4]
151/12	<b>place</b> [13] 7/20 25/14	<b>policies</b> [2] 4/21	88/1 88/2	62/18 63/2 110/8
<b>period</b> [4] 25/20	27/1 37/6 38/5 45/4	36/12	<b>post-hospital</b> [1]	122/2
25/23 102/21 136/13	50/13 52/23 71/14	<b>policy</b> [35] 2/11 4/24	100/23	<b>preparing</b> [2] 45/17
<b>periods</b> [1] 96/2	76/20 80/8 114/16	5/13 5/14 5/19 8/18	<b>Post-hospitalisation</b>	121/6
<b>permanent</b> [5] 7/15	145/5	9/9 13/4 13/9 18/16	[1] 95/2	<b>present</b> [3] 64/13
12/15 12/22 23/22	<b>placed</b> [3] 7/2 13/12	23/3 34/14 34/17	<b>post-ICU</b> [1] 95/23	79/3 142/15
54/10	74/15	36/11 39/13 39/21	<b>post-viral</b> [16] 86/4	<b>presentation</b> [1]
<b>permanent</b>	<b>places</b> [3] 20/18 21/9	43/18 44/25 45/19	86/10 86/20 87/3	30/15
<b>secretaries</b> [2]	61/24	45/20 46/9 49/24	88/10 88/21 91/18	<b>presentational</b> [3]
12/22 23/22	<b>plain</b> [2] 49/13 81/3	50/16 51/6 52/2 53/4	95/14 96/3 98/17	28/24 29/21 29/25
		63/17 70/18 72/4	110/11 115/7 135/6	<b>presentationally</b> [2]

<b>P</b>	10/24 11/6 11/12 13/25 15/10 15/12 15/13 16/25 17/10 18/17 18/19 19/14 19/24 21/5 23/15 26/12 26/20 28/9 29/2 29/16 29/16 29/20 29/23 29/25 30/3 30/8 30/11 30/25 34/24 35/1 35/3 37/18 38/13 42/10 42/22 43/21 46/5 47/14 49/22 51/17 52/24 53/9 57/20 60/21 67/13 74/3 74/18 76/25 78/17 79/1 79/23 80/9 81/3 81/10 81/23 123/12 124/3 124/16 124/25 127/20	111/11 <b>processes [6]</b> 5/9 5/10 5/14 15/16 49/16 148/9 <b>procurement [1]</b> 8/25 <b>produce [4]</b> 3/17 4/21 8/18 71/9 <b>produced [2]</b> 11/22 61/11 <b>product [1]</b> 2/19 <b>professionals [3]</b> 98/13 113/19 113/24 <b>professor [27]</b> 83/9 83/13 84/5 84/7 84/25 85/1 85/6 91/11 97/3 101/3 102/14 102/15 102/23 108/11 115/18 119/16 120/7 120/8 120/14 120/25 122/24 126/2 128/4 131/2 143/9 143/16 154/9 <b>Professor and [1]</b> 122/24 <b>Professor Brightling [12]</b> 84/5 85/1 85/6 91/11 97/3 102/14 102/23 115/18 120/14 128/4 131/2 143/16 <b>Professor Calum Semple [1]</b> 120/25 <b>Professor Chris Brightling [1]</b> 83/13 <b>Professor Khunti [1]</b> 120/7 <b>Professor Medley [1]</b> 120/8 <b>Professor Paul [1]</b> 108/11 <b>Professor Sally Singh [2]</b> 101/3 102/15 <b>Professor Stephen Powis [1]</b> 143/9 <b>profiles [1]</b> 117/25 <b>programme [5]</b> 1/25 2/8 90/23 121/20 147/20 <b>progress [1]</b> 122/6 <b>project [1]</b> 8/25 <b>prolonged [2]</b> 96/1 116/8 <b>promulgated [1]</b> 54/1 <b>proper [9]</b> 50/20 58/1 70/17 70/19 73/2 73/7 74/10 75/7 75/11 <b>properly [8]</b> 14/14 59/11 71/15 72/13 73/21 76/11 133/24 146/16 <b>proportion [4]</b> 89/5 93/4 106/15 119/7 <b>proportions [1]</b> 106/10	<b>propose [1]</b> 42/3 <b>proposed [1]</b> 43/14 <b>proposes [1]</b> 37/23 <b>proposing [1]</b> 96/18 <b>proposition [1]</b> 21/10 <b>prosaic [1]</b> 63/25 <b>prospect [2]</b> 146/23 147/19 <b>protect [1]</b> 76/14 <b>protocol [2]</b> 13/9 92/15 <b>protocols [2]</b> 92/5 92/8 <b>provide [6]</b> 1/19 1/23 35/4 42/6 45/22 105/3 <b>provided [7]</b> 1/14 5/3 47/19 70/25 110/20 111/6 129/16 <b>provides [2]</b> 51/23 113/13 <b>providing [2]</b> 11/11 35/21 <b>proving [2]</b> 39/15 113/12 <b>provision [2]</b> 1/14 68/8 <b>public [24]</b> 26/11 27/25 36/25 37/19 40/8 48/1 48/15 65/2 70/12 73/12 79/20 90/20 91/18 98/6 98/24 116/4 137/8 140/4 142/19 143/10 149/12 149/22 150/9 151/5 <b>publication [2]</b> 89/18 89/19 <b>publicise [1]</b> 144/6 <b>publicised [1]</b> 67/2 <b>publicity [1]</b> 151/2 <b>publicly [2]</b> 17/17 33/9 <b>published [6]</b> 3/3 3/9 103/16 103/17 119/24 152/19 <b>publishing [1]</b> 119/21 <b>pull [1]</b> 65/12 <b>purchase [1]</b> 80/22 <b>purpose [1]</b> 133/20 <b>purposes [4]</b> 104/19 115/25 123/1 146/8 <b>pushed [2]</b> 17/25 49/14 <b>pushing [1]</b> 68/16 <b>put [12]</b> 6/23 17/22 21/10 45/4 60/11 63/16 69/21 71/14 105/18 108/12 131/22 136/6 <b>Putting [2]</b> 34/20 58/3	<b>Q</b> <b>qualitative [2]</b> 113/21 113/22 <b>quality [1]</b> 106/23 <b>quarter [1]</b> 89/24 <b>question [16]</b> 15/10 19/17 20/24 30/21 32/2 50/24 57/21 63/23 65/6 85/24 86/1 88/18 90/5 90/7 105/17 115/21 <b>questioning [1]</b> 93/24 <b>questionnaire [1]</b> 152/15 <b>questions [21]</b> 1/9 13/19 47/2 65/25 69/20 82/11 83/10 85/15 97/4 100/3 104/18 110/18 119/17 122/25 128/4 128/5 128/16 151/24 154/5 154/12 154/16 <b>quicker [1]</b> 109/12 <b>quickly [3]</b> 16/8 132/15 139/13 <b>quite [31]</b> 11/1 27/11 28/22 38/14 39/10 41/19 53/7 53/24 54/17 56/1 59/16 59/18 65/18 68/19 93/18 94/10 94/22 95/5 106/12 117/23 119/23 122/10 126/20 126/23 131/19 137/16 138/12 139/14 140/11 140/13 140/16 <b>quote [2]</b> 134/23 144/14 <b>quoted [1]</b> 110/21 <b>quoting [1]</b> 56/12
			<b>R</b> <b>rabbit [1]</b> 65/13 <b>RACHAEL [4]</b> 83/8 83/14 127/11 154/7 <b>raise [2]</b> 53/15 152/11 <b>rally [1]</b> 13/2 <b>range [4]</b> 68/22 108/23 132/9 141/9 <b>ranks [1]</b> 23/23 <b>rapid [3]</b> 18/3 71/10 73/7 <b>rapidly [3]</b> 16/9 33/15 39/10 <b>rarely [2]</b> 44/2 67/20 <b>rate [4]</b> 16/2 94/23 114/5 149/25 <b>rather [22]</b> 19/12 25/15 26/17 30/14 38/20 40/1 40/5 44/12 45/2 55/24 58/16 60/5	

<b>R</b>	128/9 136/5 136/16	123/17	44/22	<b>respectively [1]</b> 31/14
<b>rather... [10]</b> 72/24	<b>recommend [3]</b> 36/22 69/24 110/7	<b>regarding [1]</b> 76/24	<b>replied [1]</b> 143/4	<b>respects [1]</b> 17/7
73/17 77/15 95/13	<b>recommendations [7]</b> 5/8 5/23 69/25	<b>regardless [1]</b> 20/8	<b>replies [2]</b> 137/24	<b>respiratory [5]</b> 84/8
100/22 109/9 118/20	72/8 79/14 79/22 81/5	<b>region [1]</b> 119/4	143/8	84/21 89/2 91/2 94/4
140/21 141/8 147/24	<b>recommending [1]</b> 37/10	<b>regional [2]</b> 66/23	<b>reply [1]</b> 143/9	<b>respond [7]</b> 7/22
<b>rations [1]</b> 46/13	<b>record [3]</b> 47/8 73/2	67/2	<b>report [46]</b> 1/15 1/18	12/6 12/18 14/13
<b>reach [8]</b> 50/11 52/21	73/12	<b>regrettable [6]</b> 55/11	2/19 2/23 4/18 16/15	22/10 25/17 28/1
52/22 66/5 78/20 87/6	<b>record-keeping [1]</b> 73/2	55/22 56/18 56/23	41/6 61/6 61/14 61/16	<b>responded [1]</b> 98/7
138/18 139/7	<b>recorded [2]</b> 73/21	59/25 60/2	66/5 69/8 70/24 71/2	<b>responding [6]</b> 3/23
<b>reaction [2]</b> 59/18	113/23	<b>regular [4]</b> 91/3	71/2 73/25 74/2 79/14	7/1 9/24 16/8 61/15
125/24	<b>recording [1]</b> 72/12	103/18 103/22 144/5	83/17 83/23 84/6 85/8	62/2
<b>reactive [1]</b> 3/21	<b>recovered [5]</b> 105/16	<b>rehabilitation [1]</b> 102/16	85/12 93/17 95/9	<b>responds [2]</b> 6/24
<b>read [12]</b> 19/4 48/20	106/10 106/15 106/17	<b>relapse [1]</b> 133/12	98/19 99/7 100/11	78/25
48/24 56/12 59/19	131/9	<b>relate [1]</b> 124/3	103/19 104/1 104/20	<b>response [28]</b> 3/6
59/21 60/13 77/4	<b>recovering [1]</b> 131/11	<b>related [7]</b> 26/18	104/24 110/21 110/24	3/12 3/16 6/2 9/19
78/10 78/11 119/21	<b>recovery [3]</b> 100/17	59/20 93/15 106/23	113/17 114/20 116/1	10/15 10/25 18/3
123/16	106/19 152/6	107/14 115/21 152/4	118/20 119/20 119/22	18/11 18/22 18/23
<b>readily [1]</b> 117/25	<b>rectified [1]</b> 63/21	<b>relates [1]</b> 57/21	120/3 121/4 121/11	21/18 22/22 24/3
<b>reading [1]</b> 26/8	<b>rectify [1]</b> 48/13	<b>relating [8]</b> 83/17	121/12 121/14 124/21	25/24 26/7 29/4 29/5
<b>ready [4]</b> 83/2 83/4	<b>reduce [1]</b> 147/20	98/8 98/24 100/7	<b>reported [5]</b> 41/9	30/11 34/9 36/25
109/10 122/17	<b>reduced [1]</b> 46/2	110/10 120/3 120/4	105/17 105/18 106/3	75/11 87/24 117/8
<b>real [3]</b> 109/23 128/2	<b>reducing [1]</b> 5/21	130/18	115/4	117/19 117/20 143/2
128/2	<b>reduction [1]</b> 80/15	<b>relation [8]</b> 3/5 21/18	<b>reporting [1]</b> 17/17	143/10
<b>realised [2]</b> 131/23	<b>reductions [1]</b> 8/11	30/18 30/19 66/1	<b>reports [8]</b> 3/5 3/10	<b>responses [2]</b> 143/13 152/15
132/2	<b>refer [10]</b> 94/25	70/14 97/25 110/11	3/18 71/16 72/7 103/4	<b>responsibilities [1]</b> 10/14
<b>realising [1]</b> 108/2	113/16 116/2 116/14	<b>relationship [2]</b> 57/3	121/10 122/5	<b>responsibility [9]</b> 2/10 9/4 9/7 12/23
<b>reality [2]</b> 25/11	124/20 136/9 136/21	65/2	<b>represent [1]</b> 130/2	15/7 28/12 52/4 60/23
34/22	139/25 148/15 148/17	<b>relationships [4]</b> 26/4 26/20 27/3 66/21	<b>representation [1]</b> 130/4	79/11
<b>really [49]</b> 3/15 20/23	<b>reference [8]</b> 6/25	26/4 26/20 27/3 66/21	<b>representatives [1]</b> 30/18	<b>responsible [3]</b> 10/10 11/7 56/16
36/8 67/16 90/1 92/3	10/3 20/5 21/22 43/9	<b>relatively [4]</b> 39/7	<b>represented [1]</b> 130/14	<b>responsive [2]</b> 69/19
92/6 93/1 93/6 95/6	55/13 73/24 104/21	72/20 74/13 89/16	<b>representing [3]</b> 129/11 138/8 139/16	80/1
97/16 97/18 97/19	<b>references [2]</b> 24/21	<b>relaxation [1]</b> 3/15	<b>requests [1]</b> 69/19	<b>responsiveness [2]</b> 15/5 16/13
99/17 100/21 103/7	27/17	<b>release [2]</b> 126/4	<b>require [1]</b> 11/1	<b>rest [5]</b> 18/19 18/21
105/10 106/12 107/6	<b>referred [11]</b> 14/1	144/15	<b>required [3]</b> 30/10	71/16 108/25 128/1
107/6 108/1 109/2	26/9 76/19 87/12	<b>released [1]</b> 100/20	34/12 44/19	<b>restrictions [6]</b> 3/14
110/4 113/25 117/23	93/15 99/8 101/5	<b>relevance [3]</b> 10/12	<b>requirement [2]</b> 69/12 70/10	21/19 33/22 136/10
118/11 119/8 121/9	101/6 101/11 119/25	60/4 84/16	<b>requires [3]</b> 11/9	146/16 148/8
121/24 122/12 125/19	121/14	<b>relevant [5]</b> 2/23	16/23 37/22	<b>rests [1]</b> 18/6
126/25 129/4 131/10	<b>reflect [11]</b> 2/25 10/6	23/14 39/20 40/4	<b>requiring [1]</b> 94/1	<b>result [4]</b> 40/15 40/16
131/22 132/23 132/23	20/23 21/16 25/11	79/21	<b>research [23]</b> 2/14	86/19 97/13
134/2 134/3 134/8	38/16 41/20 72/3 80/7	<b>relevantly [1]</b> 33/9	2/20 2/21 2/23 3/18	<b>results [1]</b> 106/13
135/17 137/22 139/22	85/13 124/4	<b>reliability [1]</b> 73/15	17/16 31/5 52/10	<b>retained [1]</b> 73/13
140/19 141/18 142/9	<b>reflected [3]</b> 5/2 8/11	<b>reliant [3]</b> 13/23 81/1	63/14 71/20 94/15	<b>return [4]</b> 8/7 36/9
150/22 151/6 151/9	70/5	81/2	98/14 101/16 101/17	36/10 96/20
<b>reason [5]</b> 15/10	<b>reflecting [2]</b> 121/17	<b>remain [1]</b> 84/13	101/19 101/20 101/23	<b>returned [1]</b> 38/25
30/14 31/23 39/16	121/22	<b>remarkable [1]</b> 12/1	102/15 105/24 105/25	<b>returning [1]</b> 6/13
59/14	<b>reflection [8]</b> 10/20	<b>remember [6]</b> 117/11	113/22 114/2 128/8	<b>revealing [1]</b> 107/21
<b>reasonable [1]</b> 28/10	16/17 58/16 64/23	132/6 140/16 143/14	<b>researchers [3]</b> 2/13	<b>reverse [1]</b> 78/19
<b>reasonably [1]</b> 107/2	70/17 70/19 72/16	146/12 148/24	115/14 127/23	<b>revert [2]</b> 59/16
<b>reasoned [1]</b> 58/16	74/11	<b>remind [3]</b> 2/16	<b>researching [1]</b> 134/10	60/11
<b>reasons [8]</b> 9/16 18/6	<b>reflective [7]</b> 3/18	27/13 124/7	<b>resented [2]</b> 64/7	<b>reverting [1]</b> 29/15
18/23 24/19 39/8	20/13 26/25 33/3 67/9	<b>reminding [1]</b> 105/2	64/10	<b>review [4]</b> 61/15 64/1
65/19 76/14 81/12	70/3 73/7	<b>remit [3]</b> 4/22 28/12	<b>residual [1]</b> 133/16	119/23 124/19
<b>receive [2]</b> 35/7	<b>reflects [1]</b> 83/21	63/18	<b>resilience [2]</b> 61/11	<b>reviewed [1]</b> 120/15
143/2	<b>reform [2]</b> 37/22 82/8	<b>remits [3]</b> 39/11 45/1	75/2	<b>reviewing [1]</b> 72/17
<b>received [4]</b> 27/11	<b>reformed [1]</b> 81/10	47/5	<b>resonance [1]</b> 27/21	<b>revolved [1]</b> 37/5
47/17 49/11 52/11	<b>reforms [1]</b> 67/22	<b>remotely [1]</b> 128/24	<b>resources [2]</b> 8/25	<b>rheumatoid [1]</b> 117/17
<b>recent [4]</b> 8/13 10/9	<b>regard [6]</b> 24/7 24/8	<b>renewing [1]</b> 149/7	9/1	
18/13 119/3	55/20 118/22 120/9	<b>repetitious [1]</b> 77/11		
<b>receptive [1]</b> 145/20		<b>rephrased [1]</b> 21/11		
<b>recognised [4]</b> 43/16		<b>replaced [2]</b> 39/7		
90/22 99/21 105/19		43/15		
<b>recognition [4]</b> 97/17		<b>replacement [1]</b>		

<b>R</b>			
<b>rhythm [2]</b> 38/7 38/14	<b>rules [1]</b> 3/15	37/21 40/21 41/6	54/10 60/23 69/16
<b>Ridley [1]</b> 48/21	<b>run [3]</b> 18/22 63/17 131/6	50/19 51/25 52/21	75/25 84/6 100/15
<b>Ridley's [1]</b> 49/3	<b>run-up [1]</b> 63/17	53/14 55/13 55/22	104/25 143/17
<b>right [49]</b> 4/17 20/10 38/6 44/6 44/15 49/8 49/10 51/19 68/21 69/1 69/6 70/22 75/8 75/8 75/9 80/6 83/14 83/17 83/21 84/1 84/9 86/18 88/9 88/10 88/12 94/17 95/15 96/9 97/11 100/8 101/9 103/22 105/19 107/22 108/18 108/25 111/4 111/7 111/20 112/18 116/4 116/16 127/1 136/21 138/19 139/6 143/21 143/24 146/4	<b>running [5]</b> 102/19 106/14 109/14 139/10 139/12	56/4 58/1 58/12 58/18 64/7 67/19 73/5 78/13 86/19 88/10 91/12 95/5 98/2 103/20 103/25 104/2 114/11 114/21 115/3 116/10 117/21 122/16 123/15 129/14 130/24 131/2 136/2 138/19 139/6 143/1 143/21 144/12 146/14	<b>secondly [4]</b> 21/1 71/12 117/25 130/12
<b>right-hand [1]</b> 111/4	<b>Rural [2]</b> 4/10 4/14	<b>saying [14]</b> 21/5 21/11 54/20 56/5 56/8 56/10 56/13 59/6 82/1 95/18 132/21 140/4 144/9 148/22	<b>secretariat [14]</b> 6/10 8/6 8/19 8/21 9/20 24/1 24/2 28/3 28/4 45/11 45/15 46/20 51/20 63/15
<b>rightly [4]</b> 17/9 53/24 73/5 122/10	<b>S</b>	<b>says [10]</b> 22/1 23/12 24/22 32/12 35/18 37/25 47/19 49/20 49/21 56/1	<b>secretariats [4]</b> 6/19 8/17 8/20 63/17
<b>rigorous [1]</b> 81/20	<b>saddened [1]</b> 126/13	<b>scale [7]</b> 37/14 89/11 92/25 93/8 107/10 109/17 109/22	<b>secretaries [8]</b> 12/22 12/23 15/15 18/15 23/22 38/11 40/5 45/3
<b>rise [1]</b> 148/3	<b>sadly [3]</b> 113/20 119/12 119/14	<b>scarring [1]</b> 89/24	<b>secretary [58]</b> 7/9 7/15 10/2 10/13 10/16 10/21 10/22 11/5 11/13 11/14 12/2 12/3 12/11 12/15 12/20 13/3 13/6 13/13 13/18 13/21 14/2 14/3 14/9 14/12 14/18 14/23 15/3 15/8 15/11 15/14 16/21 16/22 16/23 19/20 20/6 20/10 22/3 24/23 25/5 29/9 30/24 31/11 32/11 36/20 38/25 39/20 39/21 43/7 48/23 53/12 54/9 54/10 57/9 64/6 103/9 123/11 137/4 149/6
<b>risk [10]</b> 116/3 116/6 116/11 117/1 147/20 148/2 149/13 149/14 149/15 149/23	<b>SAGE [28]</b> 6/12 47/18 48/16 68/3 68/4 68/7 68/11 68/24 69/7 69/18 70/7 79/19 103/6 119/17 119/18 119/23 119/25 120/4 120/6 120/7 120/9 120/15 120/17 120/20 121/1 121/5 121/21 122/5	<b>sceptical [1]</b> 80/21	<b>Secretary's [4]</b> 12/14 12/18 13/11 37/10
<b>risks [1]</b> 120/19	<b>Sajid [1]</b> 145/19	<b>scepticism [5]</b> 113/14 113/18 114/5 114/16 135/2	<b>section [3]</b> 110/22 111/15 121/8
<b>Robin [1]</b> 31/9	<b>Sajid Javid [1]</b> 145/19	<b>schemes [1]</b> 71/10	<b>Section 1.6 [1]</b> 110/22
<b>Robin Swann [1]</b> 31/9	<b>Sally [2]</b> 101/3 102/15	<b>schools [1]</b> 33/21	<b>security [5]</b> 7/15 8/19 10/13 10/15 11/7
<b>robust [1]</b> 116/18	<b>same [18]</b> 10/23 17/8 17/14 22/17 37/4 45/7 50/3 77/13 78/21 80/8 87/15 102/21 116/20 126/5 126/12 126/14 132/3 148/18	<b>science [7]</b> 70/17 70/20 72/5 91/1 113/2 126/21 126/22	<b>Sedwill [11]</b> 14/4 14/4 20/5 22/2 22/2 22/11 23/4 36/20 36/22 36/22 42/3
<b>Rogers [2]</b> 130/8 151/20	<b>Sammie [2]</b> 130/12 151/20	<b>Science Council [1]</b> 91/1	<b>see [51]</b> 1/19 6/7 27/14 33/16 42/24 51/8 64/2 64/16 74/23 79/25 83/20 87/4 94/24 99/7 99/12 100/11 104/21 105/10 106/24 111/4 112/21 114/10 114/21 117/16 123/6 123/23 124/5 124/13 124/15 124/18 124/22 124/25 125/11 125/12 125/12 127/5 127/16 127/20 128/23 129/18 130/24 131/19 136/24 137/3 141/4 142/3 144/14 147/13 148/3 148/13 153/2
<b>role [17]</b> 2/10 6/2 7/1 9/23 10/1 10/2 11/8 11/15 11/20 12/13 12/14 13/11 14/9 50/9 61/22 63/3 68/7	<b>Sammie McFarland [2]</b> 130/12 151/20	<b>Sciences [2]</b> 103/5 121/4	<b>seeing [2]</b> 101/7 112/11
<b>roles [2]</b> 10/17 11/2	<b>SARS [13]</b> 88/25 89/8 89/10 89/12 89/25 90/1 90/3 91/9 91/14 91/17 91/22 94/9 95/17	<b>scientific [10]</b> 47/18 47/20 47/25 48/16 52/15 68/20 70/11 70/18 91/20 113/23	<b>seek [2]</b> 99/6 101/9
<b>roll [2]</b> 146/13 146/24	<b>SARS CoV [1]</b> 88/25	<b>Scientifically [1]</b> 94/19	
<b>roll-out [2]</b> 146/13 146/24	<b>SARS-CoV-1 [6]</b> 89/10 89/25 90/1 91/9 91/14 91/17	<b>scientists [4]</b> 16/11 69/11 69/14 144/25	
<b>room [6]</b> 27/19 32/23 77/12 80/7 126/14 126/18	<b>SARS-CoV-2 [4]</b> 89/12 90/3 94/9 95/17	<b>score [1]</b> 66/25	
<b>rooms [2]</b> 27/16 27/18	<b>sat [4]</b> 45/14 47/9 120/5 120/6	<b>Scotland [1]</b> 137/21	
<b>rotation [1]</b> 80/16	<b>saw [3]</b> 64/8 75/12 108/22	<b>Scottish [1]</b> 31/11	
<b>round [3]</b> 13/2 108/8 139/19	<b>say [56]</b> 2/5 4/19 7/23 9/23 13/8 13/15 14/19 14/23 15/20 18/4 22/13 26/9 27/8 31/16	<b>Scottish Cabinet Secretary [1]</b> 31/11	
<b>roundtable [7]</b> 102/22 124/10 126/5 143/19 143/25 144/17 145/15		<b>secretary [1]</b> 31/11	
<b>roundtables [2]</b> 103/11 103/20		<b>screaming [1]</b> 23/2	
<b>route [2]</b> 43/22 43/22		<b>screen [10]</b> 6/5 18/24 83/19 100/10 104/23 123/3 124/14 128/23 129/18 136/23	
<b>rule [2]</b> 48/20 54/23		<b>screenshot [1]</b> 22/23	
<b>Rule 9 [1]</b> 48/20		<b>scroll [1]</b> 77/3	
		<b>scrutinised [1]</b> 73/3	
		<b>seat [2]</b> 8/1 62/1	
		<b>second [12]</b> 22/15 23/18 39/16 50/23	
			<b>seem [10]</b> 16/14 17/15 25/8 51/24 58/17 117/1 135/6 141/8 145/2 146/2 <b>seemed [7]</b> 26/5 26/5 26/15 65/3 66/20 92/5 142/13 <b>seemingly [1]</b> 78/21 <b>seems [9]</b> 34/1 34/16 38/13 45/25 52/9 56/4 76/16 101/7 147/13 <b>seen [38]</b> 14/16 14/19 16/5 17/15 25/5 33/2 33/2 33/7 34/1 36/6 39/9 39/16 49/1 49/2 49/4 49/4 49/7 50/16 51/18 52/1 52/11 53/3 55/15 55/16 55/17 58/6 64/1 64/18 72/21 79/3 79/13 88/25 89/24 105/13 123/4 123/10 126/11 133/20 <b>selecting [1]</b> 60/24 <b>selects [1]</b> 15/14 <b>self [8]</b> 11/4 19/5 71/13 71/25 100/16 100/22 101/15 105/17 <b>self-evident [3]</b> 11/4 19/5 71/25 <b>self-imposed [1]</b> 71/13 <b>self-management [3]</b> 100/16 100/22 101/15 <b>self-reported [1]</b> 105/17 <b>semi [1]</b> 56/12 <b>semi-quoting [1]</b> 56/12 <b>Sample [2]</b> 120/25 121/12 <b>send [2]</b> 21/5 22/11 <b>sends [1]</b> 149/16 <b>senescence [1]</b> 117/7 <b>senior [20]</b> 2/9 4/4 4/7 14/21 15/1 17/20 21/8 28/8 28/14 32/10 37/2 39/24 43/5 46/11 56/20 75/16 77/14 77/16 77/22 78/9 <b>seniority [1]</b> 28/12 <b>sense [10]</b> 10/22 24/4 41/21 46/16 52/16 60/6 62/8 69/22 116/23 147/3 <b>senses [1]</b> 64/11 <b>sent [6]</b> 22/8 22/9 23/13 30/10 31/2 135/11 <b>sentence [3]</b> 111/5 141/4 142/5 <b>sentences [2]</b> 144/18 146/18

<b>S</b>	117/11	<b>similar [10]</b> 39/24 88/24 91/15 108/12 111/15 111/23 111/24 117/15 124/23 125/23	106/17 106/19 146/7 <b>six weeks [1]</b> 38/22 <b>size [1]</b> 93/9 <b>skills [1]</b> 11/1 <b>slagging [1]</b> 21/14 <b>sleep [1]</b> 88/7 <b>slight [1]</b> 28/20 <b>slightly [7]</b> 25/22 42/13 53/1 81/18 96/17 102/9 146/22 <b>slow [5]</b> 2/16 104/2 104/8 132/13 132/16 <b>slowed [1]</b> 69/18 <b>slower [2]</b> 134/15 134/18 <b>slowly [1]</b> 85/20 <b>small [6]</b> 2/12 18/16 38/1 46/4 89/16 91/21 <b>smaller [1]</b> 37/24 <b>so [242]</b> <b>social [13]</b> 4/12 21/19 29/10 33/21 57/9 61/7 62/16 69/14 138/22 139/13 143/12 151/7 151/9 <b>Social Care [3]</b> 4/12 61/7 62/16 <b>social media [3]</b> 139/13 151/7 151/9 <b>societal [4]</b> 47/22 47/25 70/12 79/20 <b>society [3]</b> 76/10 91/2 150/22 <b>socioeconomic [1]</b> 116/13 <b>sofa [1]</b> 73/20 <b>sole [1]</b> 15/7 <b>solely [2]</b> 2/19 37/14 <b>solidity [1]</b> 65/23 <b>solutions [1]</b> 64/13 <b>some [71]</b> 2/24 3/19 12/24 13/19 15/15 15/22 15/23 16/6 16/12 17/7 17/16 17/18 18/17 24/18 25/3 26/20 36/3 40/12 48/7 50/5 51/4 52/14 58/19 59/15 61/13 64/11 64/19 65/8 65/18 67/17 71/6 71/22 72/17 73/10 75/14 77/2 77/9 79/3 81/11 85/25 87/12 88/15 88/19 90/2 91/5 94/14 97/4 97/23 97/25 99/8 107/8 107/11 114/19 117/9 119/11 120/3 124/5 127/18 127/19 135/9 137/25 138/25 140/23 141/10 143/13 145/14 146/17 149/20 149/24 151/6 151/8 <b>somebody [5]</b> 20/21	56/3 78/11 95/17 126/18 <b>someone [5]</b> 20/20 59/20 77/18 87/25 112/18 <b>something [41]</b> 5/12 25/22 27/6 31/25 36/4 38/22 41/23 49/5 52/3 58/10 58/22 63/21 67/16 68/14 68/23 78/3 80/24 88/1 90/22 94/4 95/13 95/23 102/5 102/7 110/13 114/17 114/18 116/18 127/2 127/21 131/12 132/25 133/5 133/15 137/10 140/25 141/16 141/20 144/7 146/17 148/11 <b>somethingth [1]</b> 148/25 <b>sometimes [14]</b> 5/18 12/10 21/1 21/7 26/1 28/14 28/24 64/15 73/7 81/18 86/7 86/7 86/11 94/2 <b>somewhat [4]</b> 16/14 18/12 64/25 107/9 <b>somewhere [1]</b> 149/19 <b>soon [4]</b> 39/7 91/24 107/19 136/6 <b>sooner [1]</b> 30/16 <b>sorry [13]</b> 22/7 42/19 43/1 49/1 101/22 125/6 128/20 129/4 132/1 132/14 134/14 134/15 146/21 <b>sort [34]</b> 8/8 24/12 40/22 45/15 51/5 55/16 56/12 60/10 64/23 66/15 75/23 76/3 81/18 85/14 85/16 85/23 95/11 102/24 108/24 109/10 111/8 118/21 124/11 136/12 138/20 138/21 138/22 141/3 141/10 146/6 148/25 150/4 150/8 150/9 <b>sort of [22]</b> 8/8 24/12 51/5 56/12 60/10 75/23 76/3 81/18 85/14 85/16 85/23 95/11 108/24 109/10 118/21 124/11 136/12 138/21 141/10 150/4 150/8 150/9 <b>SOS [5]</b> 129/9 129/10 129/15 130/1 130/22 <b>source [1]</b> 65/24 <b>sources [1]</b> 79/11 <b>Southall [1]</b> 152/17 <b>Southampton [1]</b>
<b>separate [4]</b> 17/14 46/18 51/9 66/1 <b>separating [1]</b> 46/23 <b>September [5]</b> 52/8 54/8 54/12 83/25 129/22 <b>sequelae [13]</b> 86/9 88/21 90/6 90/14 91/16 92/2 92/18 92/20 92/22 93/18 104/25 107/3 122/17 <b>series [6]</b> 102/22 102/25 105/17 125/15 137/3 146/6 <b>serious [5]</b> 57/6 57/7 60/18 119/12 145/2 <b>seriously [2]</b> 23/16 145/1 <b>seriousness [3]</b> 28/17 33/4 33/14 <b>servant [7]</b> 4/2 4/5 4/7 4/8 15/1 32/10 78/10 <b>servants [14]</b> 8/12 8/14 21/3 27/25 43/6 46/11 48/21 55/20 57/4 57/12 71/24 80/17 80/19 151/5 <b>servants' [2]</b> 58/4 58/25 <b>service [24]</b> 2/11 3/10 4/13 7/10 7/10 8/9 10/7 10/9 10/11 10/23 11/6 11/19 13/24 15/2 15/18 15/19 36/19 38/24 45/19 58/19 58/20 59/3 59/4 81/9 <b>services [3]</b> 36/25 40/8 122/7 <b>servicing [1]</b> 46/15 <b>set [18]</b> 12/25 23/14 53/13 72/24 73/5 79/15 81/8 99/2 102/14 109/22 122/16 131/17 133/2 144/5 144/24 145/6 145/7 146/22 <b>set-up [2]</b> 12/25 102/14 <b>sets [2]</b> 13/10 51/21 <b>setting [9]</b> 45/17 46/4 79/1 94/15 94/24 102/5 103/10 117/3 143/20 <b>settled [1]</b> 74/17 <b>seven [1]</b> 2/12 <b>severe [7]</b> 86/7 93/25 95/7 117/5 118/24 131/14 147/2 <b>severity [1]</b> 92/22 <b>sex [2]</b> 116/12	<b>shall [1]</b> 96/19 <b>shape [1]</b> 77/21 <b>share [1]</b> 110/14 <b>sharing [2]</b> 71/15 151/23 <b>sharp [1]</b> 10/7 <b>sharply [2]</b> 93/19 95/5 <b>she [10]</b> 11/7 13/13 32/12 77/6 77/9 77/9 80/11 112/21 131/16 131/17 <b>Sherwood [13]</b> 128/14 128/15 128/17 129/7 129/8 130/21 131/25 136/24 146/12 150/3 151/12 152/1 154/14 <b>Sherwood's [1]</b> 152/12 <b>shocking [6]</b> 127/14 131/22 132/2 132/5 132/17 132/20 <b>shone [1]</b> 23/24 <b>short [4]</b> 3/21 42/17 96/24 123/13 <b>short-term [1]</b> 3/21 <b>shortage [1]</b> 52/12 <b>shortly [3]</b> 26/14 65/25 103/7 <b>should [21]</b> 5/4 11/3 11/13 21/15 30/1 32/14 35/19 41/19 42/24 55/13 58/13 60/1 62/16 68/22 73/6 75/20 80/25 114/8 138/17 140/9 140/23 <b>shouldn't [2]</b> 72/14 92/7 <b>show [9]</b> 12/1 14/7 53/18 60/18 76/22 109/23 116/24 123/2 124/2 <b>showed [3]</b> 105/8 106/16 107/6 <b>showing [1]</b> 94/6 <b>shown [4]</b> 116/11 116/16 116/20 119/11 <b>shows [2]</b> 29/8 106/18 <b>sick [2]</b> 132/7 142/15 <b>side [5]</b> 7/9 7/11 8/23 63/1 111/4 <b>side-step [1]</b> 63/1 <b>signal [1]</b> 30/10 <b>signed [1]</b> 129/20 <b>significance [1]</b> 61/9 <b>significant [4]</b> 37/22 66/6 80/15 82/7 <b>signing [2]</b> 139/11 139/15 <b>signs [3]</b> 64/1 64/2 112/1	<b>Simon [15]</b> 13/20 14/1 24/24 42/23 43/5 43/6 48/21 49/3 54/8 54/17 55/4 55/24 56/1 56/1 56/10 <b>Simon Case [9]</b> 13/20 14/1 24/24 42/23 43/5 43/6 54/8 55/24 56/1 <b>Simon Ridley [1]</b> 48/21 <b>Simon Ridley's [1]</b> 49/3 <b>SimonC [1]</b> 54/8 <b>simple [3]</b> 15/9 31/23 86/2 <b>simplification [2]</b> 27/6 27/7 <b>simply [4]</b> 112/21 114/8 123/16 142/18 <b>since [6]</b> 9/12 22/21 84/11 84/17 90/10 119/3 <b>sincerest [1]</b> 129/13 <b>Singh [2]</b> 101/3 102/15 <b>single [3]</b> 46/14 46/20 66/15 <b>singular [1]</b> 33/19 <b>Sir [7]</b> 11/23 24/20 26/8 36/22 59/16 68/16 78/16 <b>Sir Humphrey [1]</b> 59/16 <b>Sir Mark Sedwill [1]</b> 36/22 <b>Sir Patrick Vallance</b> <b>[3]</b> 26/8 68/16 78/16 <b>Sir Patrick Vallance's</b> <b>[2]</b> 11/23 24/20 <b>Sisters [1]</b> 152/17 <b>sit [3]</b> 9/18 33/16 144/16 <b>site [1]</b> 138/23 <b>sits [3]</b> 6/14 9/11 9/19 <b>sitting [5]</b> 33/17 50/3 53/25 81/3 146/1 <b>situation [11]</b> 26/1 27/6 32/21 33/13 33/13 36/13 36/15 38/16 58/16 64/22 97/12 <b>six [11]</b> 2/12 25/8 25/19 38/22 54/24 88/8 105/14 106/17 106/19 111/3 146/7 <b>six lines [1]</b> 111/3 <b>six months [7]</b> 25/8 25/19 88/8 105/14		

S				
<p><b>Southampton...</b> [1] 108/11</p> <p><b>SPADs</b> [1] 25/1</p> <p><b>spaghetti</b> [1] 6/6</p> <p><b>spaghetti-gram</b> [1] 6/6</p> <p><b>spans</b> [1] 137/11</p> <p><b>speak</b> [2] 14/22 132/15</p> <p><b>speaking</b> [2] 23/4 114/1</p> <p><b>speaks</b> [1] 56/18</p> <p><b>special</b> [3] 17/11 38/10 55/23</p> <p><b>specialist</b> [1] 101/12</p> <p><b>specialists</b> [2] 45/21 105/23</p> <p><b>specific</b> [5] 5/11 14/14 69/19 69/24 87/9</p> <p><b>specifically</b> [2] 5/4 15/23</p> <p><b>specifics</b> [1] 16/13</p> <p><b>Spectacular</b> [2] 55/4 56/11</p> <p><b>spectrum</b> [1] 95/16</p> <p><b>speculation</b> [1] 141/16</p> <p><b>speed</b> [1] 71/8</p> <p><b>spending</b> [1] 77/13</p> <p><b>spent</b> [3] 121/21 121/24 122/12</p> <p><b>sphere</b> [3] 48/14 57/17 71/7</p> <p><b>spoke</b> [2] 77/5 99/24</p> <p><b>spoken</b> [3] 23/23 25/4 34/23</p> <p><b>spread</b> [2] 76/1 76/2</p> <p><b>squeezed</b> [1] 65/4</p> <p><b>stability</b> [1] 8/6</p> <p><b>staff</b> [4] 18/9 18/13 18/14 18/15</p> <p><b>stage</b> [9] 32/11 92/4 92/12 92/21 101/18 108/4 116/25 142/10 149/6</p> <p><b>stages</b> [1] 113/17</p> <p><b>stand</b> [2] 3/2 38/18</p> <p><b>standing</b> [2] 44/12 129/1</p> <p><b>stark</b> [1] 59/18</p> <p><b>start</b> [14] 6/3 37/6 61/24 85/22 94/18 98/15 103/17 104/3 115/6 118/14 119/11 131/4 136/21 139/9</p> <p><b>started</b> [11] 90/9 91/25 92/12 98/25 100/19 101/20 109/1 113/6 131/8 146/13 146/15</p> <p><b>starting</b> [9] 28/8</p>	<p>102/24 103/1 107/19 110/18 111/5 133/18 141/4 142/16</p> <p><b>starts</b> [1] 136/2</p> <p><b>state</b> [15] 10/25 11/19 12/23 19/8 29/9 29/24 39/20 40/5 40/11 45/3 53/12 57/9 64/6 103/9 123/18</p> <p><b>stated</b> [2] 4/25 5/16</p> <p><b>statement</b> [26] 1/20 32/12 49/5 49/12 83/21 123/21 129/16 129/19 129/20 130/7 130/10 130/12 130/23 133/19 134/21 134/24 135/22 136/1 139/1 142/22 146/9 146/15 148/14 150/7 151/19 151/20</p> <p><b>statements</b> [3] 48/20 130/5 152/17</p> <p><b>stating</b> [1] 129/20</p> <p><b>statistics</b> [2] 116/11 116/24</p> <p><b>status</b> [3] 13/17 13/23 116/13</p> <p><b>stayed</b> [1] 140/22</p> <p><b>steadily</b> [1] 36/17</p> <p><b>stenographer</b> [1] 82/15</p> <p><b>step</b> [3] 37/13 63/1 107/22</p> <p><b>step 3</b> [1] 107/22</p> <p><b>Stephen</b> [1] 143/9</p> <p><b>steps</b> [1] 135/21</p> <p><b>sticking</b> [1] 100/4</p> <p><b>stigmatise</b> [1] 151/9</p> <p><b>still</b> [19] 2/8 22/3 22/11 25/14 25/18 74/17 76/16 80/23 111/18 118/1 119/3 119/6 127/15 133/10 140/17 145/11 148/22 150/25 152/25</p> <p><b>stop</b> [3] 43/17 48/12 145/24</p> <p><b>stories</b> [1] 150/18</p> <p><b>strain</b> [2] 17/22 74/15</p> <p><b>strategic</b> [2] 75/21 76/17</p> <p><b>strategies</b> [1] 118/17</p> <p><b>strategy</b> [10] 42/5 45/16 46/4 46/4 46/23 47/7 75/10 75/15 75/22 78/19</p> <p><b>stream</b> [1] 102/16</p> <p><b>Street</b> [2] 26/14 32/25</p> <p><b>strength</b> [1] 64/14</p> <p><b>stress</b> [1] 133/15</p> <p><b>stressful</b> [2] 20/19 88/4</p> <p><b>stressor</b> [2] 87/24</p>	<p>88/5</p> <p><b>string</b> [1] 21/25</p> <p><b>strong</b> [4] 39/17 52/16 65/21 138/12</p> <p><b>stronger</b> [1] 30/9</p> <p><b>strongly</b> [2] 26/19 127/11</p> <p><b>struck</b> [1] 134/6</p> <p><b>structural</b> [6] 13/8 16/2 20/14 26/17 63/22 67/24</p> <p><b>structurally</b> [2] 39/1 68/7</p> <p><b>structure</b> [15] 16/8 27/13 32/15 34/5 37/22 38/18 40/11 43/18 45/10 46/7 46/10 64/25 66/4 67/22 81/9</p> <p><b>structured</b> [1] 77/10</p> <p><b>structures</b> [6] 6/24 27/1 39/12 67/10 75/9 80/9</p> <p><b>struggle</b> [1] 140/2</p> <p><b>struggling</b> [1] 138/9</p> <p><b>studies</b> [15] 89/15 94/5 94/6 105/4 108/14 108/24 109/7 110/10 116/17 116/19 122/2 122/6 122/16 122/20 122/21</p> <p><b>study</b> [33] 32/18 34/23 92/10 92/13 93/15 94/15 94/22 94/24 95/3 96/8 96/14 97/5 104/15 104/19 104/21 105/8 106/16 107/18 107/24 108/1 108/4 108/13 108/19 108/20 109/8 109/11 109/18 109/20 109/21 109/24 110/1 110/2 110/6</p> <p><b>studying</b> [2] 84/17 85/2</p> <p><b>stuff</b> [4] 56/9 77/15 125/2 125/21</p> <p><b>Sturgeon</b> [1] 31/13</p> <p><b>style</b> [4] 3/12 32/17 40/25 46/25</p> <p><b>subcommittee</b> [7] 40/19 40/21 44/7 47/10 50/2 50/7 53/14</p> <p><b>subcommittees</b> [5] 41/13 45/23 50/9 50/14 50/18</p> <p><b>subgroups</b> [2] 145/6 145/7</p> <p><b>subject</b> [4] 42/13 47/5 96/8 96/14</p> <p><b>suborganisations</b> [1] 137/19</p> <p><b>subsequent</b> [2] 89/19 93/4</p>	<p><b>subsequently</b> [2] 30/6 73/4</p> <p><b>substantial</b> [3] 72/20 80/18 119/7</p> <p><b>substantive</b> [5] 5/24 21/17 52/2 73/18 138/7</p> <p><b>successful</b> [1] 63/11</p> <p><b>successive</b> [1] 5/20</p> <p><b>such</b> [13] 3/11 19/14 55/20 89/3 89/19 106/5 109/6 109/11 114/5 117/17 121/18 127/9 136/8</p> <p><b>suffer</b> [3] 88/15 119/12 133/9</p> <p><b>suffered</b> [2] 59/20 126/15</p> <p><b>sufferers</b> [1] 98/8</p> <p><b>suffering</b> [15] 93/16 93/19 96/12 97/6 97/9 97/14 99/20 132/3 132/4 132/5 132/10 134/10 134/20 140/7 141/9</p> <p><b>sufficiently</b> [3] 64/21 67/3 68/1</p> <p><b>suggest</b> [6] 24/8 26/15 71/20 79/16 119/3 121/23</p> <p><b>suggested</b> [1] 43/21</p> <p><b>suggesting</b> [3] 58/17 127/2 143/11</p> <p><b>suggests</b> [3] 28/4 53/3 123/12</p> <p><b>suit</b> [1] 32/16</p> <p><b>suited</b> [1] 46/25</p> <p><b>summarise</b> [2] 104/23 118/21</p> <p><b>summarised</b> [2] 26/22 152/15</p> <p><b>summarising</b> [1] 111/21</p> <p><b>summary</b> [6] 41/18 69/7 84/7 105/7 146/11 147/18</p> <p><b>summer</b> [4] 17/5 26/2 42/1 102/25</p> <p><b>Sunday</b> [1] 53/18</p> <p><b>supercharged</b> [2] 79/18 80/3</p> <p><b>superficial</b> [1] 62/22</p> <p><b>superhero</b> [2] 77/20 77/25</p> <p><b>support</b> [22] 9/11 18/14 67/7 71/9 76/25 95/20 95/20 95/21 98/14 100/24 113/10 114/2 129/12 130/3 130/9 130/18 131/18 131/18 135/17 139/10 139/11 139/17</p> <p><b>supported</b> [5] 100/16 100/21 101/15 108/15</p>	<p>133/24</p> <p><b>supporting</b> [2] 46/6 143/13</p> <p><b>supports</b> [1] 116/17</p> <p><b>suppose</b> [6] 7/1 7/5 30/5 33/6 50/21 140/16</p> <p><b>supposed</b> [2] 78/1 144/12</p> <p><b>suppression</b> [1] 75/24</p> <p><b>supreme</b> [3] 49/18 49/20 50/14</p> <p><b>sure</b> [11] 16/12 44/14 49/7 59/10 65/15 103/6 109/24 123/5 123/15 126/20 151/17</p> <p><b>surprise</b> [5] 31/18 42/19 65/16 82/23 107/5</p> <p><b>surprised</b> [4] 35/19 78/13 107/9 126/17</p> <p><b>surrounding</b> [1] 14/9</p> <p><b>sustained</b> [1] 127/1</p> <p><b>sustains</b> [1] 27/21</p> <p><b>Swann</b> [1] 31/9</p> <p><b>swift</b> [1] 72/1</p> <p><b>swiftly</b> [1] 92/1</p> <p><b>switching</b> [1] 89/7</p> <p><b>sworn</b> [1] 83/5</p> <p><b>sympathise</b> [1] 145/22</p> <p><b>symptom</b> [2] 88/2 141/10</p> <p><b>symptoms</b> [57] 86/10 86/12 86/20 87/13 88/1 88/3 88/8 88/14 88/15 89/19 95/7 95/11 97/7 97/10 97/14 99/5 99/20 99/23 101/2 105/4 106/21 107/12 109/4 111/16 112/2 113/9 114/18 114/22 115/1 115/4 115/8 115/10 115/12 115/16 115/17 116/22 116/25 119/13 120/21 124/23 131/17 131/21 132/8 132/9 132/10 132/17 132/18 133/6 135/1 135/9 135/12 135/14 140/1 140/6 140/10 141/17 141/23</p> <p><b>syndrome</b> [25] 85/25 86/3 86/15 86/21 86/25 87/10 87/14 87/15 87/17 87/19 87/19 87/22 88/11 91/18 91/22 94/4 95/14 95/24 99/11 99/22 101/13 111/5 112/1 125/2 125/20</p> <p><b>syndromes</b> [10] 86/4</p>

**S**  
**syndromes... [9]**  
 86/10 87/3 88/10  
 88/21 96/3 98/17  
 110/11 115/7 135/7  
**synthesis [6]** 18/3  
 26/7 45/20 48/11  
 63/17 70/11  
**synthesise [4]** 11/11  
 16/14 20/1 79/19  
**synthesised [1]**  
 34/18  
**synthesising [3]**  
 16/10 46/20 63/6  
**system [21]** 7/20  
 12/5 12/10 15/6 26/25  
 39/5 39/6 44/22 45/4  
 64/20 67/13 67/18  
 73/2 73/5 74/14 74/17  
 78/5 78/24 78/25  
 79/10 81/1  
**systemic [2]** 14/22  
 74/20  
**systems [4]** 67/10  
 76/19 76/21 82/7

**T**  
**take [39]** 4/24 5/10  
 5/18 5/21 8/18 28/20  
 34/7 37/6 38/5 41/8  
 44/10 45/23 45/24  
 51/4 53/16 55/3 56/7  
 56/21 56/24 59/3 59/4  
 66/11 66/13 72/3  
 72/15 77/22 80/24  
 85/7 85/20 89/10  
 92/23 114/25 115/5  
 131/3 145/5 146/14  
 147/3 150/11 150/12  
**taken [14]** 33/20  
 33/24 33/25 33/25  
 34/2 34/23 35/2 36/7  
 50/23 54/7 73/21  
 78/18 104/10 145/1  
**takes [3]** 5/20 82/22  
 137/10  
**taking [6]** 5/16 25/14  
 45/17 50/12 81/18  
 145/19  
**tale [1]** 15/9  
**talented [2]** 10/19  
 16/6  
**talk [6]** 46/13 92/8  
 101/13 115/11 115/24  
 138/8  
**talked [7]** 22/2 22/11  
 65/19 69/3 72/12  
 77/19 109/25  
**talking [9]** 54/15  
 75/22 87/2 100/14  
 118/19 124/9 132/14  
 142/15 144/25  
**tank [2]** 2/1 2/6

**target [1]** 107/20  
**taskforce [25]** 26/3  
 45/8 45/13 46/1 46/8  
 46/11 46/12 46/14  
 46/22 48/3 48/9 48/22  
 49/14 51/1 51/4 51/9  
 102/6 102/11 143/20  
 144/3 144/4 144/16  
 144/22 145/4 145/8  
**teach [1]** 109/5  
**team [12]** 2/12 2/22  
 2/24 9/11 19/21 32/19  
 46/13 60/25 61/2 61/3  
 77/21 101/10  
**team's [1]** 2/25  
**teams [2]** 9/9 9/14  
**teenagers [2]** 89/5  
 89/5  
**teens [1]** 32/8  
**tell [9]** 5/4 23/4  
 100/18 114/10 131/7  
 132/2 133/18 137/15  
 144/20  
**tells [4]** 37/18 73/14  
 87/9 113/2  
**temperate [1]** 55/23  
**tend [6]** 4/24 9/2 24/8  
 74/6 115/14 116/22  
**tended [2]** 8/10  
 145/24  
**tendency [3]** 64/12  
 64/16 65/11  
**tends [2]** 7/19 116/22  
**tens [1]** 139/7  
**term [24]** 3/21 88/20  
 89/15 90/6 90/14  
 90/21 91/15 92/2  
 92/18 92/20 93/18  
 97/7 98/2 104/24  
 104/25 106/24 107/3  
 112/13 119/13 121/21  
 121/25 122/17 133/12  
 138/12  
**terms [35]** 9/17 14/6  
 15/25 17/2 19/7 21/18  
 36/8 39/5 41/3 45/16  
 51/21 52/5 53/21 62/2  
 66/8 68/11 71/5 74/25  
 75/1 75/3 79/16 82/6  
 86/9 89/14 92/11  
 103/3 104/4 106/9  
 109/9 115/15 118/25  
 120/11 122/9 122/14  
 138/18  
**terrible [1]** 21/6  
**territory [1]** 32/20  
**terrorist [1]** 34/11  
**test [9]** 29/3 38/18  
 87/9 89/22 112/15  
 112/16 112/16 113/7  
 113/11  
**testing [6]** 89/21  
 94/17 94/21 97/15  
 109/17 109/22

**tests [4]** 106/5 106/5  
 106/5 106/6  
**text [3]** 11/25 14/7  
 71/25  
**than [33]** 4/23 10/8  
 21/15 22/14 24/17  
 26/17 30/14 40/1 40/5  
 40/22 44/12 45/2  
 46/18 51/15 53/4  
 55/24 57/4 58/16 60/5  
 72/24 73/17 74/24  
 77/15 86/22 89/12  
 89/12 89/13 107/24  
 112/6 118/6 119/1  
 119/6 137/21  
**thank [40]** 1/13 30/20  
 32/9 43/4 47/16 54/4  
 77/4 82/10 82/13  
 82/16 82/17 82/19  
 83/6 83/12 84/4 86/18  
 93/11 96/19 96/22  
 102/17 110/16 110/23  
 122/23 123/7 124/1  
 128/3 128/6 128/7  
 128/10 128/11 129/5  
 129/14 151/25 152/1  
 152/7 152/8 152/24  
 152/25 153/1 153/5  
**thank you [28]** 1/13  
 43/4 47/16 54/4 77/4  
 82/10 82/17 82/19  
 83/6 83/12 84/4 86/18  
 93/11 96/22 102/17  
 110/16 122/23 123/7  
 124/1 128/6 128/7  
 128/10 128/11 129/5  
 129/14 152/25 153/1  
 153/5  
**thanks [1]** 72/17  
**that [860]**  
**that's [76]** 3/17 4/6  
 4/16 5/2 7/5 9/2 9/25  
 11/13 14/5 15/20  
 17/13 22/2 23/1 29/7  
 29/13 33/1 37/3 37/8  
 38/7 42/9 49/5 50/19  
 54/8 56/22 69/14 78/4  
 79/13 83/14 84/10  
 84/20 85/5 87/17 88/7  
 88/9 88/12 88/17 89/7  
 92/19 95/4 95/23  
 99/25 100/14 101/9  
 101/21 102/17 103/2  
 105/20 107/21 110/12  
 111/8 112/19 112/24  
 113/5 113/20 116/4  
 116/4 116/7 116/16  
 116/16 118/6 119/6  
 119/14 120/11 124/15  
 126/22 129/5 137/22  
 138/12 141/14 141/23  
 142/9 143/24 144/14  
 152/22 152/23 152/23  
**their [60]** 12/21 12/23

13/19 13/23 13/23  
 15/3 15/12 20/22  
 20/23 27/3 30/13  
 30/19 37/16 40/12  
 46/12 47/4 50/14  
 56/23 57/3 58/13  
 58/14 60/14 64/8  
 73/11 75/1 77/13 81/7  
 81/23 89/18 92/22  
 95/12 95/15 95/21  
 95/21 97/12 97/13  
 97/13 101/7 101/10  
 101/25 109/4 113/22  
 115/7 115/9 119/9  
 126/16 132/5 132/6  
 134/3 134/5 135/13  
 135/13 135/20 138/10  
 140/2 140/10 140/23  
 141/18 149/23 149/25  
**them [37]** 5/1 5/1  
 5/17 10/19 21/4 34/7  
 39/19 41/16 51/12  
 59/18 73/12 79/15  
 79/16 80/12 80/25  
 82/7 83/25 89/17 94/2  
 96/14 98/1 98/14  
 114/10 114/10 118/24  
 127/20 130/7 132/19  
 137/24 138/9 140/23  
 140/24 141/14 144/6  
 144/20 149/20 149/24  
**theme [3]** 19/5  
 133/19 148/18  
**themes [2]** 77/10  
 134/21  
**themselves [8]** 13/7  
 41/9 60/6 68/4 70/9  
 99/6 112/22 126/16  
**then [125]** 4/9 4/25  
 5/16 5/22 6/9 8/22  
 16/4 18/19 19/14 20/5  
 22/4 22/25 26/2 27/1  
 29/8 29/16 31/1 35/9  
 36/6 36/7 36/22 38/12  
 43/3 43/6 46/6 46/21  
 47/3 51/11 52/6 53/12  
 54/19 55/1 56/10  
 56/14 75/15 83/25  
 85/19 86/18 88/1 88/6  
 88/8 89/5 90/4 90/11  
 90/19 90/20 90/23  
 90/24 91/24 92/4 92/5  
 93/3 93/4 93/9 94/18  
 96/4 97/8 99/6 99/8  
 101/11 101/22 102/5  
 102/25 103/6 103/8  
 103/9 103/9 103/10  
 104/10 104/12 104/13  
 104/15 105/13 106/1  
 106/2 106/3 106/4  
 107/11 107/16 107/17  
 107/18 107/19 108/14  
 109/3 109/10 109/13  
 109/21 110/3 110/5

110/14 111/10 113/9  
 115/3 115/21 116/10  
 116/17 117/9 117/18  
 117/20 118/11 118/14  
 118/14 118/15 118/16  
 118/24 119/7 121/2  
 121/5 121/11 121/12  
 121/15 122/3 122/7  
 122/11 122/21 122/21  
 124/5 126/25 127/8  
 136/12 137/5 146/10  
 147/8 148/16 148/18  
**theory [1]** 62/15  
**there [222]**  
**there's [18]** 9/10 11/2  
 13/21 18/16 22/9  
 35/17 62/14 65/6 86/2  
 86/5 92/24 95/16  
 112/15 113/4 116/23  
 121/16 150/14 152/10  
**there's ongoing [1]**  
 11/2  
**thereby [1]** 82/4  
**therefore [11]** 2/19  
 9/21 18/7 26/22 40/14  
 50/8 56/2 70/4 87/5  
 105/22 117/24  
**therein [1]** 15/9  
**these [45]** 7/19 20/12  
 21/16 23/19 32/1  
 39/12 40/3 40/10  
 46/15 54/13 55/15  
 55/17 58/4 59/17 60/4  
 60/14 67/25 69/8  
 72/19 75/17 80/8  
 81/19 86/20 88/20  
 90/13 92/22 93/18  
 104/1 104/19 106/3  
 108/3 115/25 117/24  
 118/3 122/16 123/1  
 132/9 135/14 140/6  
 145/20 145/25 146/7  
 147/14 148/16 150/4  
**they [130]** 2/13 3/23  
 5/14 9/11 10/5 10/9  
 10/18 11/11 12/1  
 13/22 13/22 14/17  
 14/19 17/7 18/21  
 22/17 30/24 31/11  
 33/25 33/25 35/19  
 38/14 39/13 40/3  
 43/16 43/21 44/3  
 44/13 45/24 50/7  
 54/14 54/15 54/15  
 56/20 58/17 59/18  
 60/3 62/21 62/21 64/3  
 64/7 64/8 64/8 64/10  
 68/5 71/18 72/2 72/2  
 72/13 73/11 74/7 74/9  
 74/23 77/22 80/2  
 86/12 86/13 86/13  
 87/7 88/6 88/11 89/16  
 89/19 89/20 89/21  
 89/21 92/23 93/25

<b>T</b>	70/20 71/17 71/19 74/3 74/3 74/4 74/23 75/12 76/13 76/17 78/9 79/13 80/5 80/23 80/23 81/13 81/16 81/23 82/14 82/21 82/23 83/14 88/22 89/4 91/24 98/2 98/5 98/10 99/13 100/5 100/20 101/5 102/23 102/24 103/21 104/7 109/1 118/12 120/2 120/16 122/9 127/22 129/2 133/10 133/15 136/12 136/22 138/14 138/19 139/18 139/19 140/21 141/15 141/25 143/21 148/24 151/3 <b>think tank [2]</b> 2/1 2/6 <b>thinking [6]</b> 7/6 33/6 71/16 119/7 121/24 122/2 <b>thinks [1]</b> 23/24 <b>third [3]</b> 9/8 69/20 141/3 <b>this [174]</b> <b>Thomas [23]</b> 1/7 1/8 1/12 1/13 2/15 6/7 11/4 15/25 19/1 21/11 22/13 27/12 34/20 42/20 47/17 57/24 59/6 60/7 69/5 77/3 81/4 82/13 154/3 <b>thorough [1]</b> 74/10 <b>those [118]</b> 5/14 7/11 8/10 8/16 9/7 10/25 11/2 11/10 11/19 12/7 13/16 15/25 18/1 18/14 18/16 18/23 22/16 22/17 26/23 27/18 31/3 33/18 33/24 34/1 35/13 39/15 40/7 41/22 41/24 41/24 45/21 46/7 46/17 46/19 47/13 48/17 50/9 51/6 51/10 51/18 51/20 52/19 53/5 56/24 57/19 66/13 67/9 73/2 74/8 74/9 74/20 75/21 76/5 79/19 81/25 83/24 84/18 85/3 86/10 88/8 89/1 89/8 90/11 90/13 93/4 93/6 93/19 94/3 94/6 94/12 96/5 96/7 97/22 97/23 98/3 98/7 98/16 98/22 99/22 100/4 100/24 103/15 103/17 103/20 104/9 104/16 105/16 106/9 106/11 107/14 108/5 108/6 109/2 109/7 113/25 114/25 115/16 116/10 116/14	117/5 117/12 118/8 119/9 122/6 122/20 124/11 125/25 128/4 130/6 130/13 133/1 134/1 140/22 143/22 144/18 147/1 149/24 151/24 <b>though [10]</b> 25/21 52/16 57/16 78/12 87/9 96/9 106/14 116/5 135/6 146/1 <b>thought [6]</b> 33/12 59/10 68/18 94/20 131/12 148/9 <b>thousands [4]</b> 138/8 138/16 139/7 142/7 <b>thread [1]</b> 22/1 <b>threads [2]</b> 50/5 77/2 <b>three [5]</b> 75/6 77/6 112/7 123/8 130/14 <b>three days [1]</b> 77/6 <b>threshold [1]</b> 28/17 <b>through [48]</b> 3/8 15/15 17/4 17/12 21/20 32/17 33/16 34/22 39/14 39/16 43/11 44/3 49/15 49/15 50/9 50/13 50/17 51/6 51/13 59/11 59/22 60/17 61/13 62/10 68/25 73/6 73/11 76/12 76/12 79/15 82/3 85/7 100/23 101/2 101/10 101/13 103/4 105/23 107/22 110/3 111/11 113/21 121/11 124/8 127/1 127/17 127/22 138/4 <b>throughout [2]</b> 71/12 130/18 <b>throw [1]</b> 131/13 <b>tier [1]</b> 3/14 <b>tiering [1]</b> 67/5 <b>tiers [2]</b> 67/25 77/12 <b>tightened [1]</b> 80/10 <b>til [2]</b> 55/3 56/7 <b>tilt [1]</b> 9/3 <b>time [61]</b> 4/3 4/4 4/21 4/21 7/21 8/10 13/3 14/14 24/14 27/18 31/15 34/16 37/4 38/8 38/17 38/18 40/25 41/14 45/7 46/21 47/1 48/3 48/6 48/7 54/9 54/24 57/23 76/21 77/13 78/14 81/17 82/21 82/22 86/17 90/25 94/20 105/14 108/2 113/5 114/12 118/3 120/16 120/25 121/21 121/24 122/12 124/21 125/25 126/14 128/24 132/6 133/24	138/13 139/18 139/20 141/21 144/4 144/20 146/13 148/5 149/21 <b>times [7]</b> 8/11 10/9 12/19 37/15 66/19 126/11 131/16 <b>timetabling [1]</b> 128/18 <b>timing [3]</b> 103/3 122/10 126/3 <b>tin [1]</b> 47/19 <b>title [1]</b> 123/12 <b>today [4]</b> 40/24 55/4 56/11 84/16 <b>together [25]</b> 11/10 11/12 12/5 16/17 16/24 27/25 45/7 47/21 47/24 48/3 50/4 63/5 70/13 79/19 85/9 97/18 97/21 100/25 103/4 105/19 107/13 111/13 115/16 115/17 137/1 <b>told [10]</b> 50/6 66/2 71/22 92/17 135/10 135/12 140/1 140/1 141/8 141/24 <b>tolerated [1]</b> 77/16 <b>tone [1]</b> 19/5 <b>too [12]</b> 61/25 64/6 77/10 77/11 77/16 77/21 81/2 82/23 128/22 132/14 132/15 133/14 <b>took [6]</b> 41/14 41/22 48/7 52/23 74/14 135/21 <b>top [14]</b> 6/7 19/3 21/9 22/8 27/15 46/10 75/5 77/4 77/12 88/6 96/2 104/20 114/20 114/21 <b>topic [4]</b> 90/5 92/17 93/12 96/17 <b>topics [2]</b> 85/7 136/12 <b>total [2]</b> 18/13 54/20 <b>touch [2]</b> 3/20 120/1 <b>touched [2]</b> 101/17 110/19 <b>touching [1]</b> 3/11 <b>towards [13]</b> 9/3 9/5 11/5 16/19 27/15 92/12 99/13 100/5 101/8 104/3 114/14 121/19 124/11 <b>trained [1]</b> 113/24 <b>training [1]</b> 80/18 <b>tranche [1]</b> 104/14 <b>tranches [1]</b> 152/16 <b>translate [1]</b> 5/17 <b>translational [1]</b> 105/24 <b>transmitting [2]</b> 18/18 18/20	<b>transparency [2]</b> 4/1 68/15 <b>transparent [1]</b> 80/12 <b>transparently [2]</b> 73/4 73/22 <b>transpired [1]</b> 62/19 <b>trauma [1]</b> 135/19 <b>traumatic [1]</b> 141/1 <b>Treasury [5]</b> 65/4 70/24 71/9 71/14 71/18 <b>treating [3]</b> 84/13 84/18 85/3 <b>treatment [5]</b> 95/12 118/17 128/8 136/5 136/19 <b>treatments [4]</b> 105/1 122/8 122/22 145/12 <b>trespassing [1]</b> 39/13 <b>triggering [1]</b> 28/23 <b>triggers [1]</b> 117/23 <b>trolley [3]</b> 55/1 55/2 56/6 <b>trouble [2]</b> 6/10 145/12 <b>true [4]</b> 20/23 78/4 93/8 129/21 <b>truly [1]</b> 22/6 <b>trust [2]</b> 23/21 84/23 <b>truth [1]</b> 10/16 <b>try [10]</b> 12/3 12/4 12/5 85/10 85/20 90/19 118/8 134/11 134/16 146/19 <b>trying [6]</b> 59/21 90/18 99/6 104/5 141/12 142/9 <b>turf [1]</b> 64/8 <b>turn [5]</b> 90/4 96/18 106/7 114/17 136/1 <b>turned [1]</b> 97/10 <b>two [46]</b> 7/11 8/15 14/18 14/19 14/20 17/14 18/6 22/16 22/17 25/15 38/22 39/8 42/3 43/5 44/24 46/7 46/15 46/17 50/9 50/21 55/23 57/24 71/5 77/12 83/16 85/11 89/18 92/10 92/24 102/7 103/15 105/13 112/5 116/2 117/21 120/6 124/2 125/22 129/11 129/15 130/3 130/6 137/18 137/24 143/21 149/20 <b>two groups [1]</b> 129/15 <b>two months [1]</b> 38/22 <b>two weeks [1]</b> 149/20 <b>two years [1]</b> 89/18
----------	---	--	---	---

<b>T</b>	14/8	92/17 93/21 100/18	20/10 21/2 26/5 26/11	<b>viral [22]</b> 9/22 85/25
<b>type [3]</b> 40/19 40/24	<b>unhelpful [1]</b> 17/22	105/2 105/7 106/1	26/11 27/8 32/9 33/14	86/3 86/4 86/10 86/20
118/15	<b>unit [4]</b> 18/16 45/20	106/25 107/8 107/11	43/5 44/2 50/1 51/4	86/24 87/3 87/17
<b>types [2]</b> 30/3 106/10	95/11 95/19	109/5 112/22 113/2	51/4 57/8 61/17 61/21	88/10 88/21 88/24
<b>typical [1]</b> 86/10	<b>United [5]</b> 9/17 12/25	113/7 115/5 117/18	71/10 75/12 82/13	91/18 95/14 96/3
<b>U</b>	49/19 66/7 66/22	118/12 122/15 128/20	82/13 82/15 82/16	98/17 110/11 115/7
<b>UK [9]</b> 5/22 61/11	<b>United Kingdom [2]</b>	129/6 129/19 131/7	85/9 85/22 86/8 86/8	135/6 135/7 141/10
66/11 81/1 99/2 99/10	12/25 66/22	132/2 133/18 134/9	86/14 86/16 86/23	141/24
101/10 137/11 143/2	<b>universal [1]</b> 77/9	134/10 143/14 144/21	86/25 87/19 88/9	<b>virtue [1]</b> 59/7
<b>ultimate [2]</b> 15/7	<b>University [4]</b> 84/8	145/11 147/7 150/3	88/24 90/8 90/15	<b>virus [16]</b> 55/5 76/1
60/23	84/23 85/1 101/4	150/7 151/23 152/13	90/22 91/21 92/3	76/3 86/6 86/6 86/9
<b>ultimately [12]</b> 4/12	<b>unless [2]</b> 82/23	<b>use [5]</b> 65/13 72/8	92/20 93/25 94/11	86/14 86/15 86/24
10/10 15/13 15/20	132/7	73/11 112/12 140/13	94/19 95/6 96/4 96/10	88/25 89/3 90/10 92/2
33/22 47/14 53/9	<b>unlike [2]</b> 133/16	<b>used [6]</b> 40/17 43/23	96/19 98/12 98/25	94/9 107/2 131/13
67/13 67/15 68/25	137/25	66/15 72/15 111/9	102/20 103/3 104/10	<b>viruses [5]</b> 88/20
79/12 79/23	<b>unprecedented [1]</b>	135/16	104/16 106/18 106/21	89/1 89/2 89/3 91/22
<b>unable [2]</b> 63/8 70/9	57/12	<b>useful [2]</b> 35/21 36/1	107/10 107/19 107/21	<b>vital [5]</b> 11/20 16/15
<b>unaware [1]</b> 149/15	<b>unrefreshing [1]</b> 88/7	<b>usefully [2]</b> 8/15	108/2 108/11 109/20	50/8 61/22 79/6
<b>unbelievable [1]</b>	<b>unrelated [1]</b> 5/18	41/23	110/23 111/15 111/23	<b>voice [3]</b> 97/18
127/5	<b>unsurprised [1]</b>	<b>usefulness [2]</b> 35/17	111/24 113/16 113/23	126/25 150/23
<b>uncertainty [1]</b>	26/10	<b>using [4]</b> 72/13 90/1	113/25 114/20 115/8	<b>voicing [1]</b> 97/13
141/13	<b>untangle [1]</b> 67/7	112/10 150/23	115/10 116/1 116/8	<b>void [1]</b> 70/9
<b>unclear [2]</b> 12/11	<b>untenable [1]</b> 54/20	<b>usual [1]</b> 15/17	118/1 118/8 119/11	<b>volatility [1]</b> 23/7
79/11	<b>until [8]</b> 30/25 31/17	<b>utilised [1]</b> 71/24	119/12 119/12 120/10	<b>volunteer [1]</b> 131/6
<b>uncodified [1]</b> 49/21	33/17 45/4 93/8	<b>V</b>	120/20 120/21 120/22	<b>volunteer-run [1]</b>
<b>uncommon [4]</b> 21/14	121/10 121/25 153/7	<b>vaccinate [1]</b> 147/16	121/9 121/24 122/5	131/6
35/15 45/18 57/1	<b>unusual [4]</b> 20/20	<b>vaccinated [7]</b>	122/12 124/23 125/11	<b>volunteers [1]</b>
<b>under [5]</b> 6/9 54/24	59/25 112/25 113/4	146/16 147/1 147/6	127/11 127/15 127/24	137/14
74/15 81/6 101/18	<b>Unusually [1]</b> 32/19	147/12 147/14 147/15	128/2 128/2 128/3	<b>vulnerability [1]</b>
<b>under way [1]</b> 101/18	<b>unwell [3]</b> 96/1	147/16	128/7 131/1 131/11	133/11
<b>undergone [1]</b> 95/9	133/13 149/21	<b>vaccination [1]</b> 90/19	132/7 132/12 132/12	<b>vulnerable [4]</b> 146/25
<b>underlying [2]</b> 99/24	<b>unwilling [1]</b> 63/9	<b>vaccine [6]</b> 119/3	135/5 135/5 140/14	147/6 150/19 150/21
118/9	<b>unwritten [1]</b> 81/6	121/20 122/11 146/13	141/1 142/5 142/7	<b>W</b>
<b>underneath [1]</b> 6/8	<b>up [65]</b> 6/5 10/20	146/24 147/20	142/17 144/23 144/24	<b>waited [1]</b> 69/23
<b>understand [24]</b>	12/25 13/16 13/22	<b>vaccines [1]</b> 136/10	145/8 145/15 145/20	<b>Wales [2]</b> 31/6
18/12 31/4 31/16 37/3	23/14 37/13 50/5 55/5	<b>Vallance [5]</b> 26/8	145/20 145/21 146/3	137/21
44/5 44/11 54/14	56/11 56/13 63/17	68/16 78/16 137/5	147/18 148/18 149/20	<b>want [18]</b> 29/2 55/4
54/15 63/20 76/13	65/14 65/15 68/23	143/7	149/21 150/1 150/13	56/11 56/13 64/12
83/24 90/13 104/6	69/9 77/2 80/10 81/8	<b>Vallance's [2]</b> 11/23	150/15 150/15 150/21	76/22 93/12 103/7
105/11 109/7 118/3	84/7 89/17 90/24 92/4	24/20	150/25 151/12 151/17	110/17 122/24 133/5
118/8 120/18 131/11	92/8 92/15 94/15	<b>value [4]</b> 35/15 36/18	151/22 151/25 152/1	134/23 136/20 138/3
134/5 141/17 141/19	94/19 94/24 95/19	80/5 109/23	152/1 152/7 152/8	138/5 146/5 150/16
141/20 142/14	99/2 99/4 100/9 102/5	<b>variability [1]</b> 86/20	152/10 152/24	151/6
<b>understanding [18]</b>	102/14 103/10 109/22	<b>variable [6]</b> 86/14	<b>veterans' [1]</b> 9/10	<b>wanted [4]</b> 5/21
22/16 29/7 29/13	110/21 111/3 111/13	86/23 87/1 115/8	<b>victim [1]</b> 59/20	102/17 105/10 123/25
30/20 37/8 38/7 41/18	112/9 116/8 118/14	115/10 120/22	<b>victims [1]</b> 138/8	<b>wanting [1]</b> 69/23
45/13 59/23 83/22	122/16 130/7 131/17	<b>various [16]</b> 5/25 7/2	<b>video [1]</b> 119/10	<b>war [5]</b> 24/25 74/1
91/13 93/18 116/25	133/2 134/21 136/23	9/16 11/10 14/14	<b>view [31]</b> 19/17 20/7	77/17 125/2 125/20
118/2 120/1 120/16	138/5 139/11 139/15	16/19 63/5 67/22 85/7	20/9 20/25 24/10	<b>wards [1]</b> 150/19
122/25 123/13	142/21 142/25 143/5	85/12 98/22 104/1	29/22 30/7 30/9 31/20	<b>warmed [1]</b> 32/16
<b>understood [4]</b> 59/6	143/20 144/5 144/24	124/17 143/18 143/22	33/3 34/14 35/19	<b>warned [1]</b> 96/20
87/4 93/9 120/11	145/6 145/7 147/7	152/16	39/18 40/2 44/21	<b>Warner [1]</b> 23/2
<b>undertaking [2]</b>	147/9 147/11 147/22	<b>Vaughan [2]</b> 31/9	50/11 52/5 52/21	<b>Warners [1]</b> 23/1
92/13 96/15	150/7 151/4	31/24	52/22 55/10 59/1 66/5	<b>warning [1]</b> 148/21
<b>undone [1]</b> 35/2	<b>upon [12]</b> 1/15 2/21	<b>Vaughan Gething [2]</b>	68/21 72/16 81/19	<b>was [344]</b>
<b>unduly [1]</b> 59/5	3/11 7/2 13/12 14/12	31/9 31/24	114/5 120/12 127/1	<b>wasn't [14]</b> 36/7 45/4
<b>unforgiving [1]</b> 23/24	27/18 64/7 71/22	<b>veins [1]</b> 60/17	127/9 144/20 148/12	51/8 97/15 97/16
<b>unfortunate [3]</b> 20/14	74/20 81/4 83/22	<b>very [150]</b> 6/14 6/20	<b>views [13]</b> 2/20 19/14	98/14 108/14 131/11
23/7 57/5	<b>upwards [1]</b> 41/9	7/24 10/5 10/22 11/20	20/4 20/4 20/12 20/18	140/14 142/15 142/19
<b>unfortunately [3]</b>	<b>urgent [1]</b> 79/17	11/25 12/9 14/20 15/2	20/21 20/23 58/4	149/11 149/17 149/22
116/8 141/5 151/3	<b>us [45]</b> 45/9 50/6	15/13 16/16 17/8	73/15 124/4 125/25	<b>watching [1]</b> 126/15
<b>unhappiness [1]</b>	66/2 71/22 73/14	17/12 17/19 19/6	144/21	<b>wave [1]</b> 75/25
	76/21 83/17 84/16		<b>vigorous [1]</b> 81/20	<b>way [35]</b> 1/14 3/17
	88/19 90/1 91/7 92/6		<b>village [1]</b> 36/4	

<b>W</b>	73/24 78/24 82/15 86/4 90/25 91/22 92/2 94/21 95/25 101/18 102/9 106/4 108/5 112/15 123/22 125/4 126/21 127/9 127/11 130/6 131/4 132/15 138/3 139/10 139/15 141/20 144/12 144/22 145/18 148/4 150/23 151/12 152/4 152/6	149/17 150/7 <b>what's [7]</b> 40/23 56/9 93/3 105/23 125/24 144/9 144/9 <b>whatever [6]</b> 28/4 34/25 35/1 35/10 36/18 48/2 <b>WhatsApp [12]</b> 14/6 19/1 19/4 21/25 22/14 22/17 54/7 54/7 72/19 72/22 73/5 125/14 <b>WhatsApps [9]</b> 11/22 21/16 25/9 71/23 71/25 72/9 72/13 72/23 73/11 <b>when [36]</b> 7/5 15/14 26/10 30/22 30/25 38/20 41/21 52/21 60/9 60/25 64/19 66/19 78/10 87/2 89/21 91/12 92/5 92/8 92/18 101/9 103/16 107/4 109/19 112/10 114/1 116/18 119/7 121/10 124/9 127/15 128/19 134/6 144/23 145/19 146/24 148/5 <b>where [31]</b> 9/17 13/17 22/10 27/14 33/18 33/24 53/6 56/20 63/12 67/2 72/16 79/3 87/7 87/24 88/2 88/23 92/14 93/25 95/19 99/23 105/12 107/20 118/13 119/22 121/17 128/24 131/16 135/12 138/20 142/23 145/11 <b>whereby [1]</b> 47/3 <b>whether [19]</b> 10/18 11/2 20/9 22/13 38/25 41/22 52/22 53/20 58/1 64/3 75/24 75/25 76/2 86/2 112/18 112/22 117/18 120/14 123/17 <b>which [148]</b> 1/16 3/1 3/18 3/22 5/14 6/12 7/2 7/7 7/11 7/20 7/25 8/7 8/11 8/17 8/19 11/6 11/17 12/3 12/21 13/10 15/4 15/11 16/18 17/22 18/8 19/3 19/21 21/20 24/18 25/10 25/11 25/16 25/23 26/9 33/3 33/5 33/14 34/23 36/16 40/2 40/9 40/17 41/7 41/15 41/16 41/20 43/14 43/18 44/9 44/17 44/19 46/19 47/21 49/10 50/2 50/12 51/22 51/25 53/25 54/24 56/3	56/16 57/19 58/12 59/7 60/5 60/16 61/12 62/4 64/4 67/23 68/4 68/15 69/8 69/17 70/3 70/24 71/8 71/14 73/2 74/7 74/9 74/14 74/17 75/4 76/7 76/10 76/23 78/16 78/18 79/21 81/4 83/21 84/22 85/7 86/15 87/15 88/15 88/15 89/4 89/23 90/4 90/5 90/23 93/12 93/15 94/24 95/13 95/24 101/17 101/19 102/23 103/6 103/8 103/8 103/9 104/22 105/25 107/19 107/19 108/13 109/24 109/25 111/12 111/14 115/7 115/18 116/17 119/23 121/13 122/16 125/12 131/9 131/14 133/1 134/21 136/2 139/18 141/24 142/4 145/18 148/2 149/17 150/15 151/9 151/17 151/21 151/21 <b>whichever [1]</b> 85/16 <b>while [9]</b> 5/8 26/4 47/10 62/23 100/3 136/4 145/3 145/10 146/14 <b>whilst [2]</b> 2/15 60/11 <b>white [1]</b> 22/14 <b>Whitehall [3]</b> 23/23 24/10 77/24 <b>Whitty [3]</b> 123/9 137/4 143/6 <b>who [81]</b> 8/1 8/2 10/10 10/14 15/7 15/11 15/13 22/7 22/9 22/11 22/19 27/3 28/7 28/9 29/8 39/25 41/24 47/4 48/21 48/23 49/20 57/2 59/20 60/19 60/23 65/17 67/13 67/17 78/1 78/1 78/2 78/11 84/18 85/3 90/13 93/19 95/6 95/9 96/5 96/5 96/7 96/11 97/5 97/6 97/9 97/10 104/9 104/12 104/16 108/9 110/1 111/10 111/20 115/22 116/10 116/12 116/22 116/24 117/5 117/12 119/12 120/6 120/25 126/15 126/15 126/18 126/18 137/18 137/19 138/15 140/8 140/21 140/22 141/7 147/2 149/24 150/16 150/17 151/3 151/4 151/10 <b>whoever [3]</b> 9/6	13/13 85/18 <b>whole [18]</b> 3/25 4/23 17/25 18/5 18/10 30/11 33/19 50/3 50/19 61/22 62/2 62/9 62/14 63/1 71/12 86/11 101/1 105/17 <b>whole-government [3]</b> 62/2 62/9 63/1 <b>whom [2]</b> 6/8 10/3 <b>whose [4]</b> 12/22 18/1 28/12 135/11 <b>why [13]</b> 30/15 31/19 39/5 51/11 92/6 92/18 94/12 117/1 125/19 131/11 131/13 144/10 144/14 <b>wide [3]</b> 3/16 86/4 109/17 <b>wide-scale [1]</b> 109/17 <b>widely [1]</b> 65/10 <b>wider [2]</b> 14/22 132/10 <b>will [37]</b> 2/18 5/7 6/7 7/22 8/7 9/11 13/22 32/8 38/2 48/13 53/11 53/23 62/1 65/1 68/5 80/21 85/2 85/20 87/5 95/17 99/7 99/12 107/19 110/14 119/20 123/5 123/15 123/23 124/5 130/20 132/16 133/11 133/13 144/14 149/20 151/21 153/2 <b>willing [1]</b> 145/21 <b>winter [2]</b> 121/7 121/7 <b>wise [1]</b> 47/13 <b>withdrew [3]</b> 82/20 128/12 152/9 <b>within [17]</b> 1/21 6/18 8/1 12/16 24/2 45/14 45/19 46/12 46/21 64/6 65/21 73/17 78/20 100/10 102/10 119/20 136/25 <b>without [12]</b> 46/20 49/15 51/13 58/5 73/11 73/21 73/22 77/22 94/20 99/24 113/1 148/8 <b>witness [13]</b> 48/20 82/15 82/20 83/23 128/13 130/5 134/24 135/22 142/22 146/8 148/14 152/9 152/17 <b>witnesses [6]</b> 21/21 82/25 83/4 118/1 123/24 128/12 <b>woman [1]</b> 131/16 <b>women [3]</b> 77/18 117/1 117/8 <b>won't [4]</b> 7/18 15/12
----------	---	--	---	---

**W**  
**won't... [2]** 69/2  
 138/4  
**wonder [1]** 145/10  
**wonderful [1]** 58/20  
**word [3]** 65/13  
 135/16 140/13  
**wording [1]** 112/21  
**words [6]** 3/23 23/19  
 24/6 74/13 115/22  
 125/1  
**work [37]** 1/21 2/11  
 2/21 2/25 2/25 3/17  
 4/8 4/25 5/15 5/15  
 5/18 5/19 12/5 16/17  
 16/24 23/20 32/22  
 39/19 47/10 54/2  
 69/18 71/20 77/24  
 78/2 90/23 92/6 93/17  
 100/25 108/5 113/21  
 120/3 136/6 137/16  
 137/19 137/20 151/6  
 151/22  
**work' [1]** 54/21  
**worked [5]** 34/6  
 47/15 108/11 137/22  
 144/4  
**working [11]** 16/6  
 17/23 27/3 32/17  
 32/21 39/12 66/21  
 105/22 118/7 144/11  
 150/17  
**works [6]** 4/19 16/19  
 16/19 23/24 39/24  
 79/2  
**workstream [2]**  
 102/13 102/15  
**workstreams [1]**  
 102/10  
**world [3]** 24/5 72/6  
 132/19  
**worry [2]** 132/15  
 140/5  
**worse [3]** 116/22  
 116/24 151/9  
**worsened [1]** 32/22  
**worsening [1]** 105/5  
**worst [1]** 135/20  
**worth [1]** 80/23  
**would [113]** 3/1 5/15  
 7/23 9/2 12/17 12/25  
 14/19 14/23 15/2 15/4  
 15/19 16/2 18/1 20/16  
 24/4 24/8 24/11 24/11  
 24/24 25/2 25/8 25/22  
 26/15 27/7 28/9 28/9  
 28/12 28/20 30/6 30/7  
 30/9 30/10 30/15 31/8  
 31/20 32/22 36/9  
 36/10 36/15 36/16  
 38/1 38/21 40/21  
 41/23 43/17 44/14  
 50/3 51/6 51/9 51/24

52/3 53/2 55/22 56/12  
 62/12 64/23 66/18  
 67/19 68/15 68/24  
 69/7 71/20 75/13  
 75/24 78/18 80/3  
 81/13 87/8 88/3 88/9  
 91/10 91/15 92/23  
 93/1 94/19 96/21  
 100/1 104/2 105/22  
 106/24 107/3 107/4  
 108/13 109/12 109/14  
 109/16 110/7 112/9  
 112/10 114/11 117/16  
 118/12 118/13 118/18  
 119/3 122/4 122/16  
 123/20 126/17 127/8  
 134/18 140/21 141/8  
 145/5 146/19 147/1  
 147/8 147/9 147/10  
 147/11 147/20 148/3  
 148/8  
**wouldn't [2]** 51/7  
 87/24  
**write [2]** 92/4 137/23  
**writing [2]** 83/22 92/8  
**written [9]** 13/9 49/24  
 83/16 123/19 123/21  
 123/24 126/8 127/21  
 131/15  
**wrong [10]** 20/10  
 34/6 50/25 78/3 96/13  
 126/22 131/12 139/19  
 140/25 141/14  
**wrote [11]** 19/3 23/10  
 90/24 92/15 125/1  
 136/20 138/1 143/5  
 148/16 148/18 149/3

**X**

**Xmas [1]** 56/9

**Y**

**yeah [9]** 100/19  
 101/21 102/3 119/14  
 127/14 127/21 136/11  
 143/24 152/5  
**year [18]** 25/7 58/8  
 84/1 89/17 98/20  
 99/13 100/21 103/24  
 104/3 104/14 105/15  
 106/18 106/19 109/2  
 114/14 124/12 127/2  
 143/18  
**years [8]** 2/6 7/13  
 8/13 18/13 75/6 89/18  
 94/7 95/24  
**years' [1]** 118/3  
**yellow [2]** 6/12 27/14  
**Yep [1]** 70/1  
**yes [136]** 1/24 3/7  
 6/16 6/20 8/4 11/18  
 13/15 18/12 18/17  
 22/24 24/4 29/2 29/7  
 39/4 42/14 43/20

43/24 44/11 44/20  
 49/4 50/10 54/3 54/25  
 55/13 55/18 57/11  
 59/3 59/9 59/14 61/19  
 62/3 66/10 68/10 69/5  
 71/4 71/17 72/11 73/6  
 76/5 77/8 78/8 78/22  
 79/8 79/13 79/25 80/5  
 80/14 80/17 80/21  
 81/13 83/6 83/7 84/15  
 86/23 87/2 88/22  
 92/16 93/11 93/23  
 95/1 95/16 96/4 96/22  
 97/15 98/11 99/12  
 102/9 103/14 104/7  
 107/23 110/23 112/15  
 113/20 114/7 114/11  
 114/15 114/16 115/2  
 115/20 122/19 122/23  
 123/7 123/20 123/20  
 123/23 125/16 129/7  
 129/10 129/25 130/11  
 130/16 130/20 131/5  
 131/9 132/17 133/3  
 133/8 133/25 134/17  
 135/3 135/21 136/14  
 137/2 137/25 138/2  
 138/14 138/24 139/3  
 139/5 139/8 139/8  
 139/23 140/8 140/21  
 141/2 142/2 142/11  
 142/13 142/20 142/21  
 144/2 144/4 145/23  
 146/24 147/23 148/1  
 148/14 148/20 148/23  
 149/2 149/5 149/8  
 150/2 151/11 151/16  
 153/4  
**yesterday [1]** 32/3  
**yet [6]** 43/6 49/6  
 74/17 87/14 127/5  
 132/9  
**York [1]** 131/16  
**you [438]**  
**you know [65]** 3/22  
 7/12 8/7 11/17 11/20  
 13/5 13/17 13/18  
 14/23 17/6 17/14  
 18/13 19/16 19/17  
 21/6 24/11 24/19 27/5  
 28/22 30/5 30/6 31/20  
 31/25 33/7 33/14 34/3  
 34/10 35/15 35/18  
 36/15 38/10 40/23  
 41/19 41/20 45/18  
 46/9 46/12 47/4 47/8  
 47/11 50/17 52/18  
 53/3 53/10 55/22 57/2  
 57/5 57/14 57/20 58/6  
 58/9 64/19 65/6 67/20  
 68/15 73/7 73/13  
 78/10 116/19 133/13  
 134/10 140/8 141/21  
 145/10 149/18

**You'll [1]** 152/12  
**you're [11]** 61/10  
 78/15 83/2 84/7 95/18  
 113/16 119/7 130/9  
 138/21 141/12 152/25  
**you've [35]** 8/16 8/19  
 14/1 16/18 48/20  
 48/24 49/4 50/6 50/14  
 59/10 61/5 63/3 66/2  
 70/10 71/22 71/22  
 76/19 76/20 79/15  
 81/11 83/24 87/12  
 87/16 91/24 92/17  
 96/6 98/19 99/23  
 100/10 116/18 123/16  
 128/11 130/1 133/6  
 134/20  
**young [2]** 131/15  
 132/12  
**younger [1]** 147/9  
**your [107]** 1/10 1/21  
 1/21 1/22 2/16 2/19  
 2/19 2/21 4/7 4/13  
 4/18 5/24 14/11 15/9  
 16/15 19/17 20/8  
 29/22 36/15 38/1 41/6  
 50/24 58/19 61/6  
 62/12 63/13 63/23  
 64/1 66/5 69/8 70/24  
 74/13 79/14 81/14  
 82/16 83/21 83/25  
 84/6 85/8 85/14 91/13  
 93/15 93/17 95/9  
 98/18 100/10 100/17  
 101/17 103/19 103/25  
 104/19 104/20 104/21  
 110/9 110/21 113/17  
 114/5 114/20 116/1  
 118/15 118/20 119/8  
 119/20 119/22 120/15  
 125/3 125/24 127/20  
 128/11 129/6 130/22  
 130/23 133/19 134/16  
 134/21 134/23 134/25  
 135/22 136/1 136/13  
 136/21 136/25 137/11  
 137/11 138/18 138/25  
 139/2 142/9 142/21  
 143/21 144/18 144/20  
 144/21 146/8 146/14  
 146/17 147/18 148/14  
 149/7 149/25 150/6  
 150/8 151/13 151/19  
 151/23 152/8 153/1  
**yourself [3]** 3/9 133/6  
 150/1  
**Yup [2]** 22/21 55/9

**Z**

**zero [1]** 5/19