## (10.30 am) <br> LADY HALLETT: Mr O'Connor. <br> MR O'CONNOR: Good morning, my Lady. Our first witness this morning is Professor Mark Woolhouse. <br> PROFESSOR MARK WOOLHOUSE (affirmed) Questions from COUNSEL TO THE INQUIRY

MR O'CONNOR: Could you give us your full name, please.
A. Mark Edward John Woolhouse.
Q. Professor Woolhouse, you have kindly prepared a witness statement for our module of the Inquiry, that's Module 2. at the last page but I'm sure you're familiar with the contents of this statement.
A. I am.
Q. You will recall that at the end of the statement there is a statement of truth indicating that you believe the contents of that statement to be true, and you have signed that with a date of 15 August of this year. Is that right?
A. I have, yes.
Q. Thank you.

Professor, you have, of course, given evidence to this Inquiry before. You came and gave oral evidence
A. Yes.
Q. He had been a member of SPI-M before that, before the committee was operationalised, as it were, in January 2020. Were you a long-standing member of that committee or not?
A. No, I was not, I was co-opted around about January 20th, I think. Mid-January.
Q. Yes, and do we take it, then, that you ceased to be a member of the committee I think it was in February 2022, when the committee reverted back to its pre-pandemic footing?
A. That's correct.
Q. We've also of course heard about SAGE, which is the committee that SPI-M-O fed up to. Did you attend SAGE meetings during the pandemic?
A. No, I didn't.
Q. We've heard from some witnesses that they attended maybe just one or two. Did you in fact attend any SAGE meetings?
A. None at all.
Q. Thank you. Covid-19 Advisory Group. We did hear a little from Professor Medley, and also from Professor Keeling, about the modelling groups that were established in Scotland

It's up on screen before us. We don't need to look 1

Then finally, you were also a member of the Scottish
here during the Module 1 hearings in July, I think it was, so thank you very much for coming back to give evidence again for Module 2. I know that the details of your career were covered last time, but just briefly, you are a professor of infectious disease epidemiology at the University of Edinburgh, are you not?
A. I am, yes.
Q. You're also a member of the Usher Institute, which is the University of Edinburgh's school of public health?
A. I am, yes.
Q. Finally, you are the principal investigator of the Epidemiology Research Group at Edinburgh University, which conducts scientific research on infectious diseases including novel emerging pathogens, both in Scotland and globally?
A. That's correct.
Q. And as we shall hear, of course, including Covid-19?
A. It did.
Q. During the pandemic, Professor, we know from your statement, and of course we'll be talking much about this in the next hour or so, you were a member of the committee SPI-M-O?
A. That's correct.
Q. Which of course was chaired or at least co-chaired by Professor Medley, who we heard from last week.

2
and Wales. Was this the Scottish modelling group or was it something a bit different?
A. No, the Scottish Government's Covid-19 Advisory Group, its informal name was SAGE for Scotland, so it was more at that level rather than the detailed model --
Q. So it had a broader remit than simply modelling?
A. Yes.
Q. Thank you.

I want to start in detail, Professor, by asking you some questions about the very start of the pandemic, and in particular a series of emails that you sent and received towards the end of January 2020.

But just before we go to the emails themselves, can I take you to a passage in your witness statement which describes them. So it's paragraph 273. You will see it's come up on screen. No, that seems to be the wrong reference. Let me just double-check. We can take that down, that's not quite right.

## (Pause)

Let's not worry about the statement, let's go straight to the emails, thank you.

So can we go, please, first of all, to INQ000103349, page 6.

## (Pause)

Could we go on another page? In fact, I think, to
the last page of the document. I think l've got different page numbers. Is that the last page? Is there another page? That's it. So in fact we might need to go back to the page before, just to catch the start of that. That's it, thank you.

So this is an email, Professor, that you sent to Jeremy Farrar on Tuesday, 21 January; is that right?
A. Yes.
Q. Just tell us, Sir Jeremy Farrar at the time was, worked for the Wellcome institute, I think that's right?
A. He was director of the Wellcome Trust, yes.
Q. And someone who you knew or knew well?
A. I knew well, yes.
Q. He is now the chief scientist of the World Health Organisation?
A. He is.
Q. So that's the context. We'll look at the email in a little detail in a moment, but can you just introduce it, why did you contact him then and what was your concern?
A. So I had become very concerned over events in Wuhan, going back to roughly January 8th, when I'd received a copy of a report, actually from the Wuhan municipal health authority, which alarmed me greatly. It seemed to me to be containing evidence that a pandemic was 5
governmental role at the time?
A. I believe not.
Q. The Wellcome institute was not a part of government. So was it more just a question of using him as a sounding board to check whether he agreed with you, with your concerns?
A. Yes, I very much value Jeremy's opinion.
Q. I want to move forward now to his response, and I'm not sure I've got the correct page numbers, I think it might be page 3, but perhaps we can go -- it's a response from ... it's an email from ...

Sorry, I think we can actually go to a different document. Can we go to, please, INQ000103227.

It's an email that you sent to Neil Ferguson, and page -- which I think might well -- I hope is on page 3 of that document. Yes, could we go to the next page, please.

So here we see an email that you sent a few days later. On this occasion you sent it to both Jeremy Farrar but also to Neil Ferguson.
A. That's right, yes.
Q. He is someone who, of course, is giving evidence to the Inquiry tomorrow, an epidemiologist at Imperial College London, a professional friend or colleague?
under way --
Q. Yes.
A. -- and possibly was already irreversible. So -- sorry.
Q. So, we see, after you've asked him or hoped that everything is well with him, you question are you "right to be increasingly concerned about the slow drip feed of ... information on the Wuhan coronavirus".

There is then a paragraph where you go into a little more detail as to what you've seen and what your concerns are.

Then if we can go forward to the next page, please, I just want to pick it up with the last paragraph, last substantive paragraph, you say:
"My own position is that there is a very significant likelihood of this going global (I've thought that for a while, but the likelihood is increasing daily at the moment). In which case, it would be prudent to start planning for that eventuality ..."

Does that capture your thoughts at the time?
A. It does. And you asked me why I contacted Jeremy Farrar --
Q. Yes.
A. -- and the reason is that I valued his opinion on this. He's very expert in this area.
Q. He of course wasn't working in any form of sort of 6
A. Yes, I've known Neil for many, many years, and again somebody whose views on this matter I would greatly value.
Q. If we look at this email together, Professor, again, it's on very much the same theme, is it not?
A. It is.
Q. In terms of expressing your concern --
A. Yes, it's the same thing but with more numbers, more data.
Q. In particular, if we see in the second paragraph, you are focusing on the R number being 2 and the case fatality rate of $4 \%$ ?
A. That's correct.
Q. Just in a few sentences tell us why those numbers are significant, or at least the significance they had for you then.
A. The R0 number, as that is, that's directly connected with what's known technically as the attack rate, that is that if there's a wave of infection that goes through the population how many people will be infected during that wave. It's directly connected to that.

And the case fatality rate, as it says, is a measure of how many of those people, what proportion of those people infected will die.
Q. Thank you.

Then looking at the next paragraph, you say:
"If we take those numbers at face value we quickly get a ballpark estimate of almost half the people in the UK (and many other countries) getting this infection over a year or so, at least a doubling of the gross mortality rate much more during epidemic peak), and a completely overwhelmed health system."
A. Correct.
Q. Just focusing on that for a moment, Professor, you've used the term "ballpark estimate", we've heard about modelling and about the different types of models, whether they produced predictions or scenarios, this appears to be, if you like, a back-of-a-scrap-of-paper exercise in statistical prediction. I mean, perhaps you won't agree with that description, but there doesn't seem to be anything, put it this way, complicated about the analysis that you're undertaking there?
A. No, this is a very standard -- it's a very crude analysis, but I wouldn't call it back-of-the-envelope --
Q. All right, we'll go with crude.
A. -- it's a very, very crude analysis, and I think I say elsewhere in the email this is the sort of calculation that I would expect my undergrad class to be able to master.
Q. Yes. Are you trying to make the point that it's 9

Mr O'Connor is going to discuss with me later, I was
already at that stage discussing this with the Chief Medical Officer of Scotland. Basically what I --
I think I'm jumping in Mr O'Connor's evidence here.
LADY HALLETT: I apologise to Mr O'Connor if I've jumped in.
MR O'CONNOR: It's your evidence, Professor, not mine.
A. Shall I go on then?

MR O'CONNOR: Do answer --
LADY HALLETT: Carry on, he'll forgive me.
A. So I think it was around about that time that I was alerting the Chief Medical Officer of Scotland to this. I did not want to do this without essentially getting my view peer reviewed. I didn't want to do that without confirmation from people I knew knew this subject that I wasn't making a huge mistake. And I got that reassurance through this correspondence.
LADY HALLETT: Thank.
Sorry, Mr O'Connor.
MR O'CONNOR: Not at all, not at all.
I am going indeed to take you shortly to those emails that you exchanged with the Chief Medical Officer for Scotland, but before we do, let's just look at one or two more references in this document.

If we can look at the paragraph starting "What's the right response?", please, again just to understand
something really quite clear and obvious to you at the time?
A. Yes. And in the context of these emails, it's something that I fully expected would be obvious and clear to Jeremy Farrar and Neil Ferguson, which of course they confirmed.
Q. Yes.
A. They agreed.
Q. Then if we can just look at the next paragraph, it's there that you refer to why you are this being something that you would expect your undergraduates to do with a pocket calculator in a few minutes. But you also -sorry, if we go down to the paragraph underneath that ...

## (Pause)

LADY HALLETT: Professor Woolhouse, why did you start the chain? Did you feel like you were a voice in the wilderness and therefore were seeking views from colleagues whom you respected, or did you feel that other experts in your field were thinking the same thing? Did you feel alone or ...?
A. No. It's a very good question.

So I fully expected my two correspondents on this to have the same interpretation of the data and the information that was emerging. As I suspect 10
the nature of your concern, you say:
"That's [and I take that that that is referring to your calculation based on the R0 number and the case fatality rate] not a worst case; that's based on the central estimates published by WHO."

Now, we've heard about worst-case scenarios being part of a system where one models a number of different possible outcomes and the reasonable worst-case scenario being the most pessimistic in a way, but you're saying that this is not a worst-case scenario; does that mean that it's something more confident than that or more precise than that?
A. No, it doesn't mean that. If you wanted a worst-case scenario you would have to do a lot more work. It's based on those numbers published by the World Health Organisation.

And again, to come back to my Lady's question, if I'm talking to the Chief Medical Officer of Scotland with this, I want to do so with some authority, and rather than -- you know, the data I would use is the data that was coming out of the World Health Organisation.

Now, I didn't necessarily agree with that data, but I used it anyway, and the reason is the critical number there is the case fatality rate, because the R0 number,
as it is there, is large enough that that tells you you're going to have a very big wave. If nothing else happens to mitigate it. But you're going to have a big wave. So then it does become very, very important what the case fatality rate is. And case fatality rate for seasonal influenza, for example, seasonal influenza not pandemic influenza, would be something like $0.1 \%$. So $4 \%$ is very, very high.
Q. Yes.
A. But it's not as high as it could be and, as elsewhere in this trail, actually an even higher number comes out. So I have to say at this point I was very, very concerned.
Q. In a nutshell, your feeling was that if these calculations, if this analysis was sound, and that's why you're checking with others, this is something that people need to start preparing for?
A. Absolutely
Q. Let's, if we may, look at Neil Ferguson's response, he responded within an hour or so.

We'll need to go to the page before to pick up the beginning of his response, but it's at the very bottom of the page.

He says this:
"Fully agree. Jeremy [that's Jeremy Farrar] and 13
the email that you then sent to Catherine Calderwood.
Before I do, can we just briefly go back to that initial email exchange that you had, the earlier email exchange with Jeremy Farrar, because there was one particular email from him that I omitted to take you to and it's quite important.

So can we go back to the first page, please, of INQ000103349. Now, you'll recall a few minutes ago there was that initial email that you sent to him saying: I'm worried about this, am I right to be worried? My guess is there's a significant likelihood of it going global.

He responded, amongst other things, by sending you some internal emails that he had sent around the Wellcome Trust.

You weren't quite sure what he was in fact saying, whether he was actually agreeing with you about your prediction or not, so we see that the second email down:
"Thanks. Just to be clear. You DON'T think it will go global? Or that it will?"

So you're just wanting him to be clear?
A. Crystal clear, yes.
Q. And his response to that then is at the top:
"It will.
"It probably already has.

I were saying the same to Patrick Vallance and Chris Whitty last night. I hope (and think likely) that COBRA will meet early next week."
A. Yes.
Q. Now, he also says that, I don't think we need to go back to the previous page to see this, but he sent you a report at that point, did he not? He said, "l'm sending you an attached report"?

Shall we have a look --
A. Yes.
Q. Perhaps we do -- let's just look to be clear. He says:
"We will be releasing the attached in the next hour or [so]. It is a longer version of a report circulated", and so on.

I don't know if you recall, but the subsequent emails then do go on to be a discussion between you and Neil Ferguson about that case fatality rate and the possibility that it's actually higher?
A. Yes, so we're both recognising that that is an absolutely crucial number to have, that it's very difficult to estimate it accurately in the early stages of a pandemic, this is a long-standing problem, so we have doubts and concern about it, and Neil shared those. And it was a crucial question, how high that is.
Q. Yes. I'm going to go on in a moment to look at 14
"So many asymptomatic, very mild infectious individuals who can transmit -- sort of worst hybrid of flu+SARS!"

Just help us, if you will, what's the significance in this context of "asymptomatic ... mild infectious" cases?
A. That's absolutely crucial. So you'll recall the SARS outbreak of 2003 which was brought under control by a very impressive global effort led by the World Health Organisation, but the central feature of SARS that allowed that effort to be successful, was there was very little transmission in the absence of symptoms.

So if you could detect people with symptoms quickly enough, and isolate them, quarantine them, you could bring outbreaks under control.

We knew from much earlier in January, as soon as the genome sequence of SARS-CoV-2 had been published, that this was very closely related to SARS. Very, very closely. The International Committee on Taxonomy of Viruses called it actually the same species; it was that close. So there was obviously a question of whether or not it would behave as SARS. But if it didn't, if there was asymptomatic transmission, then it couldn't be contained in the same way that SARS was contained. And that is why Jeremy raised the flu scenario, because 16
a lot of flu transmission is asymptomatic, and that makes it very hard to control the same way that SARS was controlled.

So it's a technical point but it is a crucial one for the type of response that would be appropriate.
Q. Now, you've already told us in a slightly different context that you were not getting a complete picture from the data from China at the time, and you refer, in your emails, to needing more data. But what we do see here, at the very least, is that there is a discussion about asymptomatic cases as early as the end of January 2020?
A. Yes. And for the reason I gave, that it's crucial.

There's another reason it's crucial, actually; may I raise that?
Q. Yes.
A. We talked about the importance of the case fatality rate being $4 \%$, but that's a ratio. So it's the number of deaths -- which was being recorded in China, we didn't know at the time how accurately, but it was a number -divided by the number of infections. Well, that is a much more difficult number to estimate, and if there was significant asymptomatic transmission then that number could actually be quite large. The consequence is that $4 \%$ figure would come down quite considerably,
the third page. It's the email that starts at the bottom of this page.

You had been in touch with her before, had you not?
A. I first got in touch with her I believe on 21 January --
Q. Yes.
A. -- very shortly after speaking to Jeremy.
Q. But this one is on Saturday, the 25 th, so it's -- and it's shortly after those emails you exchanged with Jeremy Farrar and Neil Ferguson?
A. Yes, but, as I say, it's the second.
Q. But that's why there is a sort of existing email chain?
A. Yes.
Q. And you're referring back to an email at the very beginning, but you say there:
"Forgive me bothering you on a weekend ..."
Is that a significant comment? You could have waited until the Monday, but the suggestion is you thought it was too important to wait.
A. Correct.
Q. Can we move on to the next page, please. What we see here, Professor, I'm not going to take you through it line by line, but it's a very similar message to the message you had been, as it were, testing out on Neil Ferguson and Jeremy Farrar.
A. It is.

17
and in the end, as I think you probably know, it came down to about 1\%.
Q. Yes
A. But at this stage, because we didn't know whether there were these asymptomatic cases, we couldn't make that judgement with --
Q. That's what I wanted to press you on a little.

So you've explained why, in a situation like this, the possibility of asymptomatic cases is so important, but what Jeremy Farrar seems to be saying is that there are asymptomatic cases. Was that something that you were confident about at the time or suspected or simply didn't know?
A. I was not confident about it at the time. I simply didn't know.
Q. All right. Thank you. As I say, I just wanted to go back to that email.

You'll recall we were looking at emails between you and Neil Ferguson and Jeremy Farrar a few days later, and you then went on, as we will see, to send an email to Catherine Calderwood on the same day, and I'd like to look at that now, please.

That is INQ000103352. Thank you.
I think it may be the third page that we need. Yes, in fact it's the very bottom -- sorry, could we go to 18
Q. One small difference, if we can see, about ten lines down, after you've referred to the R0 rate of 2 and the case fatality rate of 4 , again you talk about putting those numbers into a model, but here you talk about the effect of that being that "the gross mortality rate [would] triple", whereas when you had been speaking to Neil Ferguson and Jeremy Farrar earlier you were talking about it more than doubling, I think were the words you used there. Is that because of the subsequent discussion you'd had about the case fatality rate or can you not help us with that now?
A. Yeah, it's ... there's an element of judgement going on here. The -- you call them "back-of-the-envelope calculations", they are quite sophisticated, but they don't incorporate all the detail that you would need to actually make those estimates rigorous. So there's some element of judgement. I used my judgement in trying to come to something sensible to communicate to a Chief Medical Officer who is not --
Q. Yes.
A. -- expert in this area. Judgement, but consistent with the data that I had.
Q. And you are sending her an important message?
A. Yes.
Q. What were you hoping or expecting that she would do in
response?
A. I wasn't actually certain, not knowing the Chief Medical Officer of Scotland that well at the time. I'd only met her very, very briefly. What I hoped to do was that Scotland would start to think about pandemic preparedness immediately, and I had not, from my own contacts within Scotland, at the time got any impression that they were. So I was very anxious to hurry the process along.
Q. Let's just look, go back, please, so we can see her response. We see it's just a one line response. She thanks you. This is on the same day. She says she has shared it with her CMO/DCMO colleagues.

Now, we can see it's copied to Gregor Smith, who I think was the Deputy Chief Medical Officer?
A. He was at the time, yes.
Q. Can you help us whether Catherine Calderwood might be talking about sharing it with other CMOs throughout the UK, for example Chris Whitty, or are you unable to tell us what that email means?
A. I didn't take it that way, but of course I was aware from the correspondence we were discussing earlier that Patrick Vallance and Chris Whitty had been alerted to this, if they weren't alerted to it already, by Jeremy Farrar and Neil Ferguson. 21
is closely aligned to the advice that Chris Whitty and Patrick Vallance have received from Jeremy Farrar and Neil Ferguson. Presumably you said that on the strength of what they had told you in those emails?
A. Correct.
Q. You talk about there being "three scenarios in play". I just want to ask you briefly about them, each of them.
"First, there is containment of any introductions/outbreaks within Scotland/UK."

But you go on to say that that is a strategy that depends on all countries, as it were, containing the virus within their borders.
A. Yes. So this is essentially the -- would be a replay of the SARS epidemic in 2003, where it is possible to contain the virus, wherever it gets around the world, but without it getting into the community and causing a pandemic.
Q. Yes, and then the second possibility or the second scenario is what you describe as the "not-much-worse-than-a-bad-flu-season scenario", and I think, drawing on what you've already told us this morning, Professor, that possibility revolves around the chance that the severity of the infection is actually much, much less than was being understood at the time, and because the -- if there had been more mild 23
Q. All right

But in any event, she says she is going to discuss it at a meeting on Monday. Is that a meeting that you were supposed to be going to --
A. No.
Q. -- or not?
A. No.
Q. So how did that strike you as a response?
A. Well, that's just a holding response. I think I sent her another briefing very shortly afterwards, as more information became available. I wasn't waiting for a detailed response to provide updates. This -- I was cold calling the CMO Scotland on this one and I continued to do so.
Q. Yes. Well, as you say, you did send another, in fact on the next day, so the Sunday.
A. Yep.
Q. We'll need to go to the next page forward of the document. No, it's page 2 -- sorry, I meant it's page 2, because it's an email chain so we're working backwards. Thank you. In fact, that may have been the one you went to before, I'm sorry.

So we see here the email you sent back on the Sunday. You say that you're extending your briefing, and you say that the advice you're giving her 22
and asymptomatic cases, then it would have been a less serious event when it reached the UK.

Is that what you're trying to describe here?
A. Yes, partly that. That's important, what you just said, but the other one is that if there was a lot of asymptomatic transmission, as I said earlier, it was unlikely you would be able to contain this in the way that the SARS epidemic was contained, so you would have to have a more flu-like response.
Q. Then the third scenario, which you describe as the scenario that was "outlined ... yesterday", so the emails we've seen, that's the SARS scenario?
A. Yes.
Q. Thank you.

So we see here, do we, it would be wrong to read your earlier emails as suggesting that there is only one course that this developing situation can take, you're here outlining three different possibilities?
A. Yes, in the earlier emails I was acting, as I said before, directly on the data coming out of the World Health Organisation, which seems to me to be a good starting point for a discussion of this kind.
Q. Thank you.

Can we now, just to finish this off, go back to the first page of the email chain, which is obviously 24
the last email, which is sent a bit less than a week later, so on Friday, 31 January, at the very end of the month. You're updating Catherine Calderwood with some further data, some further information, and you describe it as "not much good news". You refer to the two parameters being the basic reproduction number and the generation time.
"Estimates of the former [that's the reproduction number] are higher than before and estimates of the latter are slightly lower than had been assumed."

And as you say:
"This means that any epidemic will be bigger and faster than we were anticipating a week [before]."

You also, and this is the second point you make, say:
"... there is now some evidence of transmission from cases before symptoms are apparent."

So this is the asymptomatic transmission that Jeremy Farrar had mentioned in that email a couple of weeks beforehand?
A. Yes.
Q. But now you're saying that there is some evidence of it.

Can you help us with what evidence was available of asymptomatic transmission at the time or how confident you were in that evidence? In fact, you do go on to 25
of the burden on health care systems, but the consensus
seems to be that we could be completely overwhelmed
(including any surge capacity) within 2-3 months of the epidemic taking off."

Then you say this:
"As always, I must stress that this is NOT
a prediction. But it is a possibility that cannot be excluded ..."

I just want to ask you, in that earlier email about
a week beforehand you had said it's not a scenario but
it is what the data were telling you. Here you use slightly different language, you say it's not a prediction but it's a possibility that cannot be excluded.
A. So I believe in the first email you referred to I was saying this is not a worst-case scenario.
Q. Yes.
A. Which was correct, because the data were still consistent with a higher RO, a higher attack rate and a higher case fatality rate, so I wasn't giving them a reasonable -- I wasn't giving the CMO Scotland a reasonable worst-case scenario. But I never at any point, and I was very careful to do this, in my communications with her or any other officials, said I was predicting anything. My line on this is I can't
talk about it
A. Yes, it's low quality, I think I'm referring to the report you said earlier from Neil Ferguson, so he will be able to give you chapter and verse when you speak to it, but it is, as I said earlier, very difficult to get reliable estimates of extent of asymptomatic transmission this early on, but I believe Neil thought there was some evidence that this was occurring.
Q. Certainly, I mean, is this fair, there was enough evidence of asymptomatic transmission at that time for it to be a factor that was important to bear in mind?
A. To bear in mind, yes, as I quite clearly say. The evidence I thought was low quality, but a factor to bear in mind, as you say.
Q. Then if we can go down a little bit below what's -thank you. Just to summarise, you reached the point of saying:
"As we stand, however, the epidemiological indicators make the potential epidemic in Scotland of the same order as the Reasonable Worst Case for pandemic influenza used for planning purposes, and perhaps even more severe than that scenario. In which case our preparedness will be tested to the very limit. There has not yet been, to my knowledge, any formal modelling 26
be $100 \%$ confident, or even anywhere near it, of what will happen, but I can be 100\% confident that government should be paying attention to this.
Q. Right. Of course, the amount of attention that's paid to a problem like this does depend, we may hear, to some extent, on how likely people think it is that it's going to happen. Is that something that you could engage with at all, or could you simply say, "Look, it's a possibility, you need to look at it"?
A. That's what I said. I said, "This is a real possibility and you need to look to it."
Q. Well, you've used a qualifying word immediately there by saying it's a "real possibility"?
A. I was trying to emphasise it, not knock it down.
Q. Yes.
A. Yes, this is definitely a real possibility. This is something we should be preparing for.
Q. And we've looked at these emails in a little detail now and one can be left in really no doubt that you were expressing your concern about the developing picture?
A. Yes. I was very, very concerned at that point.

The worst-case scenarios were really frightening.
Q. I want to move to another document, with that discussion in mind. It's minutes of a COBR meeting.

If we can move to INQ000056226, please. Of course 28
this was a meeting that took place in London. You weren't there. The date, we see from the top, is 29 January, so it's very much around the same time as these emails we have been looking at. In fact it's between that weekend where you contacted Catherine Calderwood and the Friday, the 31st, when you sent the email we've just been looking at.

We can see from the front page it was chaired by Matt Hancock, and if we can go on to page 5, please, which I think is where the substantive minutes ... yes. I want to ask you about two different passages.

Paragraph 2 records the contribution made to the meeting by Patrick Vallance, the Government Chief Scientific Adviser, and he, amongst other things, says that there was "limited evidence of asymptomatic transmission".

Perhaps that's really just encapsulating the same point that you were making around the same time: some evidence but not necessarily very good evidence of that.
A. That's how I would read it, yes.
Q. Thank you.

Then if we may we'll look at paragraphs 3 and 4 .
Here we move to Chris Whitty, the CMO. First of all, he says that:
"... the UK planning assumptions were based on 29
"That there was a 10 per cent likelihood of [that] happening but that this figure had not been agreed by SAGE."

How are we to understand, what's your reaction to what Chris Whitty is recorded as having said there in paragraph 4?
A. I don't know where the $10 \%$ figure comes from, and I don't actually know where he gets the data precisely for the reasonable worst-case scenario. I, in my communications that we've already gone over, I was concerned this would be worse than pandemic influenza, and I remember continuing to express those concerns over many weeks subsequently -- many weeks, in SPI-M-O meetings and others -- that the reasonable worst-case scenario for pandemic influenza was not adequate for the actual crisis that we were about to face.

So I never agreed with using pandemic influenza as a reasonable worst-case scenario. Now, I said it could be influenza-like, but that was not the worst case.
Q. Yes. As far as the $10 \%$, you've already told us that you would not be inclined to give that sort of risk or you would not be inclined to put a number on it. So, I mean, is your position just that, that you wouldn't engage with giving a likelihood of that nature, or can you say whether you think that that $10 \%$ estimation is 31
the reasonable worst case scenario. There were two scenarios to be considered. The first was that the spread was confined within China ..."

So just pausing there, that's similar to, is it not, the first of those three scenarios that you defined? It's not quite the same, because your first scenario anticipated the virus escaping China, but then being contained within the countries that it reached. But it's a limited scenario where the virus is contained; is that fair?
A. Well, obviously I don't know what was intended by this. Just because this virus, this new disease would turn out to be like SARS would be absolutely no reason for complacency. So I'm not sure -- if that's -- the spread was confined within China, I thought that was unlikely -- I think that's unlikely, at the time.
Q. Let's go on to the second of the two scenarios. He says that the second is that the spread is not limited to China and there would be a pandemic-like scenario, with the UK impacted. The second scenario was plausible but it may take weeks to months. Then this:
"The CMO said that the Reasonable Worst Case Scenario ... was similar to the [Reasonable Worst Case Scenario] for pandemic influenza."

And he said:
30
too high or too low?
A. I wouldn't want to comment on the $10 \%$ figure, I don't know where it comes from, but I actually repeat what I said to you earlier, which is that I may or may not be $10 \%$ confident about the reasonable worst case happening, but I'm 100\% confident the government should be paying attention.
Q. Just to a lay reader, Professor, and it may be that we can't take this any further, but to a lay reader of your emails, it does -- even if it's just the fact that you're bothering the Scottish CMO on a Saturday and the persistence and so on, the impression that comes across is that this was rather more than a $10 \%$ risk that you were concerned about. But they're your emails.
A. Well, he's asking about the $10 \%$ risk of the reasonable worst case happening. So, for the reasons we've discussed, the uncertainty in some of the key numbers, it is difficult to put a range of possibilities on it. But if you thought I thought a pandemic, not a reasonable worst case but a pandemic, was $10 \%$ likely, I would say it was far more likely than that.
Q. All right.
A. But I did not put numbers at the time, so forgive me if I don't put numbers on it now.
Q. That's understood. You, looking further ahead, then, 32

Professor -- thank you, we can take that down -- as you said, you continued to engage with Ms Calderwood and her deputy, we're not going to go to all of the emails, but you carried on engaging with them, and as we will see you attended SPI-M-O meetings going through February and into March.

In summary, using these early concerns as a sort of starting point, what's your reflection on the response that then followed to the fear of a pandemic?
A. Well, I think the first thing to say is that the pandemic that unfolded, terrible that it was, was not as bad as my own personal reasonable worst case that I was worried about in the darkest days of early -rather, late January. And, as I say, I was very, very concerned. So it didn't turn out to be that -- it certainly turned out to be bad enough, but it didn't turn out to be as bad as the worst case that I personally was fearing.

Are you asking about the whole -- the weeks after that? Because I can summarise that --
Q. Do summarise. I am going to take you in a little detail to some of the meetings, but I think it would be helpful if you were just to summarise in general terms.
A. So I am in complete agreement, not only for the UK but for the world, with the report of the Independent Panel 33
that they were as concerned as I was about what was unfolding, but having seen the minutes of SAGE I didn't feel that that was reflected. So I knew some SAGE members were very concerned, but the minutes didn't seem to me to capture that concern.
Q. I don't know whether you were following the Inquiry, Professor, but we looked with Professor Medley at some of the SAGE minutes during February in the context of the possibility of the NHS being overwhelmed. He said in his statement that he and others on SAGE had formed the view during February, I'm paraphrasing, that it was likely that the NHS would be overwhelmed. But that didn't seem to be reflected in the minutes.

Is that the sort of practical example that you would give of the minutes not conveying the seriousness of the situation?
A. Well, I think I'd point you to my earlier evidence in the sequence of emails you discussed with me, with Catherine Calderwood, where I pointed to that possibility in January 20-something, in mid to late January I was pointing at the possibility of the health system being overwhelmed.
Q. From your evidence that you can give us, of course you weren't on SAGE, but you were present at the SPI-M-O meetings.

35
A. Yes. So I knew, of course, that both Jeremy Farrar and Neil Ferguson were on SAGE, we've already established 34
A. Yes
Q. Was this possibility of overwhelm of the NHS something that was discussed during those SPI-M-O meetings?
A. So I did watch your session with Graham Medley, and as I -- what I understood him saying for that was the evidence hardened up over the month of February. And I completely agree with that.

As you quite rightly said, you know, one -- or implied, one email from someone like myself using what you called a back-of-the-envelope calculation is not enough evidence to say the NHS is going to be overwhelmed. I'm warning of the possibility but I'm not saying it's going to happen. A lot of -- I beg your pardon. A lot of the -- a lot of the things I was discussing in January, all the ones we've discussed today, the evidence firmed up over the period of February.
Q. Yes.

Then if we can look over the page, please, we could go to paragraph 107, you say you also believed:
"... there was some complacency regarding the UK's pandemic response planning. The problem was that this planning was undertaken with an influenza pandemic in mind. Covid-19 wasn't flu and required an even more vigorous response."
And so on.
Help us with that. Why was that a possible cause of that lost month, as you describe it, in February?
A. Well, I don't know if it was a cause of it, but I do recall very clearly there was a lot of discussion about the reasonable worst-case scenario in the SPI-M-O meetings of February 2020, and I'm quite clear that I repeatedly said that I didn't think it was bad enough, that reasonable worst-case scenario. And certainly that it was different.
And I gave this evidence to Module 1, that the way you respond to a pandemic, an influenza pandemic, and the way you would respond to a SARS-like pandemic are different. I gave a lot of evidence on that to
Module 1. And I was worried that this wasn't fully being captured in keeping hold of the reasonable worst-case scenario for pandemic influenza for so long.
Q. Just one more of these points, if we can go to the next paragraph, please, and you refer at the top of the page to "optimism bias", and it may be that this is linked with this point, which is to do with the influence of the swine flu pandemic in 2009. Is that a fair way of putting it?
A. Well, that's one possible cause of it, but yes, it is.
Q. You make the point here that, as it were, the swine flu 37
we have heard and we will continue to hear is the idea of going early, going hard. That's something that Patrick Vallance talks about in his witness statement. We heard it from Professor Hale, I think it was.

You, in your statement, suggest a rather different approach. I'm not going to go to it, but you say a better maxim is that earlier action can be less drastic action.

Can you tell us what you mean by that, and perhaps
with particular reference to that month of
February 2020?
A. I think the significance of that goes well beyond

February 2020, it goes throughout the pandemic. And
I think it's a really important distinction. I think it's one that sets the tone for the whole approach to the pandemic response in the UK.

So this idea, and as I remember Patrick and others repeated it several times, go hard, go early, and go wider than you would -- in fact, I think that was the phrase: go harder than you want to, earlier than you want to, wider than you want to.

Now, that, for me, is a good maxim in a particular situation where your strategic objective is to eradicate the virus. You're going to try and clear it out completely. That's what was done with SARS in 2003, and 39
pandemic in 2009 had not been as bad as at one point it was feared it would be. Is what you're saying here that that experience impacted on the way people thought about this pandemic in February 2020?
A. Well, that's my fear. As I said, I'm concerned about it. It impacted on me too, because the root cause of the -- or one of the main causes of the overestimation of the threat of swine flu was that the early estimates of the case fatality rate, that we were discussing earlier, were way too high. Way too high. And I knew that, from back in 2009, so I was naturally concerned that the same thing was happening again, that we would be exaggerating the scale of the threat, which is why I kept going on -- this emphasis on we need to know what this case fatality rate is, to know if we're really facing a threat.

But I do think that what happened in 2009 was likely to make people suspect the scientists were just crying wolf again, you know, as they did ten years earlier.
Q. I want to move on, Professor, and, as it were, move the story forward. You've referred to February as being the "lost month", which implies that things that should have happened during that month didn't happen, and I want to ask you about what it is you think should have been done during that month, and one of the phrases that 38
there I would hold on to that as a good maxim.
My -- mine was different. I did not think, from very early on, that eradicating the virus was even the remotest possibility. I'm not going to say $100 \%$, I will never say that, but I was pretty convinced that was not going to be the case. In which case, this go hard, go early, go wide is going to mean severe restrictions of some kind, it's going to -- your intervention is going to be very disruptive. So I was always interested, from early on, in trying to find a sustainable intervention. And so my maxim is: if you go early, you don't have to go so hard. And I think there's a very big difference between those approaches. And the UK went down the first approach, in the end, it went down the go hard. I wanted to go early. And there's a difference.
Q. There are perhaps at least two reasons why going early and not going so hard might be a better route to adopt, and I want to just explore with you whether you have in mind both of these reasons or only one of them.

One is that it's a more effective way of controlling the virus. The other -- and appreciating what you say about the aim being controlling rather than eliminating -- is that it is a course which minimises the other impacts that are felt by society from NPIs, 40
the most obvious one being lockdown. I know that certainly the second argument is one that you've made.

Do you think that it's actually also a better --
simply a better way of keeping the numbers down, or are you really only relying on the fact that it has a reduced collateral impact on the population?
A. A better way of keeping the numbers down. I think we'll probably come on to that. So if your response is to keep the numbers down as low as you possibly can, then yes, you go hard, you go early, you go wide, and what that essentially means, in almost caricature, but we will come on to it perhaps, is you lock down, you do something as drastic as that very, very early on and you stay there, and that's the way to minimise the actual numbers of cases.

Now, that was not something that was being talked about, an indefinite lockdown, at any stage. And since we're on this subject, for the record, no country in the world went for an indefinite lockdown. Everyone realised that, you know, lockdown wasn't going to be a sustainable measure. And given that, my emphasis was on sustainability. And I said a little while ago to you that I was convinced that it wasn't going to be a transient phenomenon, that this virus was going to be with us for a long time, and there was work done in 41

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I don't want to get into the detail of that paper, but
I think it's right that that paper provides the context
for this exchange between you and Professor Edmunds?
A. Yes, and the paper was an important element of
a discussion that was going on in SPI-M-O anyway at that
time, but the paper was important, yes.
Q. So with that in mind, could we -- I think we'll need to go to the next page, please. Yes.
So the email I want to start with is the one at the very bottom of this page, and we'll have to go on to the next page. So you are emailing John Edmunds quite late at night on Wednesday, 11 March. First of all you say this:
"We were given the policy objective of flattening the peak."
We've heard of course about that, with
Professor Medley and others. You say that you have modelled it, and then you also say that you've "described [the policy] to the policy makers here" -"here", does that mean in Scotland?
A. Yes.
Q. "... as possible, but it would be good fortune as much as anything."
I'll ask you about that in a minute. Let's read on to see what you say in the next line. You say:
    I don't want to get into the detail of that paper, but12

America actually on modelling the long-term dynamics of this pandemic as early as, I think, February, but certainly March 2020, published papers showing that it would go into an endemic virus, that it would actually eventually become a seasonal infection.

So scientists were thinking about this long term, that we were in this for years, as early as that, and therefore my thinking, starting then, was that whatever we did it had to be sustainable. And we come back to this, going harder than you want, earlier than you want, wider than you want is not sustainable. So that's my -I had a different view of how we should be handling this.
Q. Thank you.

Many of those themes, or some of them anyway, emerge in an email exchange I want to ask you about. This is an exchange between you and Professor Edmunds, in the days before the decision was taken to impose the first lockdown.

So if we can go, please, to INQ000103343. Now, to set the context, Professor, there was a paper, was there not, by Professor Steven Riley in, I think it was 10 March, which went to SPI-M-O and which initiated a discussion about moving to a complete lockdown? Professor Riley is coming to give evidence tomorrow so 42
"[You] also told them that the most likely outcomes are either that we'll see a peak that the NHS couldn't cope with, or we'll end up in the grip of severe BSIs with no way out."

BSIs, does that stand for behavioural social intervention?
A. Yes. I mean, that's gone out of fashion --
Q. We see different --
A. -- that particular acronym, so non-pharmaceutical interventions, but particularly social distancing.
Q. Yes. So starting from the fact -- you see, you're describing the policy as being trying to "flatten the peak", and it appears you're saying that your view during February and running up to early March was that that might work but that you thought it was more likely that it wouldn't, because you would either end up with a pandemic that overwhelmed the NHS or you would be forced, presumably for that reason, into having very severe lockdown?
A. So that's right. In other communications I think I put that much more strongly, that trying to walk this delicate balancing act of keeping the epidemic roughly the same size without either falling into severe restrictions or, worse, having a big epidemic was ... well, it would be luck more than anything. I didn't 44
think we could manage the pandemic well enough. And I was actually quite concerned about this. There seemed to be an idea that somehow we could manage the epidemic curve, and another analogy I used -- I fear it might not be in my evidence, so I apologise -- was directing a jet of water from a hosepipe but holding the thing 2 feet from the end. I mean, you can't manage the course of a pandemic with any kind of -- that kind of precision. So I was very concerned about any policy that said it had to follow a very narrow path to be successful, I did not think that was viable, and I expressed it much more forcefully in other communications than I did in this one.
Q. That's actually why I wanted to pick you up on that word, your use of the word "possible", because, as you say, other people have expressed the view that it was never going to work, at least in this email you seem to be giving the view that it might have worked but that you didn't think it was likely. But perhaps what you're telling us is this email doesn't fully represent your views at the time?
A. Well, again, you've got the whole body of my emails at that time, so you can suggest that. But yes, I mean, we're holding the hosepipe 2 feet from the end, we might hit the target but it's not something to guarantee. 45

Is that because Neil Ferguson at the time was arguing or was continuing to argue for, as it were, a flattening the peak type approach?
A. So I'm going to have to apologise to you here, because, having seen that you wanted to talk about this, I went back to try to work out for myself what I was referring to, and I can't categorically identify it, I'm afraid, as to what I was referring to there. So --
Q. If you can't --
A. I'm sorry about that.
Q. No, that's fine.

That, in any event, was a discussion that you had with Professor Edmunds during that week, and as we will see there were important meetings that took place towards the end of that -- that week and then over the weekend, which set the course towards the lockdown.

If we can look at, please, going back to your statement, page 29, paragraph 160, it's right, isn't it, Professor, that you did support the idea of that lockdown at the time when, in the end, the decision had to be made whether it should be imposed or not?
A. That was at March 23rd, and I did, yes.
Q. Yes. So paragraph 160 you say:
"For [you], the key driver of that recommendation was not model outputs, it was data on the rapid doubling 47
Q. Let's look, if we may, at Professor Edmunds's response. He says:
"You can't have a lockdown for months, let alone the years that Steve ..."

That's Steven Riley, isn't it?
"... is suggesting? However, I agree there may actually be pressure for a lockdown. And they will work, temporarily."

So that's the view he was taking.
Can I then ask you about the email that you then sent in response to him. You say:
"What I was trying to say is that I think we are likely to end up with your scenario by default."

So that was Professor Edmunds's scenario. What was he campaigning or arguing for at the time?
A. So he was arguing for a response that involved on/off lockdowns. And actually, of course, that's, as I --
Q. Yes.
A. -- said here -- what I'm trying to say is "I think we'll end up in your scenario by default", and that is what we ended up with: we ended up with on/off lockdowns. So that's what I was communicating there.
Q. Then the next line:
"Neil's [Neil Ferguson] won't be allowed once they realise the toll on the NHS."
times of hospitalisations and deaths ..."
Is it a fair summary that, given the position the country was in at that time, you took the view that that was really either the only course or the best course to take?
A. Yes, I didn't -- didn't think there was any other option on the table on that date.
Q. You go on, in your statement, though, Professor, to express the view that although this wasn't known at the time, with hindsight and in particular with access to mobility data that has become available since, you wonder whether in fact that lockdown was necessary. Could you expand a little on that point for us?
A. Yes. Do you want me to explain what the mobility data --
Q. Yes, please.
A. -- are?

So Google, which is the one that was using -anonymously can track movements, not of individuals, but of its whole population of phones, and it was making those data -- it made those data available later on in the pandemic.
Q. Professor, sorry, can I just ask you to try to keep your voice -- or keep reasonably slow, please.
A. Sorry, I beg your pardon.

48
information on where people are by quite broad categories. So are they in residential areas, are they in city centres, are they in transit, so -- and those data were used quite widely, when they became available by ourselves for some of our research on the topic and many other groups. And what the data from Google clearly show in the week leading up to the lockdown on March 23rd was that the amount of time people in the UK were spending outside residential areas, so presumably where they lived, had fallen off a cliff, in the week before lockdown. And when lockdown was introduced, it didn't actually fall any further.
Now, that's not to say there weren't lots of other things going on that might have influenced the spread of the virus, but based on that particular data stream the job was already done.
Q. The inference you draw in your statement is that what had caused or probably caused that reduction in population movement was the, as it were, milder NPIs that had been introduced in the week or two before the lockdown?
A. Two things. So one of them is that. So the whole raft of measures, quite severe restrictions, had been introduced up to that time, but we didn't have sight of 49
LADY HALLETT: Are we talking about 2020 with the Google data?
A. Yes. Oh, yes, it was made available in 2020, but I can't right now recall when.
MR O'CONNOR: My Lady, I'm about to move to another topic. Is that a convenient moment?
LADY HALLETT: Yes, of course. We will break now and I shall return at 11.55 .
(11.40 am)

They made those data available, and they give
(A short break)
LADY HALLETT: Mr O'Connor.
MR O'CONNOR: Professor, before we had our break, we were debating the issue of the decline in population movement, which you had said was apparent in the mobility data which became available after, some time after, the first lockdown, and what may have caused that decline in movement.
We, I think, covered the topic of the earlier NPIs, the less extreme NPIs, which might have contributed. I think there was another half to your answer which you were going to come to. Perhaps you could come to that now.
A. Yes, the other very real possibility during that period, the days or the week up to lockdown, was that people 51
how effective they'd been. We couldn't even see how they'd changed people's behaviour, which is the earliest indicator of those being effective. So we'd introduced them, but we hadn't given ourselves time to see if they worked, which is one of the reasons why I keep saying earlier action can be less drastic action. If we'd done them earlier we could have waited to see if they'd worked. But we didn't, so we couldn't wait for that. So that's the --
Q. Yes.

LADY HALLETT: When did you get access to the Google data?
A. My Lady, I'm not sure.

LADY HALLETT: Roughly.
A. It was some time after. It wasn't even -- I don't think it was very quickly after.

Later on in the pandemic there was an even better, more purpose-built data source, which was called CoMix, a survey of people's actual behaviours, which was incredibly valuable information. But CoMix, like so many of our key data gathering structures that were set up during the pandemic, wasn't available in those crucial months up to the time of lockdown, so we couldn't see how people were behaving because we weren't surveying it. So the best we can do is look at the Google mobility data.

50
were changing their behaviour anyway; they weren't waiting for the government to announce a lockdown but they were taking precautions and changing their behaviour, changing their habits accordingly. And I think there is very likely to be some truth in that view, all the way through the pandemic, once we did have the better data that I was describing to my Lady earlier, it was clear that quite often the public was anticipating what the government would do and they were responding perhaps not purely to government directives or government regulations and rules about what we could and couldn't do, but they were making decisions for themselves.
Q. Yes.
A. And I came to the view, over the course of 2020, that this actually was a very important driver of what we were seeing. And we might come to this point, but if you tried to understand that simply on the basis that it was government rules and regulations that were changing people's behaviour, you were probably getting it wrong, that the public was making their own decisions.
Q. No doubt, Professor, one can take from what you've just been telling us that if one looks ahead to the next pandemic, the absolute need for as much of this mobility type data in as real time as possible is something that
must be aspired to?
A. Absolutely. And for a very particular reason. So the influenza models were actually quite well informed by real data on people's movements, but obviously before a pandemic. And what we're now asking ourselves to do is make a -- how are people going to behave in the face of what was actually a once-in-a-lifetime -- we hope -crisis? And there is no sound basis for predicting that. Behavioural science, I learnt over the course of that year, is not a predictive science. And predicting how people are going to respond was very difficult. And that made all predictions, by whatever means, very, very difficult, because you have to work out how -- not just people, how are people going to behave, businesses, institutions, every element of society, what's it going to do in response to this crisis?
Q. Yes. Lastly on this, Professor, I think what you've said is that this data, which you found out about later, has caused you to reflect on whether in fact that lockdown really needed to be imposed when it was, because of the change in movement that was seen. Are you able to go further and offer any view as to whether, in fact, had that lockdown not been imposed then, it might never have been needed or it might have been needed to have been imposed later, or is that simply too 53
avoided if possible; and the other, which is related, is the whole idea of segmentation, which is a policy you proposed sort of during 2020.

As far as lockdown is concerned, you've just referred to it as being, as it were, at the outer edge of NPIs. If we could look in your statement, please, at page 31, paragraph 169, you put it a little more strongly. You say:
"... I think it is fair to describe lockdown not as a public health policy but as a failure of public health policy; lockdown is what you do when you have failed to control the epidemic in other, more sustainable ways."

Is it with a sense of, as it were,
a disproportionality of lockdown; is that what you're trying to get at there?
A. No. I want to be very, very clear at this -- about this. So there is a view that if we were more -- if we weren't so keen to go into lockdown, that it would increase the death toll. And that is a genuine concern and it's the last thing anyone would want to see, including me. So that's not the question. And the debate often got phrased in that: you either want a lockdown or you don't, and if you don't you're prepared for more people to die. And I can't tell you how distressing it is to hear that argument, and I was 55
complicated, too counterfactual a matter for you to express a view on?
A. Well, as I said, I didn't think it was avoidable at the time. There have been a number of retrospective studies on the impact of lockdown. Some of them -- we may come to this -- are -- the conclusions are very clear, they thought lockdown was critical and essential, but there are others in the scientific literature that said that it wasn't, that what we would call the marginal effect of the very severe end of lockdown, particularly the instruction to stay at home, all around the world, not just in the UK, was actually quite small.

But that doesn't mean you don't have to do all the other things. So it's not as if there aren't restrictions in place, whether they're imposed or self-imposed on us, but the very -- the legal requirement to stay at home, I haven't seen any good analysis that said that actually was the killer punch, the thing that was really needed.
Q. I want to move on, Professor, and, as it were, survey the remaining period of the pandemic, which of course is most of it, and there are perhaps two themes in your statement about that period.

One, which you've just referred to I think, is the idea that lockdown is a harmful measure which should be 54
presented with it many times.
May I give a bit more context?
Q. Yes.
A. So actually Tom Whipple, The Times science editor, wrote a review of a book I wrote about the pandemic, and he was discussing this very point, and he put it beautifully, he said: at that phase of the pandemic, supporting lockdown became a test of virtue. And I completely agree that. It was very, very difficult to say that you didn't support lockdown.

So every time, without exception, I am recommending less lockdown, I am balancing that with saying what we could have done instead. The options are not lockdown or no lockdown. The options are lockdown or a whole raft of other public health interventions that would achieve the same effect as lockdown. And if they didn't, I would never support or recommend them.

So that's why I think lock -- I just call lockdown not as a public health policy but a failure of public health policy. It's what you do when all those other things you know you can do haven't worked. It's a last resort. And it should always be that, in my view.
Q. Thank you, Professor, that's very clear.

One of or perhaps a group of those lesser measures that you describe, which you proposed during 56
\begin{tabular}{ll} 
the pandemic, we can classify as a segmentation policy. & 1 \\
It seems to have been described by various different & 2 \\
tags along the way, segmentation and protecting, or & 3 \\
people talk about cocooning, let's not get hung up on & 4 \\
the names. & 5 \\
Are you able, Professor, to summarise for us what & 6 \\
that policy that you proposed was and what you were & 7 \\
hoping that it would achieve? & 8 \\
A. I can, but I need to give you a context again. & 9 \\
Q. Yes. & 10 \\
A. So what I just said relates partly to segmentation and & 11 \\
shielding, but again I want to be very, very clear on & 12 \\
this, that I was always of the view that it was & 13 \\
necessary to reduce the transmission rate of this virus & 14 \\
as part of the control measures. What I'm disagreeing & 15 \\
with is the mechanism by which we did that. So there's & 16 \\
a lot of interventions, to do with Covid safety & 17 \\
measures, to do with testing, to do with quarantine -- & 18 \\
to quarantine you have to do the case finding -- sorry, & 19 \\
there's a whole raft of measures that would reduce & 20 \\
the transmission rate. And these were looked into, and & 21 \\
they might not be enough. & 22 \\
hopefully we've suppressed the number of cases. But & 23 \\
it's a tremendously important other layer that, in my & 24 \\
\hline
\end{tabular} 57
proposed --
A. Sorry.
Q. -- what were the measures that you proposed should be adopted?
A. I'm going ... but the point I want to make is that it was always, in my view, tremendously important that whatever else we did we protect those vulnerable people. This is a virus that's really targeting a subset, so we need ...

So the measures we proposed went well beyond shielding. So this was recognised. It wasn't that this was unknown, but the measures that the governmental in the UK put in were shielding. And that became to be seen as enforced self-isolation by the elderly. It was very unpopular and very, very difficult to manage, for people to manage it, so that turned out not to be a very successful policy.

So we decided that we needed to go further and we identified that many of these people cannot actually reduce their contacts to zero, because they need care, they need healthcare, they need social care, they need informal care. So how do we protect them best? By protecting their carers. The people they need to -must come in contact with must also be virus-free. So that -- and that's called cocooning, where you protect 59
Q. So what was it, in summary, Professor, that you 58
the people around the people you're trying to protect. And that policy was something that we developed over the coming --
Q. Yes, please, and I'd like to ask you some questions. As you say, you drafted with others a series of papers over the sort of spring and summer of 2020?
A. Yes.
Q. I want though to take us, as it were, to the end of the story, where these matters discussed at a SAGE meeting.

So for these purposes can we have, please, INQ000061570.

Perhaps if we can go to page 3, we will see the section headed "Segmentation" starting -- yes.

Perhaps I should have asked you, Professor, I'm sure you're aware of this meeting, but were you at it? Because of course you weren't a regular member of SAGE, and in fact I think you've told us you didn't go to any SAGE meetings, so presumably you weren't there at this one?
A. I was not there at this one, no.
Q. We see that SAGE endorsed the paper on age and risk-structured segmentation. Looking down at paragraph 19, there is a reference to:
"SAGE [having] previously advised that segmentation 60
by age is not without considerable risk, is
operationally difficult, and is unlikely to be
successful in reducing mortality and morbidity.
However, taking additional precautions in those at increased risk is important."

If we can go over the page, please, these I think
then -- the minutes really come to the core reasons why this segmentation policy was not taken forward.

First of all, it says it:
"... would be unlikely to prevent potential spillover from younger to older populations. Even if segmentation were initially achieved and high levels of immunity could be reached in younger age groups (the duration of which would be unknown), its almost certain that a further wave of the epidemic in older people would occur once segmentation ended."

\section*{Secondly:}
"An unconstrained epidemic in younger age groups
would also have the potential to overwhelm the NHS", and so on.

Can I just take those in reverse order. One of the concerns, then, is that that part of the population that weren't segmented would still suffer from Covid with the risk to the NHS, and there's an additional problem here, is there not, with Long Covid being 61
Q. I see.
A. -- I'm afraid, and something that I believe would have 2
worked, as far as I can tell, was never, never
considered by them.
Q. All right. Well, thank you, Professor. That's something we may then take up with others in due course.

I want to ask you just about two final broad areas.
One is the question of transmission in children. Can we go, first of all, please, to your statement at page 34, paragraph 187. Thank you.

Now, at this part of your statement, you refer quite expressly to the period in sort of early-ish or mid-2020. First of all you refer to March 2020 and then later in the paragraph you refer to June 2020, and what you say by reference to those dates is that there was no evidence that school-aged children were at significant risk from Covid-19, as you say, for the good reason that they were not. And then you talk about teachers being exposed.

Do you agree that whatever the position in early 2020, later on in 2020 there did become evidence -- there was evidence available that children were in fact at risk and were catching Covid-19?
A. So there was definitely a clinical risk to some children, particularly those with a variety of
a long-term sequelae which, as we know, were being experienced by people of all ages, certainly not just the old, and that sort of group of problems were certainly one of the things that were considered by SAGE. Did you consider those to be sound objections to your policy or not?
A. I'm not even sure that they were speaking about our policy in these minutes, though we'll come to that. I think they were talking about the Great Barrington Declaration at the time. And I think that our segmentation and shielding policy, which is different, got caught up in their eagerness to disapprove, not accept the proposal in the Great Barrington population.

I have to say this is one of the occasions where I became very, very frustrated with SAGE. I don't think they looked at the cocooning proposal. We had looked at it, we had published it, the evidence was there, that cocooning worked. When, to my best recollection, according to the minutes, SPI-M-O was also asked to look at it, they didn't do it properly. They didn't look at the proposal we'd made, they looked at their caricature version of it, which I already knew wouldn't work, and they confirmed it wouldn't work, and that is what SAGE is saying here, it wouldn't work, but our baby got thrown out with that bathwater --
comorbidities, but healthy children, the risk remained extremely low throughout the pandemic, and if it hadn't, of course, we wouldn't have re-opened schools when we did, as almost every other country in the world did. So that was generally agreed. So the clinical risk to children was not that great.

So what I think you're talking about is the risk of infection in children, which, you're quite right, evidence did accumulate that children, particularly older teenaged children --
Q. Yes.
A. -- in the later years were getting infected, yes.
Q. Pausing there, you're quite right, that is what I was talking about. It's just the fact as to whether children were infected.
A. Yes.
Q. Briefly, because I think you accept this, but let's just look, if we may, at INQ000207121, this is a report from Professor Edmunds and Angela McLean, which I know you're familiar with. It's dated 17 October, so later in the year. It's based on or it reports or records two strands of evidence: one, serological data from Public Health England, and the other sort of ONS swab testing.

As we can see, we may not need to go beyond the first paragraph, but what this report tells us, or 64
Q. Yes. So you've got no reason to doubt the evidence that 14 was there at the time that children were being infected with Covid, perhaps much more than had previously been understood. And I know that there is a separate matter which you remained concerned about, which is the question of whether allowing for the new data which suggested that children were being more widely infected than had previously been understood, it followed from that that children should be seen as driving transmission of the disease in the community, and what were your views on that?
A. So even more specific than that is whether transmission 65
the question of whether schools should be closed or not, and I think what you're saying is that, notwithstanding this evidence that children themselves, particularly older children, were being infected more than had been understood, you remained of the view that schools themselves and being open wasn't a driver of the pandemic?
A. Yes. But we don't have to argue on the basis of my opinion versus John and Angela's opinion, we can look at the data. So it was quite clear from conversations in SPI-M that in the November lockdown in England that there was a view that if we didn't close schools the lockdown wouldn't work. And that's consistent with the idea that schools are driving it.
Q. Yes.
A. So, if I can -- sounds a bit grim, but if I can call it the "experiment" was done, because the government didn't take that view, and they imposed the lockdown but kept the schools open, and cases fell. And what's particularly striking is that about two weeks, I think it was, into the lockdown, with the schools open, cases fell in the schoolchildren too. That, for me, is the end of the argument. Schools were not driving this.
Q. All right, thank you.

Professor, just finally l'm going to try to ask you 67
going on in schools was driving the pandemic and this -- that view, which was held, definitely, by some people in SPI-M, I'm sure they'll tell you themselves, but I think John and Angela both held it, was, of course, a powerful argument for closing schools and keeping them closed. If they were driving the pandemic.

Despite this evidence, which as you say I do accept, it doesn't say directly: are schools driving the pandemic? And it also, when it was published, flew in the face of studies from around the world that said: no, schools are not driving the pandemic, they're playing -- they're making a contribution to transmission, and there was a lot of argument about how big that contribution was, but they're not driving it. So it's that aspect that I continue to challenge.

But I have to say, this caused me a lot of concern, could it be true, but I came to the view that it actually wasn't true, that schools were not driving the pandemic.
Q. Sorry, let's try and unpick that double negative at the end there.
A. Sorry, I beg your pardon.
Q. As you say, at least one of, perhaps the most important practical issue, to which this data referred, was 66
some fairly brief questions about these, what l've described as SAGE ways of working. And there are, in your statement, various reflections and criticisms of the way the SAGE structure, in other words SPI-M-O, with SAGE sitting above it, worked.

I want to ask you about just two of those. The first is the question of the composition of SPI-M-O, and if I can summarise it in this way: you say in your statement that SPI-M-O was eminently well suited by its composition to perform all the sort of public health modelling tasks that it was set, but it was limited to that, and you were concerned that there was no expertise either on SPI-M-O or anywhere else that was modelling all of the other impacts on society of the lockdowns and the other NPIs that were being discussed.

Perhaps you can expand on that point and tell us how you think the system should be changed to accommodate those concerns.
A. The harms of the social distancing measures, particularly lockdown, the economic harms, the educational harms, the harms to access to healthcare, the harms to societal wellbeing, just the way we all function, mental health, were not included in any of the work that SPI-M-O did. And as you say, as far as I could tell, no one else was doing it either.

So my concern is not so much I think that SPI-M-O wasn't doing it, it would be a much bigger committee, and I think it did a valuable role in doing what it does best, which is looking at the public health component, but somebody somewhere had to be looking at everything else, or I don't see how we could possibly make balanced judgements about what to do.

\section*{And may I ?}
Q. Yes, do, please.
A. It comes back to this, that lockdown is a failure of public health policy. And I take the view that it would have been very helpful, in making its strategic objectives clear, if the government said explicitly: we don't want to go into lockdown, what's your advice, how can we both minimise the health burden and stay out of lockdown? And we could have given a lot of advice on all the other things you could do other than lockdown.

I think they're more likely to do that if we all in front of us had evidence of the harms that lockdown would do, all those harms, and I couldn't find anyone doing it.

But the question how to avoid lockdown was never asked of us, and I find that extraordinary, and I think that's one of the causes, is we didn't have in front of us the figures that would show how harmful this would 69
true, yes.
Q. The argument in favour of consensus, really just redrafts that paragraph we're looking at. The argument is that policymakers will find it easier if they are given one view which a group of experts have, as it were, coalesced around. What do you say to that?
A. I say that it does exactly what I said, that will channel policy decisions along a particular route that is actually set by the advisers. We're, for example, not offering them alternatives to lockdown, so -- may I? -- in the build-up to that November lockdown in England that we discussed, as far as I could see, SAGE was simply telling the government it should lock down. I was saying what l've said to you before: earlier action can be less drastic action, we don't have to lock down. And in fact there's good evidence now that that lockdown was not strictly necessary. But we could have done much more to avoid it if we had taken early action. And I don't think that view was ever communicated to SAGE, because, as you said to me at the beginning, they were at this harder than you want, earlier than you want, wider than you want point of view. And that clearly was something government was resisting.

So I think government was not given, in the build-up
be.
Q. Thank you, Professor.

Then the other aspect of the way in which SAGE worked that I wanted to ask you about was the consensus procedure. You refer at an earlier part of your statement to the effect of adopting this consensus procedure being that minority views weren't heard or weren't heard by SAGE and those to whom SAGE communicated.

Then if we can go to a passage towards the end of your statement, please, you return to this theme on page 50, paragraph 281

If we can look at, as I say, paragraph 281, you say that:
"... SAGE and its subgroups put too much emphasis on consensus and too little on minority views. The most likely outcome -- intended or otherwise -- of only expressing a single view is that it presents policy makers with an overly limited set of options and so will channel policy decisions along a particular route."

May we take it, Professor, that you felt that it was often your minority view that wasn't being heard by policymakers?
A. That's where I'm most sensitive to this issue, that's 70
to that lockdown, the full range of policy options it should have been given.
MR O'CONNOR: Yes.
Professor, thank you very much. Those were all the matters I wanted to raise with you.

My Lady, there will be one or two questions, I think two at least, from Ms Morris, who is here.
LADY HALLETT: Thank you. Ms Morris.

\section*{Questions from MS MORRIS KC}

MS MORRIS: Thank you, my Lady.
Good afternoon, Professor Woolhouse. I ask questions on behalf of the Covid Bereaved Families for Justice UK. Just two short topics, please.

Firstly, in relation to the evidence of Professor Thomas Hale, have you had the opportunity to read his report or did you hear his evidence to the Inquiry?
A. I wasn't given his report and I didn't see it, I am afraid.
Q. Not to worry, we can have that called up for you. Just two short points I'd like to address with you, please.

It's INQ000257925, page 36, please.
Professor Hale, as you may know, was tasked with the ominous task of looking at NPI effectiveness both in the UK and abroad, and he gave his evidence to her Ladyship last week.

72

I'm hoping that can be called up. It's page 37 of his report, at paragraph 66. It's focused on the issue of testing, Professor, just so you know where I'm going with my question.

Thank you, it's page 37, paragraph 66, please. (Pause)
I'll give you a moment to read that. It's talking about the success of the UK in terms of setting up effective testing, contact tracing, isolation and support measures to prevent small-scale spread of the virus from growing in significant waves.

And Professor Hale made the point that at no point -- I think it's a typographical error, it says "now point", but says he confirms in evidence that:
"... at [no] point was the UK able to achieve a level of testing, contact tracing, and isolation and support at which it could be confident that these light intervention measures would have a chance of preventing new waves from arising."

I wanted to give you the opportunity to comment on that, whether you agreed or disagreed with his --
A. I very, very strongly agree with that.

There was -- as I'm sure everyone in the room recalls, there was a target set sometime, I think, in the summer or maybe the first half of 2020 of 73
tests, the self-tests wasn't fully available until maybe November. It was trialled in Liverpool in 2020. That's when we knew we could make the test and do it. So we were relying on a much more cumbersome test, which, to be fair to the 100,000 target, was actually the test they were talking about -- well, one of the tests they were talking about in that target. But, you know, it comes back to, even if we were restricted to the PCR tests, the more cumbersome ones, we needed to be thinking on a much, much bigger scale than 100,000.
Q. Understood, thank you.

One more section of Professor Hale's report, please, this is on page 36 , and it's paragraph 64. If that could be enhanced, thank you.

I'll give you a moment just to review it.
Professor Hale is talking here about the trifecta that the UK experienced: of (1) high numbers of excess deaths and other health impacts; (2) long periods of closure and containment policies; and (3) a significant economic toll. And in his words:
"In 2020 and 2021, especially, the country [that is the UK] followed a 'rollercoaster' pattern. As a new wave arose, restrictive measures were often introduced only when it became apparent that the health system as a whole would be at risk, not earlier, when there might

100,000 tests per day. I'd already expressed my view as to the what I call informally SAGE for Scotland, the C-19 advisory group there, that absolutely testing would prove to be vital in controlling the spread of this infection; going back to what I was saying to Mr O'Connor, always been keen on reducing the rate of spread of this infection. It would be vital. But 100,000 wasn't even close. I mean, it was so inadequate. I had no interest in it, 100,000.

What I wanted to see was mass testing on a scale of literally millions a day, and I was told when I first proposed it that my advice was not serious, that this was not a realistic option.

By December 2021 we were doing self-testing on a scale of ten millions of people a day. It was happening. But there was absolutely no realisation of what needed to be done in that first year. And even then we were so slow to roll out the self-testing. That was a tremendously effective intervention but we didn't get it until the Omicron wave.
Q. Are these some of the early and less restrictive options that you have been expanding upon this morning, that are necessary for suppression?
A. No, because I believe Mr O'Connor was asking me about the early months, so the technology for the lateral flow 74
still have been potential to prevent a wave from rising in the first place."

Would you agree with that statement,
Professor Woolhouse?
A. I would. Earlier interventions can be less drastic interventions for precisely that reason. The NPIs we implemented became very much associated with the \(R\) number, keeping the \(R\) number well below 1 , and the reason for that is because we'd allowed the level of infection to rise up in the first place, so you have to drive it down. If you don't let it rise up you don't have to drive it down, so the interventions you need are less severe.
Q. Understood, thank you.

My second topic, please, is on care homes and hospitals. Given what you've said this morning in particular about the vulnerability of certain sections of the population, you've noted in your report and your statement that none of the core SPI-M-O models used in the early stages of the pandemic -- they didn't explicitly represent care homes and hospital settings; is that correct?
A. That's correct.
Q. These were areas which were known areas of risk for transmission; is that fair to say?

76
A. Absolutely, yes.
Q. Is there a reason why they weren't expressly represented in modelling?
A. My impression of that, I'm sure other views will be shared with you, is because at heart they were influenza models, and they had to be adapted. So influenza models focus on things like schools, because influenza, unlike Covid-19, is driven by infection in schools. Certainly it was in swine flu. So that's what the flu models had in them. They didn't have these other settings because they weren't thinking of them.

And it actually refers back to a question Mr O'Connor asked me, which was about did the lockdown work in the sense of was it essential. One of the things lockdown was not effective at doing, and this is tremendously important, actually was rapidly driving down cases, and their sequelae, in care homes and hospitals. Because those are major institutions and they have their own dynamics. What lockdown did was drive down transmission rates in the wider community. All of us who had to stay at home, we weren't transmitting the virus. But within a hospital, with lots of precautions, but they do have to carry on, and the same with care homes, so the dynamics of the virus in those settings were different, and lockdown did not 77

Professor.
Thank you, my Lady, those are my questions.
LADY HALLETT: Thank you very much indeed, Ms Morris.
Thank you very much indeed, Professor. I'm not sure
that I can make you a promise that we won't call upon your services again, if we may, but you have been extremely helpful, both in the last module and this one, and a lot of very interesting points that you make. Thank you very much for your help.
THE WITNESS: Thank you, my Lady.
LADY HALLETT: And for also trying to alert people to the problem at such an early stage.
THE WITNESS: Thank you.
LADY HALLETT: Thank you.
(The witness withdrew)
MR O'CONNOR: My Lady, I think we're going to go straight on to our next witness, who is Professor Costello.

PROFESSOR ANTHONY COSTELLO (affirmed)
Questions from LEAD COUNSEL TO THE INQUIRY
MR KEITH: Good morning, Professor. I'm sorry you've been kept waiting. Could you commence, please, your evidence by giving your full name.
A. Anthony Costello.
Q. Professor, thank you for the provision of a witness statement. You have provided a statement INQ000281260,

MS MORRIS: Thank you, that's helpful. Thank you
dated 25 September 2023. You've signed it at the conclusion and you've provided the usual declaration to the effect that the contents are true.

May I start, please, with your professional qualifications. You are professor of global health and sustainable development at the UCL Institute for Global Health; is that correct?
A. That's correct.
Q. The institute implements and evaluates solutions to global health problems through research and teaching; is that true?
A. That's correct.
Q. You were, until 2018, director of maternal, child and adolescent health at the World Health Organisation, which is of course in Geneva, and I think during that time you spent 18 months or so as part of the core emergency team dealing with the global Zika epidemic outbreak; is that correct?
A. That is correct, yeah.
Q. You are currently chair of the Lancet Countdown for climate and health action, again based at UCL, but you're also, for our purposes, most significantly a founder member of Independent SAGE?
A. Correct.
Q. What was or is Independent SAGE?

80
A. Independent SAGE was set up specifically to educate and answer questions from the public to engage especially about the public health details of the whole pandemic. It really got going in April 2020. I had been somewhat shocked by the 12 March press conference. I had been following things closely up to then, but of course we didn't know anything about the membership of SAGE or any of the decisions at that point. And after the 12 March press conference I wrote my concerns down about almost everything that had been said there, because I disagreed with many of the points, I put it into a tweet, which went viral. I was then asked to write articles, which I did, in various national newspapers, laying out my concerns about the lack of a public health approach, and the idea of letting a very serious new virus spread across a population struck me as being the wrong approach.
Q. Why was your undoubtedly extremely worthy and impressive group, Independent SAGE, calling itself Independent SAGE? It wasn't, was it, the government's Scientific Advisory Group for Emergencies, that was SAGE. You weren't SAGE. To what extent did you believe that the government's advisory group, SAGE, wasn't sufficiently independent?
A. Well, the use of the phrase "SAGE" is not -- is very 81
discover their membership, we felt -- and we may come on to this later -- that the composition was failing in some ways because it didn't represent -- there was no independent public health person, there was no black/minority ethnic group member, the distribution of gender and expertise we felt was wrong. There were very good people on that SAGE, but it was lopsided. And that's why we chose a group of people who did cover a lot of those bases, and some very eminent people from public health and covering a range of disciplines, including two members who were actually on the SAGE SPI-B, the behaviour group.
Q. We'll come back to the composition --
A. Yeah, sure.
Q. -- of the government SAGE in a moment.

Do you accept, because you acknowledge that the calling of your group Independent SAGE may have caused some degree of concern or confusion perhaps, that there is no question over the independence of those many scientists who gave their time freely and with great devotion to SAGE and the subcommittees? They were independent scientists?
A. Oh, absolutely -- well, no, that's not quite true actually.
Q. Well, the CMO isn't, obviously, nor is the Government 83
commonplace. At WHO I was involved in both the -a little bit with the SAGE for -- scientific advisory group of experts for immunisation, and I helped set up a SAGE for maternal, newborn and child health, so the use of the word "SAGE" -- to distinguish ourselves from official SAGE there were two phrases used initially, "alternative" or "independent", and it was decided to choose the word "independent". I didn't think that was particularly controversial or confusing, but I think some people did.
Q. So are you saying there were other bodies in the WHO, for example, which were specifically called SAGE, so SAGE is an acronym which is in common use?
A. Very common use, yeah. Not just in WHO.
Q. Because this SAGE was the government Scientific Advisory Group for Emergencies?
A. Yeah.
Q. All right. To what extent were the scientists on SAGE, in your view, or the group SAGE not sufficiently independent such that you were required to call yourself the Independent SAGE?
A. "Independent SAGE", not "the", but --
Q. Why did you call yourselves Independent SAGE?
A. Well, just to show that we were separate from the government set of advisers. Because when we did 82

\section*{Chief Scientific Adviser.}
A. Actually nearly two-thirds of the members of SAGE were not classified as independent scientists.

So let me give you an example. The first day I went to WHO, I was told I was no longer an independent scientist, because I --
Q. Professor, I'm sorry to interrupt.
A. Sure.
Q. We must keep this within some bounds.
A. Okay.
Q. Are you suggesting that the majority of the scientists who attended SAGE were not functionally independent? So obviously we have -- there were government scientists like the CMO and the Chief Scientific Adviser and representatives of the NHS, PHE, BIT --
A. That was the majority, yeah.
Q. All right. The other scientists, the scientists from places like Imperial and the London School --
A. Yeah, they were independent.
Q. They were all independent?
A. Yeah.
Q. And insofar as any scientist came from a non-government entity, they were also independent --
A. Correct.
Q. All right.
that in preceding articles and -- et cetera, and so that's when they finally released it, the first day of our public meeting.
Q. Was that 4 May, in fact?
A. I think so, yeah.
Q. So that we are absolutely clear, there was plainly a lacuna of information because nobody knew who was on SAGE and its minutes weren't being published, and so Independent SAGE's first meeting took place at a time when no one knew that information?
A. Correct.
Q. I think Independent SAGE then ran weekly online public meetings. Online, as I say. It produced short reports, developed by a very wide range of experts from epidemiology, primary care, virology, immunology, public health and so on; is that right?
A. Yeah.
Q. As you have said, you provided all your reports and recommendations to the government, but in particular the CMO and the --
A. Correct.
Q. -- GCSA.

The first report that you published was titled
"Covid-19: what are the options for the UK?" and I think that was published on 12 May 2020.
Do you accept that with the publication of some materials by Independent SAGE, however valuable and however worthy, that some degree of confusion was caused in the outside world as to whether or not you were speaking on behalf of the government and SAGE or a different body?
A. I don't really accept that. I don't think -- we aimed to communicate with the public and we spoke to media, and it was fairly clear from our emphasis on a number of things that SAGE were not emphasising, particularly, the desire to set up a proper system to isolate people and to suppress the virus, that we were putting forward a very different view.
Q. Could we have INQ000230014, please. This is a document produced by Sir Patrick Vallance. It's an "Independent SAGE Report". It happens to be report 29. It's dated 8 January 2021. It's called "A 'Safe Schools' policy for re-opening education as soon as possible and mitigating the harms of closure", and it says at the bottom:
"Submitted to the UK Government and the People of Great Britain \& Northern Ireland by Sir David King former Chief Scientific Adviser, UK Government, Chair of Independent SAGE."
For those not intimately familiar with the workings

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 A. 8
of SAGE and Independent SAGE, a report appearing like that may well impress itself as emanating from government, wouldn't you agree?
A. Well, Sir David King made it very clear from the beginning that he would submit all of our reports to Sir Patrick Vallance and to SAGE, so that there was communication going on. I don't think many people would have read these footnotes to gain the impression you obtained, but we were sending an Independent SAGE report to the government.
Q. One of the main drivers for SAGE, according to your witness statement, was the perceived lack of transparency over the SAGE process. It's right, isn't it, that before Friday, 29 May, SAGE had not published the minutes of the many -- the 34 meetings, in fact, that it had held hitherto?
A. That's correct.
Q. Had SAGE or the government published the list of members of SAGE before the time at which it started publishing the minutes? So was there a rolling out, if you like, of information? When did SAGE explain the membership?
A. As I recall, it was leaked by The Guardian at the end of April, but officially they only released it on the very first day or our very first meeting, when they released the names, and also -- because we had been calling for 86

Perhaps we could have that up, if it's in the system. INQ000249693. Thank you very much. If you could go, please, to page 5 .

\section*{Recommendation 1:}
"The government should take all necessary measures to control the virus through suppression and not simply managing its spread. ... We detect ambivalence in the government's strategic response, with some advisers promoting the idea of simply 'flattening the curve' or ensuring the NHS is not overwhelmed."

Now, the date of this report, 12 May, was plainly after the lockdown had commenced. But I want to ask you to what extent did Independent SAGE nevertheless believe that the government was still applying a particular type of strategic response?

So even though the lockdown had started, did Independent SAGE believe that there was a driver or a particular approach driving the government's strategic overall response?
A. Yes, because the minutes of their very first effective meeting, it was actually their second meeting, on January 28th, came up with the idea that they were going to follow a pandemic influenza strategy, and that they were going to simply model all of the interventions that the modellers subsequently did, except for suppression 88
of the virus. And this went against WHO advice at the time and it went against all the practices of the East Asian states that managed to reduce their death rates to five times lower than our death rates.

So we felt that this was the wrong approach, particularly as two elements of pandemic science show us what was considered to be the right approach to a coronavirus outbreak back -- after SARS-1, papers published in 2004 and 2006, including actually three members of SAGE, showing that for a coronavirus outbreak you need to pursue a very different strategy from pandemic influenza.
Q. Now, there's a number of points in there. Could we perhaps just delineate them.

Firstly, East Asian states had, you've explained, undergone the experience of SARS-1, and some other states, of course, had gone through MERS as well, the Middle East Respiratory Syndrome?
A. Correct.
Q. In general terms, did they therefore have the knowledge, the system to be able to respond efficiently and quickly to the outbreak of a viral pandemic?
A. In SARS-1?
Q. No, we're now coming forward to coronaviruses.
A. Yeah, absolutely. I mean, there is this confusion 89
is not so high or its incubation period is not so short.
Now, for influenza, we know that exactly that's the problem, and therefore the strategy to just simply reduce the spread and mitigate is the only real option. But for coronavirus, it's quite different. That's what those two papers, after SARS-1, written by British scientists, showed very clearly.
Q. Are there, therefore, two vital aspects of a scaled-up, efficient testing system: firstly, it enables the country to know what the spread of the virus is, because if you test and the tests are accurate, you know what you're dealing with; and secondly, if it is combined with an absolutely reliable contact tracing and isolation system, then it will break the chain of transmission of the virus?
A. That's exactly what happened in the East Asian states: they suppressed the virus within about six weeks and they did not have national lockdowns, with the exception of Taiwan, and they did not suffer any of the enormous economic damage that we suffered, because they suppressed their epidemics very quickly.

And it's also not true that you would then have to maintain horrible lockdowns for a long time, as they were implying. In fact all they had then was an effective surveillance system that enabled them to
between the words eradication, elimination and suppression.
Q. Can we come back to that --
A. Okay.
Q. -- conceptual debate a little later.
A. Yeah.
Q. I'm just asking you about the East Asian states.

Was it fundamentally on account of their earlier experiences that they were in a better position to be able to respond to the viral epidemic that was coronavirus?
A. Well, I, you know, Patrick Vallance and others have put forward the view that they had a much better infrastructure. I think the infrastructure was more in the mind than in reality. They knew that they had to act very fast, and that's exactly what the World Health Organisation was saying at the time, and therefore they put in place a rapid organisation to get a test, a rapid organisation to mobilise community healthcare workers, so that you could do contact tracing at scale, but most important, and I think this is really important to emphasise, the really key thing to getting a pandemic under control is isolation. If you can isolate a case and its contacts, the household contacts, then you can suppress that pandemic, as long as its transmission rate 90
spot new outbreaks and suppress them locally very quickly. So they hit their hotspots very quickly. In Korea, two hotspots, around the same time when we could have started, we had two hotspots in England, in the West Midlands and North London -- and also in Glasgow for Scotland, but if we had hit those with limited numbers of tests -- and we've heard millions of tests being requested. If you look at Korea, at the end of February, when they started to get their epidemic falling, they only got up to 18,000 tests per day. Why? Because they were targeting that all at hotspot areas.

I don't see any reason why we couldn't have done the same. I don't see any reason why we couldn't have mobilised people to have a national contact tracing system -- way different from the later one that we set up that was never going to work.
Q. Before we look, and it will be after lunch now, at the detail of what actually happened, and whether or not it was possible and whether or not a test -- a full, scaled-up testing, contact, isolation system was called for and whether it was put into place, just on this question of the flu, the genesis of the thinking as to the relevancy of past flu pandemics, the UK Government strategy, you are aware, had been based to a large extent upon a 2011 document called the pandemic flu 92
strategy?
A. Yeah.
Q. Could you just explain why testing is available and so important if you're dealing with a virus that has a long -- longer latent period, that is to say the gap between when you become infected and when you might begin to infect other people, and a flu which may have a much shorter latent period and in relation to which testing, according to the strategy, is of much less assistance? Why is that? What is that point?
A. Well, if you've got a flu virus that's -- let's say it's transmitting with an R value of 10 , which a lot --
Q. Just pause there, meaning that one person infects --
A. Could infect --
Q. -- ten other people in an unimmunised population.
A. Exactly. And that that has an incubation period of one to two days.
Q. Pause there. What is an incubation period?
A. It's the time between being infected and developing the disease.
Q. Symptoms?
A. Yeah. And so therefore you've got almost no time to do it, you've got no time to get your test in, and it's already spread. So there are certain diseases and that's what the paper written by Roy Anderson, 93
interval -- that's the interval between one person having symptoms and passing it to the next person and them having symptoms -- was somewhere between eight to ten days.
Q. So just pausing you there, there was a window in which --
A. A much wider window --
Q. -- testing could take place --
A. Yeah.
Q. -- which would enable the government to know the extent of the virus and, if combined with a proper isolation and tracing contact, quarantining system, could have enabled --
A. You could go further and say you don't actually, in the early stages, even need a test. If somebody is symptomatic, you have to close it down. So you need to have boots on the ground. Shoe leather epidemiology, we talk about in public health.
MR KEITH: Well, that's a very good place to pause, thank you, Professor, for lunch.
LADY HALLETT: It's not an expression I have come across before, I have to say.

2 o'clock, please.
I'm sorry we have to break but --
MR KEITH: My Lady, may I just mention that there is legal

Neil Ferguson and others that I quote, with that nice diagram, shows, that for influenza you really cannot do it, as you cannot for HIV, because the other factor is how many infections are asymptomatic. So with HIV, \(95 \%\) plus of infections are asymptomatic, so you don't know that you've got the virus until it happens.

But with SARS, the reproduction rate was about -was under 3, it was thought, in January 2020. So one person would infect about three people, let's say.
Q. Just to pause you. When you say SARS, you --
A. Well, SARS-1 --
Q. Do you mean SARS-2 --
A. I beg your pardon, SARS-2.
Q. -- coronavirus?
A. SARS-1 was somewhere between 3 and 6 . It -- you know, it changed over time, I think. SARS-2 was at that stage -- the data coming out of China and also in the papers published in The Lancet on January 24th -I think the figure was 2.8. But of course it was, you know, still rudimentary, so there was quite some confidence intervals there that you would need to take account of.

But let's assume it's 3 , you've got 1 to 3 , you've got an incubation period that we then knew to be probably around the five-day mark, and a serial 94
argument scheduled before you for 2 o'clock, so could we impress upon the Professor to be ready again at 2.30.
THE WITNESS: Oh.
LADY HALLETT: Sorry, I had forgotten.
( 1.02 pm )
(The short adjournment)
( 2.00 pm )
LADY HALLETT: Mr Keith.
MR KEITH: If it pleases you, my Lady, oral submissions will be made first by Mr Hill on behalf of Sir Patrick Vallance.

\section*{APPLICATION}

Submissions on behalf of Sir Patrick Vallance by MR HILL
MR HILL: My Lady, we're grateful for this opportunity to address you, and I won't keep you long.

The background is that this is a procedural matter. It is about how Sir Patrick's evening notes should be displayed on the screen and on the website during evidence. It does not in any way affect how your counsel and core participants may use those notes when asking questions of witnesses, or when making opening or closing statements

Contrary to the submissions of the media organisations, it is not an application for a section 19 restriction order.

The context is set out briefly in the written submissions that we have provided to you, and also from paragraphs 471 onwards in Sir Patrick's statement, second statement. In short, the notes were, in his words, a brain dump. They were written at the end of immensely stressful days to protect his mental health. They represent a snapshot of how he felt in the moment of writing them. He did not amend them if he changed his mind later, he made no attempts to correct them as and when he learnt new information. He describes them as, and I quote:
"... a form of release that helped me to focus on the challenges of the next day, rather than dwelling on the events of the last. It was my way of creating some space for myself in what could have been an overwhelming situation."

As Sir Patrick makes clear, the notes were never intended for publication. He had not shared them with anyone else, and they would have remained unseen had it not been for a request by this Inquiry. In response to that request, Sir Patrick voluntarily provided the notes to the Inquiry in full, in unredacted form, and within the timescales agreed with your team. Since then, he and his legal team have worked with the Inquiry to allow for the notes to be disclosed to core participants to 97
according to the strict terms of the Inquiry's confidentiality undertaking, and those terms require that those notes are only seen and handled by those that have signed that undertaking, they are only to be used for purposes of furthering the work of this Inquiry, and they are not to be published unless and until they are shown in the hearings or by an order that your Ladyship makes.

We understand that those terms are taken extremely seriously by your Ladyship, and by your Ladyship's team.

There is an obvious distinction between disclosure to core participants under the terms of that strict undertaking and publishing the material to the world forever.

We note that in the Prince of Wales case, disclosure to a group of associates of the Prince of Wales did not exhaust his reasonable expectation of privacy and his Article 8 rights in diaries that he had written and circulated to that group. Mr Bunting, gloss in his submissions for media organisations, ignores that distinction, he ignores that authority.

So returning to the law and on the basis that we are right that Sir Patrick retains Article 8 rights in the notes, the measures taken in respect of those notes must be proportionate, and the well established test for
inform their work in this module. Both sides, we hope you will feel, have taken a constructive approach to this and, despite the sensitivity of the material, the redactions have been agreed in all cases.

The legal position is set out in our written submissions, and I won't repeat it in full. We say that the Inquiry's use of the notes amount to an interference in Sir Patrick's right to private and family life under Article 8 of the European Convention of Human Rights and the common law. Authority for that proposition, should we need it, comes from the Prince of Wales case, which is at paragraph 7 of our submissions. That is the Court of Appeal case. It also applies to the High Court case as well.

We say that that means that each and every action taken by the Inquiry in respect of those notes must be proportionate in order to be lawful, and it's here we say that the media organisations get the law wrong. It's not enough to say, as they do, that once the notes have been redacted and disclosed to core participants, then Sir Patrick has no reasonable expectation of privacy left, and he has no Article 8 rights left. We say that's just wrong.

Sir Patrick retains that reasonable expectation of privacy, not least because the notes were disclosed
proportionality is that at paragraph 7 of our written submissions, taken from the case of Bank Mellat. In particular, a tribunal must consider what the purpose of an interference is, whether it can be achieved by a less intrusive means, and ultimately whether a fair balance is struck between the interests of the individual and the interests of the community.

The interests of the community include the Article 10 rights of the media, and important considerations of open justice. They also include the public interest in witnesses to public inquiries having confidence that sensitive material that they provide will be handled lawfully and fairly.

Applying those principles in this case, the purpose of showing the notes on the screen and the website is to facilitate the understanding of the evidence that is heard in this room and to facilitate for reporting of that evidence, including by those who are not here but are following remotely, and we agree that is a legitimate purpose. Nothing we propose will inhibit reporting of what is said and what is referred to in this hearing room. The submissions that we make are aimed at what Mr Smith, at paragraph 10 of his helpful note, describes as material that is "not directly relevant to the witness's questioning", the extraneous
material that the witness is not being taken to.
Having agreed that that is a legitimate purpose, the next step must be to assess what is the least intrusive means of achieving that purpose, and we say that it is clear from Mr Smith's note that there is a less intrusive means and the usual approach of showing the whole page. Mr Smith acknowledges frankly at paragraph 11 that various options are, in his words, possible but undesirable.
We would say that the proposed approach at paragraph 15 is the best one, which involves the creation of a new document containing the relevant extracts, and that is something that we had suggested at paragraph 16 of our written submissions.
We say that is eminently achievable and we say that it strikes the correct balance. It allows the media to report accurately the oral evidence, including in respect of material to which reference was made.
We accept that this means that there will be an additional burden on the Inquiry legal team. We do not ask for it lightly, not least because we are conscious of how exceptionally hard your team is working, and we, core participants, only get to see a fraction of that. However, we say that is what the law requires.
will be some reference to them, but a manageable amount
for these purposes, and that's seen in the evidence proposals for the coming week: two extracts for Professor Ferguson, nine for Professor Edmunds and the/same eight for Professor Yardley and
Professor Rubin. It would be highly surprising if the witnesses were in fact taken to all of those extracts.

Second, the Inquiry does require, where possible,
passages of evidence to be put to witnesses in advance,
and that is for the purposes of getting their best
evidence about those passages. We say the system can be
adapted for these purposes, and we understand that
Mr Smith considers that it can be as well, albeit with some extra work.

Third, as Mr Smith acknowledges there is a failsafe, in that the extract, if needed, can simply be read to the witness if the necessary preparation work hasn't been done. That's been done to date and it's been done with no detriment to the witness evidence. No sensible argument could be made that that has impinged in any way on the press's Article 10 rights.

We would also say that if it proved necessary
a document could be produced retrospectively, we would have no difficulty with that.

Fourth, adopting this approach will not in any way 103

It's not unusual for some documents held by a public inquiry to require additional care in the way that they're handled and the way that they're disclosed and the way that they are shown. The most obvious example is documents relating to national security, but it also applies to more personal documents, such as medical notes or graphic video footage. It's an added difficulty, it's an added burden, but it goes with the nature of the work.

We say that Sir Patrick's evening notes are in that category. We also say that they have been treated with appropriate care by the Inquiry to date. For example, assurances were given on how the unredacted notes would be handled, how the transcripts would be produced. We are grateful for that approach and we ask only that it is continued.

The approach at paragraph 15 of Mr Smith's note is a practical and proportionate way of doing that. Your Ladyship is well served by an extremely experienced and able team of solicitors, and we have no doubt at all that another spinning plate could be added to the pile that they have without the whole thing crashing down.

I make four additional points.
First, Sir Patrick's evening notes are one of many thousands of sources for the Inquiry to consider. There 102
inhibit your counsel or core participants from putting materials from the evening notes. At most, it requires them to be a little bit more organised in how they do it if, and only if, they wish that passage to be shown on the screen.

In conclusion, we say that the legal position is clear, and as is described above. The paragraph 15 approach is for least intrusive means available. The law requires that it should be adopted.

It's also, however, a question of fairness and of mutual respect. Sir Patrick has done all that could reasonably be asked of him to assist this Inquiry. He has provided witness statements in Module 1, Module 2 and he will provide one in Module 4. His Module 2 statement is some 100,000 words long and is, on any objective reading, a thoughtful, analytical and full response to the many questions posed of him by the Inquiry. It was the product of an immense amount of hard work.

He has provided his most intensely personal and private notes to the Inquiry in full, without redactions, and in line with the Inquiry's deadlines. He produced them voluntarily without recourse to the courts. He accepts that relevant sections should be disclosed to the core participants. He accepts that 104
some part of the notes have and will be used in 1
the hearings. I do not pretend that that is easy for Sir Patrick. It is no doubt obvious to all how uncomfortable it would be for anyone to have their hastily written, private and personal reflections published to the world. Sir Patrick has nonetheless co-operated entirely with the Inquiry, because he respects the importance of its work and he shares in the common goal of learning lessons to improve our resilience in the next pandemic. All he asks in this application is that the Inquiry continues with the approach it has taken to date of handling his notes with the appropriate care and sensitivity.

Unless I can assist further, those are my submissions.
LADY HALLETT: No, you have been very helpful, Mr Hill, thank you very much indeed.

Who else wishes to make submissions? I have
Mr Bunting KC's submissions on behalf of the media organisations.

Does anybody else present wish to make ... Ms Mitchell.
Submissions on behalf of Scottish Covid Bereaved by MS MITCHELL KC
MS MITCHELL: My Lady, I'm obliged.
105
could be done.
I would respectfully submit in the circumstances that it is unnecessary so to do, and also that it may, if granted on this occasion, encourage others to take the same approach, and that may mean a considerable degree of extra difficulty.

Further, I suppose the question as to whether or not it's relevant can be seen when examining whether or not any of those pieces of evidence that we might cover up when looking at a particular statement can thereafter, in any event, be used in any of the core participants' closing statements, and of course if they're relevant they may do so, and that was evidenced by Mr Keith in his opening statements. So it seems rather an oddity to say we must cover up these things just now so we can just deal with this particular question, but still allow for the fact that core participants could refer to any part of the disclosed document in their closing statements.

So, in conclusion, my Lady, I would respectfully submit that the Inquiry should just proceed as it has done in other cases, satisfied that the Article 8 test has been met and satisfied.

I'm obliged.
LADY HALLETT: Thank you very much indeed, Ms Mitchell.

Those representing Sir Patrick Vallance, both in written and oral submissions, gave the acceptance that Article 8 is engaged and, and I quote from paragraph 10:
"In essence the public interest in this degree of disclosure justified the interference in Sir Patrick's Article 8 rights. Sir Patrick accepts the assessment and approach. He asks only that it continues to be applied."

My Lady, the Inquiry in this case has taken the documents, they have applied the derogation of Article 8, namely 8.2 , test, and have supplied only to core participants those documents which are relevant to the purpose at hand. As a result, the Article 8 test has been carried out and is satisfied. It's respectfully submitted that what need not happen in those circumstances is that the Article 8 test continues to be applied like a matryoshka doll-type exercise, where we get smaller and smaller pieces of evidence.

It's respectfully submitted in the circumstances that once that test is carried out, we need not go further on to that. So that is the matter of law. In relation to the practical matter, it's obviously a matter for this Inquiry as to how they wish to carry out the procedure, and Mr Smith's note is very detailed in that regard, identifying the various ways that it 106

Ms Morris.
Submissions on behalf of Covid Bereaved Families for Justice and Covid Bereaved Families for Justice Northern Ireland by MS MORRIS KC
MS MORRIS: Thank you, my Lady. On behalf of Covid Bereaved Families for Justice and Covid Bereaved Families for Justice Northern Ireland -- I'm sure Ms Campbell will prod me if I make any submissions that she's not content with me to make -- we indicated on Friday that we wanted to make some oral submissions to you on this topic, but that was before we received the submissions provided by Mr Bunting King's Counsel made on behalf of eight media organisations, with which we entirely agree and endorse.

All that I will add is that the bereaved families have the utmost interest in open justice and transparency at this Inquiry, and therefore even if Article 8 is engaged, which we don't entirely accept, the significance of this Inquiry and the significance of the evidence that Mr Vallance has to give to it weigh in favour of the fullest evidence in its proper context being published.

So, my Lady, those are my short submissions.
LADY HALLETT: Just before you sit down, I'm afraid I'm going to use you, Ms Morris, because Mr Bunting is not here.

108
MS MORRIS: I'm a poor substitute but l'll do my best,
    my Lady.
LADY HALLETT: The submissions from the media organisations
    don't seem to address the Prince of Wales case, which
    I was reading just before I came in to hear the
    submissions. Do you have any comments about the
    judgment of the Lord Chief Justice and
    Master of the Rolls in --
MS MORRIS: I would have to defer to Mr Bunting on that one,
    I'm afraid.
LADY HALLETT: I'm sorry if I asked you a -- threw a fast
    ball.
MS MORRIS: No, my Lady, I'm entirely content to try to
        assist you if I can, but it won't be in this moment,
        I'm afraid.
LADY HALLETT: Don't worry, I'll read the judgment myself.
        Thank you very much.
            Anybody -- oh, yes, we have.
Submissions of the UK Health Security Agency by MS DOLAN KC
MS DOLAN: My Lady, I intend to only address you very
    briefly to express the views of the UK Health Security
    Agency. I hope to be of assistance to you in
    delineating the issues that we say you need to decide
    here.
            We do say, my Lady, that first you will need to
S DOLAN: My Lady, I intend to only address you very

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}
these notes, then of course you will have to go on to consider the real issue that is being challenged here, which is whether the display and publication of the disputed information will be a further interference with the Article 8 rights.

Now, what is currently being proposed by your inquest legal team is that material that is irrelevant to the particular question or issue that the witness is being asked about, or is being probed by your counsel or probed by any core participant, because we are all at liberty to ask questions about these notes -- that material that is irrelevant to the probing issue will be displayed on the screen simply because it happens to appear on the same page as the relevant material which is being asked about.

That is the issue, whether that should happen. And of course, my Lady, also remembering these are transcribed notes. They were written in Sir Patrick's handwriting. Your team have put in a lot of work to cope with the handwriting by transcribing them into a Word document. Matters may appear on a particular page just because of the way they've been transcribed.
LADY HALLETT: I did check on that. I think I was assured that in fact they appear on the same page as the original. I think. I was interested in that point as
determine whether Article 8 rights are engaged. It appears to UKHSA that the information within the personal reflective evening notes of Sir Patrick must engage the protections of Article 8 of the Convention, given the nature of those notes and how and why these notes were created.

My Lady, we say the Court of Appeal decision in the Prince of Wales case against the Associated news press makes that abundantly clear. They are, we might even say, more protected, if that is possible, than the manner in which the Prince of Wales had created his diary notes, in the way these personal reflective notes came to be created and their purpose.

My learned friend Ms Mitchell seems to suggest to you that the Article 8 issue has already been dealt with because you've balanced that when you came to the view that the notes with the small redactions should be provided to all core participants.

My Lady, we'd say that approach is misconceived. These personal notes do not lose the protection of Article 8 for all purposes just because you have decided that they can be disclosed under the strict undertakings that you've required of all of us to the core participants.

My Lady, if you agree that Article 8 is attracted by 110
well.
MS DOLAN: Be that as it may, my Lady, we understand Sir Patrick's objection is only to displaying, and then obviously publishing the next day, this extraneous information. That is not considered by yourself, the Inquest legal team or any core participant who is asking a question to be material to the question or the issue that is being asked.

In our view, to reveal private and irrelevant information, I mean irrelevant to the topics anybody wants to enquire into, must be an interference with Article 8 rights.

So then the question you must ask, my Lady, is: is there lawful justification for that interference? Because it will only become an infringement of an Article 8 right if the interference is not justified.

Any interference must have a lawful justification under Article 8.2 and, put broadly in this case, the matter for your consideration will be: is it necessary to display this extraneous material when you are balancing the rights of others?

Your public inquiry team seem to readily accept the material wouldn't otherwise be displayed on the screen or even released to the public if it didn't happen to be incidentally located on that particular 112
page, and the only reason put forward by your team for it being necessary to reveal this extraneous material is their own administrative convenience.

Now, my Lady, we don't make light of the burden that is on your team. Our team are receiving the documents that are being disclosed by your team and it runs to tens of thousands of pages for this entire Covid Inquiry, but of course what your team is saying is it would create an additional work for teams who are already working extremely hard if they had to prepare these documents in a way that only revealed the material people want to ask about. It's simply too much work for them, they say, to cut and paste from the Word document and then only display the relevant material the screen.

What we say is it's just not necessary to display this material, and administrative convenience is not a sufficient reason for you to justify the interference with any individual's Article 8 rights, and administrative convenience is the only matter being put forward by your team for why it's not being done.

You must, of course, consider the position of the press and their Article 10 rights, the press and the public, and what Mr Bunting KC says is that Article 10 is engaged and that, in the spirit of openness and transparency, the press and the public should have full 113
the Inquiry which have been shared with all of the core participants. You required us all to sign strict undertakings that we wouldn't do so, save of course when those documents are put into public during the evidence and properly probed.

As you have already recognised, in your own control and your own oversight of that disclosure process, the press and the public are simply not entitled to see a copy of every document that everybody has handed to you. It's the ones that are relevant to the Inquiry in public that of course should be made public.

So, my Lady, we say the real point you must consider in determining this application is whether material irrelevant to any question asked by anyone should be presented -- sorry, extraneous to any question asked by anybody should be presented in public in these hearings at all. Sir Patrick only seeks a ruling that when his personal reflective evening notes are displayed in public, the only parts put on screen and later published on the Inquiry website are the parts that him or another witness is asked about or a core participant wishes to refer to.

The UKHSA do support that request. We say extraneous material and personal notes should not be shown simply because it appears on the same page as 115
access to the evidence presented in these public inquiry hearings.

My Lady, of course that must be right. The principle of open justice doesn't need repeating by me. They are very good ones that you should follow and that UKHSA support. But the question you must ask is: openness and transparency about what? Sir Patrick is not objecting to anyone seeing any information that is relevant to any question anybody wants to ask of him or of another witness, and that includes your team and core participants.

There is no issue being taken by Sir Patrick about anybody using this material to probe it and to probe it with any witness. No suggestion for curtailing Article 10 rights in that respect. The press can freely report anything said in this room, and will be able to freely report the content of anything that is put to a witness by anybody. It's for that reason it doesn't appear to us this is a request for a section 19 restriction order either, as the press have construed it in their written submissions.

If section 19 does bite here, surely the necessary restriction has already been directed by you when, for very good reason at the outset of this Inquiry, you ordered that no person may publish documents received by 114
the relevant matters that are properly being probed in the Inquiry, and that inconvenience to the Inquiry legal team to abridge pages -- and we say that's the correct word, this is not about redaction, it's about abridging to the relevant matters -- and that abridgment may be administratively inconvenient but that it should still be done.

> My Lady.

LADY HALLETT: Thank you very much indeed.
Anybody else? Mr Keith.

\section*{Submissions by LEAD COUNSEL TO THE INQUIRY}

MR KEITH: My Lady, the issue at the heart of this particular argument is whether the principle of openness demands that where CTI or a core participant has referred to a particular passage from a page of Sir Patrick's evening notes in the examination of any witness, and has had that passage put up on the screen, the rest of the page, perhaps even the rest of the diary, part of which would have been displayed alongside the particular excerpt, must then be published and made available to the press.

My Lady, in fact just to make absolutely plain the factual premise of this argument and, I apologise to the core participants, to move a little way the target at which they have been aiming, Mrs Laura Taylor, who is 116
the Module 2 lead solicitor, assures the Inquiry legal
team that it is quite straightforward in practice to
type up each excerpt to which any witness may be -- may
have that passage referred to, individually on
a separate page, on the screen, and therefore, in the
course of time, to have that particular page with only that particular excerpt published.

But the point of principle is still required to be resolved by you, my Lady, because, firstly, that doesn't dispose of the issue as to whether or not in any event there is an obligation for the rest of that page and the original diary to be published or the rest of the diary itself. And also the ruling may have relevance to other dairies which are in the possession of the Inquiry, parts of which may also be put up in due course by way of individual excerpts.

The ruling may also have relevance to WhatsApps and texts, because the WhatsApps form part of groups and the texts form part of screenshots, although of course very different weighing up considerations will apply to such material because they are all, by definition, material sent by one person to another, and therefore the engagement of privacy rights is attenuated.

Turning to the substance of the legal argument,
the first issue for you is whether there is a reasonable 117

So Sir Patrick's reasonable expectation of confidentiality and privacy still endures.

My Lady, the heart of this part of the legal argument may be thought to be this: such part of the notes as has been disclosed to the core participants was disclosed because it was relevant to that particular part of the Inquiry process, that is to say the provision of material to the core participants to meaningfully engage in this process. They weren't disclosed to the core participants to enable the core participants to publish them or with an expectation that they would automatically be published. So you may readily conclude Sir Patrick still has a reasonable expectation of privacy.

The second argument concerns the well known weighing up exercise between Article 10 and Article 8.
Article 10, the freedom of expression, is of vital importance in the freedom of the press, it is statutorily reinforced by section 12.4 of the Human Rights Act, and it is an important Convention right. But on the facts of this case, it is limited in this particular way: we are not here dealing with a case in which a document has been given to a judge by way of a skeleton argument in the course of an open extradition hearing, the Guardian News and Media case, where plainly 119
expectation of privacy on Sir Patrick's part. In essence, is there an interference with his Article 8 rights?

My Lady, the excerpts all come from a diary which was compiled and held privately, and Sir Patrick has explained it was not meant to be published or, indeed, known to anyone. And of course he has given it to the Inquiry only because the Inquiry sought its provision under Rule 9. The diary is confidential and of a private nature, even though, of course, the contents traverse matters that were very much in the public domain, and of course are relevant to the Inquiry's work.

It may be thought that a diary is a paradigm example of material protected by confidentiality. You may conclude his views were private and protected by privacy, even if what he talked about was not.

His notes were given to the Inquiry quite properly and to the core participants, but the notes which have been provided to the core participants are still protected by confidentiality obligations. They're held subject to an undertaking. Although many members of the groups will have seen the material under the terms of those undertakings, many others have not, and the confidentiality obligations still endure. 118
openness and the principle of transparency demands that material be published and made available.

Nor is it a case in which material has gone to a decision-maker in the course of a criminal trial, where plainly the principles of open justice demand that such evidence or material be publicly disclosed. This is material which has so far only been given to core participants under confidentiality undertakings in the course of a public inquiry.

My Lady, you will recall well, of course, the general advice in the Prince of Wales case, which you are familiar with. Neither article has precedence over the other automatically. There must be an intense focus on the comparative importance of the right being claimed on the facts of the case. The justifications for interference with each right must be taken into account. And the proportionality approach in Bank Mellat in the Supreme Court must be applied.

Article 8 undoubtedly applies because, for the same reasons which deal with the reasonable expectation of privacy, the material, by virtue of being given to the core participants, has not been made publicly available.

In that weighing up exercise, you may conclude that the following particular aspects are of great importance:

120
1. The confidentiality of dairies reflect an important public interest.
2. Private dairies engage the highest level of confidentiality, Sir Patrick Vallance has the right to a private space, the right to be able to commit his private thoughts to writing and to keep them private, the more so as he is a public figure.
3. The press will be able to publish, of course, those parts of the dairies which are put to witnesses and are put on the screen by way of the individual excerpts appearing on a single identifiable page, they don't need the rest of the diary to be published in order to be able to publish that material.
4. Matters which are not drawn to the particular attention of a witness by CTI or the core participants, and are not put up on the screen, are by definition of lesser public interest.
5. Sir Patrick Vallance would not have expected and could not reasonably have been expected, when he provided the dairies to the Inquiry, that the whole of the diary would be published, not just the parts that were put to witnesses. He would only have expected that the core participants themselves would be able to see all the material, bar sensitive and irrelevant parts.
6. You have the useful analogy with the 121
referred to in their witness statements again, and I will give my decision as soon as I am ready to do so. In the meantime, we will continue with the same system we have been utilising to date, which is that if we don't have the system in place whereby just the passage can be put up online, then counsel will read out the relevant passage until \(I\) have reached my decision.
MR KEITH: Thank you very much, my Lady, that's extremely helpful.
LADY HALLETT: Thank you.
PROFESSOR ANTHONY COSTELLO (continued) Questions from LEAD COUNSEL TO THE INQUIRY (continued)
MR KEITH: Professor Costello, you remain under oath.
We were talking before lunch about basic infection control measures, and your evidence was to this effect, if I may summarise it without injustice: that a core infection control measure is testing alongside trace, contact, isolation, for the purposes of, firstly, understanding the spread of the virus, secondly, breaking chains of transmission.

At what point can a government be expected to conclude that such basic infection control measures are required? Is it when an epidemic spreads from another country, becoming therefore a pandemic once it approaches a number of other countries? Is it when

Associated Newspapers case in which Prince Charles successfully persuaded the Court of Appeal to grant relief restraining publication of eight handwritten journals which, although copied to the Mail on Sunday by a disgruntled member of staff, had been seen by and disclosed to between 50 and 75 advisers or officials. His claim to breach of confidence and interference with Article 8 rights was upheld.

So, my Lady, those are the core features in the weighing up exercise which must be weighed, of course, in that balance between the extremely important right of freedom of expression, attenuated though it is in the particular circumstances of this case, and the Article 8 rights of Sir Patrick Vallance.
LADY HALLETT: Thank you very much, Mr Keith. I think you may need to express your appreciation to the stenographer. You were going quite speedily.
MR KEITH: Luckily my diction is now extremely familiar to our hard-working, beloved stenographer, but I apologise if it was faster than usual.
LADY HALLETT: I couldn't even get in to interrupt.
Right. Now we're returning to Professor Costello. I should just like to say that having heard those submissions I shall reflect upon them very carefully, I'd also like to go over the judgments that people have 122
infection breaches our own borders and is traced by way of such limited testing as there was of travellers as they enter the United Kingdom? Or is it when the science makes it clear, both from an understanding of the infection fatality rate -- which enables you to know what you're dealing with, how many cases there are, by comparison to how many will die -- and the degree of asymptomatic transmission? When -- or perhaps a mixture. When should a government, should this government have said, "We must now take infection control measures"?
A. Well, you need to prepare for it from the very beginning, when there is the first indication that things are serious. And I would argue from the evidence of others that by the third week of January, when people were dying in the streets in China, when three papers were published in The Lancet detailing human-to-human transmission, and Jeremy Farrar was saying that by 24 January it was clear this was very serious, that John Edmunds and Graham Medley both gave an interview to Reuters in which they said they knew this was very serious by that time, so the preparation would therefore need to be made for any virus for which test, trace, isolate and support could reasonably be expected to control the virus.
Q. Just pause there. Thank you.

We have a chronology, Professor, and --
A. Yeah.
Q. -- I would just like to take you through some of the more significant dates in January and February. INQ000303290. On the chronology, we can see on 9 January the World Health Organisation issued a statement regarding the cluster of pneumonia cases in Wuhan in China.

On 13 January, over the page, please, the Ministry of Public Health in Thailand reported the first case outside of China.

On 20 January, the World Health Organisation reported 282 infections, four of which were outside China, and six deaths.

The following day, on 21 January, the World Health Organisation published its first Novel Coronavirus (2019-nCoV) report.

What was the significance of that 21 January World Health Organisation report? Did it say anything about the extent of human-to-human transmission, therefore the likelihood of humans infecting other humans?
Well, WHO had been handicapped because the director of WHO in China, Dr Gauden Galea had not been allowed access to Wuhan, despite repeated requests, so this was 125
A. Yeah.
Q. -- of the nature of the virus was apparent?
A. Well, it was changing very fast at that time. And you're quoting the 22 nd, which was the day after China had, for the first time, admitted the scale of deaths in Wuhan. For the previous five days they'd been saying there were none. And so it was a fast-moving situation, but certainly by the 24th, if you go on, it was becoming clear that there was human-to-human transmission. And there were three reports in The Lancet which referred to this which were published based on data that had been collected in the first three weeks of January.
Q. That data published, as you rightly say -- I think there was an article in The Lancet. There was also another article in the Journal, the New Journal of Medicine, showed that in relation to particular clusters of infections in China, there was sustained human-to-human transmission between close family members.
A. Yeah.
Q. So should one have taken from that that transmission between humans generally was now established? If it was happening between close family members, it was likely to happen between members of the public?
A. I think so, but it would also indicate that you have an even better chance of closing it down if your
a report which just said that the evidence now emerging was that human-to-human transmission was happening, in which case the threat of a substantial pandemic would be likely.
Q. On 22 January, in the United Kingdom, the Public Health England UK risk level was raised from very low to low. I'm not going to ask you about the meaning of that --
A. Yeah.
Q. -- it's a term of art on which we will hear evidence from others.

That 22 January was, in fact, the first time that SAGE sat, it sat on a precautionary basis, that is to say it had not been formally convened --
A. Yeah.
Q. -- but it came together on a precautionary basis without formal activation by COBR. The minutes record, if you take it from me, please, Professor, at point 7:
"There is evidence of person-to-person transmission. It is unknown whether transmission is sustainable.

There is no evidence yet on whether individuals are infectious prior to showing symptoms."

So by this week in January, do you believe that it was clear that the virus in China would spread outside China, would eventually reach all countries? In which case, what degree of understanding --

126
supposition was not correct, that, you know, the most important thing is to close down an infection from close family members, and therefore that makes it easier if you can close down households. And that's the first principle.

Remember that in the early days you don't have tests, so what you go on are symptoms and close contacts, and if you can close that down then you hope that you can bring about containment.
Q. Of course --
A. And suppression actually.
Q. -- at this point, on 22/23 January, there had yet been no cases in the United Kingdom at all?
A. No, correct.
Q. All right.

Around that same time, Imperial College issued what was then known as its third report, which estimated that the basic reproduction number, R , was above 1 , meaning every single person would be likely to infect more than one other person in an unimmunised population, which indicated self-sustaining human-to-human transmission, and they stated that that implied that control measures were needed to block well over 60\% of transmission to be effective in controlling the outbreak, because the likelihood was that one person would infect between 128
two to three people, in fact, and therefore, with that level of increase, a corresponding amount of pressure would have to be applied to keep the outbreak under control.

By that week, so the week of 24/25 January, do you believe that the United Kingdom Government should have been taking active steps to prepare for the inevitable arrival of the virus here?
A. Well, I certainly think all the alarm bells were running -- were flashing, and therefore having a meeting, which they then went on to have on the 28th, would have said: look, we know this is a coronavirus, what are WHO saying? What's happening in the East Asian states? And should we be setting up advisory groups to deal with how we get a national test, how we can set up community mobilisation for contact tracing? And what should be our quarantine and isolation policies?

Those are the kinds of things. And obviously if this is growing -- you know, between the 24th and the 28th things started to happen, and in fact that was the time, on the 27th, when I sent a message to Dr Peter Singer at WHO, who was one of Dr Tedros's advisers.

As you know, on 23 January, the PHEIC committee, the public health emergency of international concern 129
how big the outbreak is, how widely the virus spreads,
and how great the transmission is?
A. Except by the 27th we knew that it had spread to 17 countries.
Q. Right.
A. We knew that it was, therefore, spreading quite quickly.

We also knew from the studies in The Lancet and from anecdotal reports that the case fatality rate of people in hospital was worryingly high --
Q. Just pause there.
A. \(--5 \%\), yeah.
Q. Just pause there, because you've raised something that we need to explore. The case fatality rate, as it suggests, is the number of people who die amongst the number of confirmed cases --
A. Correct.
Q. -- hence case fatality rate?
A. Yeah.
Q. That's not the same, is it, as the number of people who die amongst everybody who has been infected?
A. Correct.
Q. That is the infection fatality rate?
A. Correct.
Q. But at this stage, no one knew what the infection fatality rate was, did they?
committee, at WHO met. That's not an internal committee, it's an external -- you're going to come on to that.
Q. Just pause there, just to make plain, when you say "PHEIC", you mean P-H-E-I-C, the acronym, not "fake", F-A-K-E.
A. No, that's right, I beg your pardon.
Q. Professor Woolhouse was telling the Inquiry earlier that one of the major problems when facing an emerging outbreak, an emerging epidemic, is knowing whether or not the number of cases in which people are seriously ill or will die is reflective of the whole scale of the outbreak?
A. Correct.
Q. So they may be a very small proportion of people who are infected, or they could be a very large proportion of people who are infected?
A. Yeah.
Q. At this stage, the UK Government couldn't and didn't know whether or not people who were dying in China were a large proportion of the people who were infected or a small proportion?
A. Correct.
Q. That was a vital issue, was it not, because without knowing the answer to that question they wouldn't know 130
A. No, they didn't, but one knew that, being a coronavirus that the SARS had had an infection fatality rate of \(15 \%\), SARS-1. MERS was \(30 \%\). So the likelihood was that this was going to be significantly more serious than seasonal flu.
Q. Right.
A. So, on the precautionary principle, you would have to say: yes, we think the infection fatality rate is going to be lower than the case fatality rate -- and I thought Chris Whitty got this about right, he thought he would bring it down to \(1 \%\). And that was something that -I shared the same view. But even at \(1 \%\), if you've got a respiratory virus that spreads around a country and infects \(60 \%\) of the population, \(1 \%\) is a lot of deaths.
Q. Just pause there.

You've introduced the notion, the subject of the precautionary principle. Is that a term of art or a shorthand for saying you may not know what the precise nature of this outbreak is, you may not know its latent period for sure, how long it takes for someone to be able to infect somebody else, how often it doubles, what its infection fatality rate is, but if you believe that that virus is coming your way, you must act early in a precautionary way to cover the eventuality that it breaks through. Is that the nub of it?

132
A. Yeah. And I think that, on the 28th, when they met for the second meeting, that's the kind of thing they should have been talking about: who are the coronavirus experts? What are the plans we should be making? And -- rather than taking a very final decision about this is pandemic flu.
Q. Just pause there. So could we have INQ000057492, please, which are the minutes from this -- it was the second stage, wasn't it, Professor --
A. Yeah.
Q. -- on 28 January.

Just to get out bearings, we can see this is the -well, it's called the "Addendum to the second SAGE meeting":
"This addendum clarifies the roles of the SAGE attendees ..."

There are then the attendees listed.
My Lady, the names of the junior officials and the secretariat are redacted under the ordinary principles.

If you could go, then, please, over the page.
Paragraph 1:
"[Department of Health and Social Care] to send PHE isolation plan to behavioural scientists (see further action below)."

If you could scroll back out, please, 8: 133
want a screening or a test that will pick up all potential cases or as many as possible.
Q. Just pause there.

The capacity to run 400 to 500 tests per day, at this stage in the process, Public Health England, the government, was testing some people who were arriving, because there were tests done on travellers, as well as testing of index cases. That is to say, persons who have got the infection and they're being tested, as are their contacts, to try to identify the first few hundred cases; is that correct?
A. Correct.
Q. Would a capacity of 400 to 500 tests per day suffice in the event that the virus spreads, known or unknown, and reaches thousands or more?
A. No. But can I just point out that this refers to the capacity of PHE. Public Health England is a misnomer. Public Health England does not cover most of the public health services of England. The -in 2013, when the Lansley reforms came in, all the districts, 309 districts in England, their public health was moved from NHS control to local authority control. So all of the district public health teams were under local authority control. Public Health England was a little bit like a sort of government
A. Which is worse, of course, the false negative. So you 134
thinktank of experts with a limited number of laboratories, I think they had eight laboratories. But around the country we had 44 molecular biological laboratories for virology testing, which was completely outside of the Public Health England control.

So when we're talking about the 400 or 500 , that's what they would have managed. And later it was argued if they could only manage that there was no point in us developing it.

And I should point out that South Korea --
Q. I'm sorry, Professor, there is a method to my madness. We will be coming on to these issues. But the way in which you answer makes it difficult for us to follow and for the stenographer to record, so please try to restrain your answer.

So this is a reference, then, to PHE testing?
A. Yeah.
Q. We'll come back to the question of whether there were other testing facilities available of which PHE failed to avail itself. That's a separate issue.

Could we look, please, at paragraph 19:
"Control measures: ideally infection control in healthcare settings and rapid detection of cases."

20:
"It was agreed that Pandemic Influenza infection 136
control guidance should be used as a base case and adapted."

What do you understand that agreement to have amounted to?
A. Well, I --
Q. And shortly, please, Professor.
A. Yeah. I've linked that to their decision to allow the virus to spread, and to come up with their strategy of contain, delay, research and mitigate rather than suppress. If you're following a pandemic influenza strategy, then you cannot control the virus.
Q. Just pause there. There is a reference, a plain reference to "Pandemic Influenza infection control". Is that a throwback to the strategy that you referred to earlier, the 2011 pandemic flu strategy?
A. Yes.
Q. There was a strategy for dealing with flu pandemics?
A. Yeah
Q. Under that control guidance, as you described earlier, there's little point having a test because people become infected and then show symptoms and infect others so quickly --
A. Yeah.
Q. -- there isn't a window in which to test?
A. Correct.
Q. Where does it say in paragraph 20 "we cannot suppress this new virus"?
A. It's an implication from saying "Pandemic Influenza infection control".
Q. Is it?
A. Yeah.

LADY HALLETT: Doesn't the "Action" suggest it as well?
"... SPI-M to advise on actions the UK could take to slow down the spread ..."

Not suppress it.
MR KEITH: Is slowing down the spread part of either mitigation or suppression or neither?
A. Suppression is where you control so that you get the \(R\) value below 1 and the number of cases will peter out, and then you put in place a system whereby if there are any outbreaks you can jump on them quickly.

But --
Q. By way of test, trace, contact, isolate?
A. Yeah.
Q. In paragraph 21, SAGE makes the point that there is:
"Currently no evidence of control measures having an impact on transmission rate, but [that that] is to be expected ..."
A. Yeah
Q. Do you understand that is because no one, let alone in 139
Q. And the best control is to identify whether you have a symptom, and if you do, isolate.

Does it appear to you that there was any debate about the sort of control guidance that might be needed for a coronavirus as opposed to a pandemic influenza? That is to say, testing, whole-society isolation, stay at home orders, lockdowns.
A. No, not necessarily lockdowns. I mean --
Q. Well, that's for a later day, Professor.
A. Yeah.
Q. Just please focus on the question. Does this paragraph indicate to you that there was any debate on any of those other measures?
A. No, I can't say one way or another, because there's no mention of coronavirus control in the notes.
Q. No. But you describe the decision to draw upon pandemic influenza control guidance and vary it as being a fatal error. Why is it a fatal error, in your opinion?
A. Because if that's what they're assuming, that you cannot suppress this virus, then it completely releases the pressure on them to set up a group to look at scaling up a national testing system, a national contact tracing system and, very importantly, policies that would enable people to be quarantined and isolated and financially supported.

\section*{138}

China, had produced the data which showed what the impact would have been or was of applying measures?
A. Correct.
Q. All right.

At the bottom of the page, as my Lady has noted,
there is an action. You describe this action as being a second fatal error, and the Inquiry understands that you do so because the action was directed at SPI-M.
A. Yeah.
Q. The modellers. What, in your opinion, was wrong about asking SPI-M, modelling scientists, to advise on, by implication, practical actions that the United Kingdom could take to slow down the spread of the outbreak?
A. Well, first they called it scientific pandemic influenza modelling.
Q. Would --
A. Well, no --
Q. Professor --
A. -- this is important, because actually it should be SPC-M, It should be about coronavirus. So the wrong virus and the wrong strategy.
Q. Let us not get into a debate about the correctness of the terminology under which the group operates. What, in your view, was the fallacy or the error in having --
A. Right.
Q. -- SPI-M as a group of expert, well intentioned scientists, albeit modellers, advising on actions that the United Kingdom could take?
A. Because they were asked to model slowing down the spread, but they were not asked to model the impact of test, trace and isolate, and they did not do that. They basically looked at a whole number of other measures like school closures, like large events, like face masks, you know, whatever, all the various so-called NPIs, but they didn't model what all the East Asian states were doing and what WHO was recommending.
Q. Because those measures were measures more usually associated with flu pandemics and they were the measures which in fact were reflected in the 2011 strategy?
A. Yeah.
Q. Right.

To what extent do you understand that SAGE was calling here for practical steps to be taken to put boots on the ground, as you describe it, as opposed to modelling what might happen?
A. Yeah, they seemed to be focusing mainly on modelling, and the absence of an independent UK public health expert on the committee meant that there was no one challenging this idea. To me, and particularly in light 141

The director general, Tedros Ghebreyesus, said:
"The continued increase in cases and the evidence of human-to-human transmission outside China are of course both deeply [disturbing]."

Had you contacted the WHO yourself in order to persuade them to declare a PHEIC sooner than it did on 30 January?
A. Well, after the decision on the 23 rd, I was fairly certain that many of the internal people at WHO were keen to have declared a PHEIC straightaway.

Remember, WHO had been very severely criticised about the slowness of its response to Ebola in 2014/15, and I therefore sent a message to Tedros's -- he calls himself Dr Tedros, so it's -- to say: listen, it's spreading, 250,000 cases are predicted by the end of the week, it's in 17 countries, we therefore -I strongly urge you to try and persuade the independent committee to get a PHEIC.

In fact Tedros was already on the plane to China to get a commitment from \(X i\) Jinping to let them in, and in fact a PHEIC was declared on the 30th.
Q. All right. From the viewpoint of the United Kingdom, what difference would it have made, if any, if a public health emergency of international concern had been declared on 23 January, as might have been possible,
of what WHO were saying at the time, and later from the evidence in February from all the East Asian states, we needed to move fast to get a national test system, to mobilise contact tracing and to set up isolation procedures, and we weren't doing that, and we were therefore effectively allowing things to spread or to accept that we couldn't suppress it.
Q. In your statement, you say that:
"From January 28 the UK advisory die was cast. The UK medical and scientific group of experts saw it as a flu epidemic. In their view there was nothing the UK could do to stop it, only to manage its progress, [and ultimately, of course] to protect the NHS."

Is that the genesis, in your view, of the contain, delay strategy and also the strategy, as it became apparent in March, of mitigating, levelling the curve --
A. Yeah.
Q. -- suppressing the sombrero as opposed to trying to stop the virus in its tracks?
A. Yes, I think so. And I think it's backed up by what Patrick Vallance and Chris Whitty have said.
Q. All right. That's a matter for my Lady, not, I think, for a witness.

The World Health Organisation then reported on 29 January, INQ000268222, at page 4. 142
rather than on the 30th?
A. Difficult to say, but a declaration of a PHEIC does have certain implications from the International Health Regulations, and I think it would have probably brought forward some of the discussions going on with the SAGE. But it's difficult to speculate beyond that.
Q. All right.

At the beginning of February, on 3 February, SPI-M-O, the operational modelling subcommittee of SAGE, issued a consensus statement, and I'm just going to read out two of the conclusions, Professor. You won't find it on the page in front of you.
"The number of confirmed cases of 2019 novel coronavirus in China is estimated to be at least ten times higher than the number currently confirmed."

Number 7 of the consensus minutes:
"It is unclear whether outbreaks can be contained by isolation and contact tracing."

If you had read on 3 February that consensus statement from SPI-M-O, what view, if any, would you have reached on the likelihood that the virus would inevitably reach the United Kingdom?
A. Well, I -- by that time I was pretty certain it would, because it was going -- it was already spreading at speed. Whether I would have agreed with their unanimous 144
conclusion about it not -- that measures would not control it, is another issue. And I would not make that decision without consulting with East Asian groups and with WHO, who were making it very clear that at all costs you have to act fast to suppress the virus.
Q. I think to be fair to SPI-M-O, Professor, I read out the words that made it absolutely clear that they're talking about the cases in China, so all they were saying is, at number 7 , it is unclear whether outbreaks, in parenthesis in China, can be contained by isolation and contact tracing. They weren't saying to the East Asian countries, other countries, "Don't put measures into place".
A. Well, by 18 February, a report in early March showed, they had already in China nationally got their R0 below 1 .
Q. We will come to that.

On 4 February, SAGE minutes record that the figures showed that potentially only one in 15 cases in China was being ascertained and that asymptomatic transmission cannot be ruled out and transmission from mildly symptomatic individuals is likely.

At what stage does a Government need to know the degree of likelihood of asymptomatic transmission before deciding whether to take proactive steps to put 145
A. Yeah, I would have expected that the week before, yeah.
Q. -- put a new test and trace and isolate system into place, to start seriously considering steps for social restriction, for breaking the physical gaps between members of the public to stop transmission. All this, Professor, before there are any more than a handful of cases in the United Kingdom?
A. Yeah, I mean, we -- at that stage we had to assume that a pandemic was going to happen, it was spreading fast, and therefore we needed to know that we would have the basic tools for control rather than having to go into a kind of national lockdown with 400,000 people dying as a result of a \(1 \%\) mortality rate.

So, you know, you have to weigh up options, but you want to make sure that the country has the option to control it, as indeed the East Asian states showed they could control it and suppress it, in the ensuing few weeks. So that's what I would have advised, yeah.
Q. Two questions, please.

LADY HALLETT: I'm just wondering if that is a convenient moment.
MR KEITH: My Lady, yes, it is.
LADY HALLETT: Do you want to ask those two questions?
MR KEITH: No, they will no doubt open another
Pandora's box, so perhaps that is a convenient moment.
measures into place?
A. Well, obviously if you don't have an antibody test you can't measure it, so you have to make some good guesses on the basis of pandemic science, and if you were at some stage to show me the diagram that was published by Anderson, Ferguson and others after SARS-1, which shows the relationship between R0 and asymptomatic spread, then it would very clearly show to my Lady the limits and desirability of different strategies.
Q. That is in fact the 2004 report --
A. Correct.
Q. -- to which you refer in your statement.

But I'm going to decline your invitation, Professor, and not put it to my Lady, because I'm driving at a different point, which is not whether the science shows that there are measures open to you to take, depending on the degree of asymptomatic transmission, but whether, given that it was understood by 4 February that asymptomatic transmission cannot be ruled out --
A. Yeah.
Q. -- you would have expected measures to be taken by that stage by the United Kingdom Government?
A. To do?
Q. To take -- set up working groups, as you suggest in your statement, to --

146

LADY HALLETT: All right, 3.30, please. (3.15 pm)

\section*{(A short break)}
( 3.30 pm )
LADY HALLETT: Sorry for all the breaks in your evidence, Professor.
MR KEITH: Professor, on 22 February, United Kingdom passengers from the Diamond Princess cruise ship came back to the United Kingdom. The Inquiry has heard evidence that that was a cruise ship which was quarantined by the Japanese Government after there was an outbreak on board. I think a passenger tested positive for Covid having left the ship, and he had earlier been taken on board in Hong Kong, so the virus had spread on board.

The crucial feature, though, of that cruise ship and the infection was, wasn't it, that because they were all tested, the authorities in Japan and then the rest of the world were able to work out how many -- what the percentage was of those persons had showed no symptoms, and were there asymptomatic?

Around the same time there was a field report from the World Health Organisation, 24 February, which showed their up-to-date thinking in relation to the extent to which the virus was asymptomatic.

148
What was the impact, in your view, or what should have been the impact in your view, on the United Kingdom Government of those two separate pieces of knowledge?
A. Well, on the WHO report, they had gained access to China, a big independent 25 -person team to go and look at the situation, and they measured the case numbers at the beginning and the end of their stay, which was nine days, and then they held -- they published a report straightaway and held a press conference. So it was very widely covered. And they basically laid out all the details of a proper mobilisation of a country. Remember, they didn't have a national lockdown, they had a local lockdown in Wuhan, and then in the rest of the country they put in place all that was needed to mobilise people, to get tests out there and, most importantly, to isolate and to support people to isolate. Their bills were paid, their food was paid. You know, they made sure that people weren't worried about isolating. Which was a huge problem in this country, as you know, later.
So there was the guidance that should have really been absolutely critical to guiding the UK response, but I didn't see any discussion of it in any of the minutes that I looked at, in SAGE.
Q. In essence, is your evidence that certainly by that 149
were they referring to the current end of winter, being the end of February? I'm not quite sure what that means.
Q. By 18 February, Professor, SAGE 8, Public Health England informed SAGE that they could cope with five coronavirus cases per week, generating 800 contacts that would need contact tracing. So each person who's infected goes into the system of contact tracing and isolation, each person generates a large number of contacts, five people would generate around 800 contacts, for argument's sake, that was the limit that PHE were saying they could deal with.

By this stage, 18 February, from the same standing start, how many people were South Korea testing?
A. By -- I think it was by about 22 February, they were getting up to beyond 15,000 tests per day.
Q. 15,000 per day?
A. Yes. And with regards to contact tracing, be aware, coverage is everything here. You know, people on the ground. Wuhan brought in 9,000 people for 11 million population. In Korea they mobilised a thousand junior doctors and many other volunteers to go to the hotspot areas of Daegu and another one.

So they were mobilising people very quickly. What I think they're referring to there at PHE was they had 151
stage, at the very latest, there should have been the pulling of a major alarm cord and a call for and the putting into place of a proper process of test, trace and isolate?
A. Yeah, and support.
Q. The reality, Professor, can be seen from some of the SAGE minutes as to the extent of the testing system which was then in place. Could we have, please, INQ000057492, page 2.

This is the minutes again of 28 January which referred to the 400 to 500 tests per day. At paragraph 8, there we have it again:
"Specific test should be ready by the end of week, with capacity to run 400 to 500 tests per day."

Could we have INQ000051925, please, the third page.
This is dated 4 February, paragraph 26:
"Although the UK is building regional diagnostic capability within weeks ..."

Is "diagnostic" a word for scientific testing?
"... overall capacity is limited. Capacity cannot be substantially increased during this winter influenza season."

What does that mean?
A. I'm not sure. Do they refer to the following winter, which would mean in another nine or ten months' time, or 150
just 270, approximately, contact tracers.
Q. Just pause there. So PHE had employed expert contact tracers, the people who phone round and contact and make sure that they can identify each contact of an infected person?
A. Yeah.
Q. But they had a number of -- a limited number of people available to do that job?
A. Within the narrowness of PHE. But across the country, we had a district public health protection team in every district. And my argument is that if we had wanted to mobilise, I worked out on coverage that to get the coverage of Wuhan you would need about 150 contact tracers per district on average, obviously proportional to the size of the population. So it would be possible, and indeed when they put out a call on March 24th for volunteers to help with the whole crisis, instead of getting 250,000 people that they wanted, they got 750,000 . And they weren't subsequently used, they only used about 20,000 of them to do tasks. So my argument is a lot of those people would have been health workers, retired GPs, I know some that volunteered, and they could have been employed to help manage on the ground contact tracing and, most important, ensuring that people isolated and stayed isolated for 14 days.

152
\begin{tabular}{lc} 
Q. Just pause there. \\
You've told us already that there was a limit on \\
the number of existing Public Health England regional & 1 \\
laboratories -- & 2 \\
A. Yeah. Yeah. & 3 \\
Q. - - who were in a position to do the testing, but that & 4 \\
there were other specialist molecular virology & 5 \\
laboratories capable of processing tests? & 6 \\
A. Yeah. & 7 \\
Q. \(\begin{array}{l}\text { In a number of statements from the Chief Medical } \\
\text { Officer, the Government Chief Scientific Adviser, and } \\
\text { other members of SAGE, there are references to the fact }\end{array}\) & 8 \\
that those other specialist molecular virology & 9 \\
laboratories didn't have the physical capacity to be & 10 \\
able to scale up the testing to the sorts of levels that & 11 \\
you have in mind. What do you say to that? & 12 \\
A. Well, I've heard this, and I would want to query if this & 13 \\
is correct. If we had set up at the end of January & 14 \\
a group, for example, with Sir Paul Nurse, Nobel prize & 15 \\
winner Professor Venki Ramakrishnan -- & 16 \\
Q. Well, don't worry, Professor, about the individuals. & 17 \\
\hline A. Okay. & 18 \\
Q. I'm asking you questions about -- & 19 \\
A. All the experts -- & 20 \\
Q. Excuse me. & 21 \\
\hline
\end{tabular} 153
A. Sorry, I beg your pardon.
Q. I'm asking you about the system --
A. Yeah.
Q. -- and whether the system could be scaled up to carry out the valuable work which you have said in your evidence was required to be done.
A. Yeah.
Q. Could those molecular virology laboratories have been scaled up, do you think, to meet the sorts of numbers that you have in mind?
A. Well, Allan Wilson, the director of the Institute of Biomedical Science, I referred to in my witness statement, has said why did they go to a Wild West scenario, he called it, of lighthouse labs when they could have used their own backyard people, who were linked in with all of the NHS facilities, so that the reporting of case -- of tests could have been quickly used to control the virus.

So my view is that an independent group should need to look and see whether we could have done this. But we are a big biomedical country, we have a lot of expertise across universities, across many different research facilities, and I would be surprised if these people, when consulted, could not have made a material contribution, but they weren't invited to do so. 154
A. Exactly.
Q. All right. So that may not take us much further at this point.
A. Correct.
Q. All right.

The government stopped all community testing on 12 March, and to recall the position, Professor, there were around about, at that time, some -- well, fewer than a 500 cases --
A. 500 , yeah, and about 10 deaths I think.
Q. What was the significance of the government stopping testing in the community?
A. I think their explanation was that they had limited number of tests and so they wanted to focus on hospitals, to make sure they could test there and presumably, later, other care facilities. But it was interesting that the very next day Dr Tedros put out a statement, I think aimed at the UK Government, saying it is -- in switching from containment to mitigation is both wrong and dangerous just because we've declared a pandemic. Because it was on the 12th the government were saying because WHO had declared a pandemic, which kind of everyone knew was taking place, that that was why they stopped testing. And I think that was a bit of a non sequitur.
Q. Your evidence is that the government's explanation was that they had stopped community testing because they had limited number of tests --
A. Correct.
Q. -- and they wanted to focus on hospitals?
A. Yeah.
Q. So if the reality, Professor, was they had to stop community testing because they had no tests and what tests they did have had to be focused on hospitals and the sick and the dying, why do you say in your statement that the United Kingdom should not -- you say it:
"... stopped all community testing ... This should not have happened."

Isn't the reality that they had to stop community testing because they ran out of tests?
A. Yeah, but we'd had six weeks where we could have prepared for this I believe in a way that Korea did, that China, that all the others did. I need to be convinced that in that six weeks of inaction, because of their strategy saying this was pandemic flu, that they could not have generated sufficient tests to cover the hotspot areas that we had at that time. That's the key to suppression.
Q. So the position is, then, Professor, isn't it, that it wasn't that decision to stop community testing on 157
test, trace, contact, isolate, support structure in place; correct?
A. In the early stages, remember in China and in South Korea they didn't have a test necessarily at the scaled --
Q. I'm sorry to talk over you. I'm asking you specifically about early March.
A. Yeah.
Q. You've established very effectively that South Korea, which developed a diagnostic test on the same day as the United Kingdom --
A. Yeah.
Q. -- scaled up its processes whereas we did not.
A. Yeah.
Q. But by early March, which is what I'm asking you about, given that there was no test, trace, contact, isolate support system, we had dropped the ball --
A. Yeah.
Q. -- given that there was no other non-pharmaceutical intervention measure short of a lockdown that would have the same benefits as a proper test, trace, isolate system, why does it matter if strategically the British Government did tell everyone it was continuing to pursue a mitigation rather than a suppression strategy?

12 March --
A. Yeah
Q. -- that was so wrong, it is that the reality of having to stop community testing was reflective of the terrible position in which the country had got itself, which is that there had been, by that stage, no attempt to scale up --
A. Correct.
Q. -- the testing process?
A. Correct
Q. Right.

In your statement, you then proceed to another error, or "fatal error" you describe it as, on the part of the government, which was to remove the possibility of epidemic suppression. So this issue of the government pursuing mitigation of a virus, of the virus, by way of reducing the levels of incidence, the spread, the overall numbers, as opposed to suppressing it and stopping it in its tracks.

From what you've said, there was by early March no effective scaled up test, trace, contact, isolate, support system in place; correct?
A. Correct.
Q. There were no real measures short of a lockdown that would stop the virus in its track, because there was no 158
A. Well, the first reason is that we ended up with serial lockdowns. We ended up with the biggest economic damage to our country in 300 years. We ended up with \(£ 407\) billion spent on furlough schemes, because it spread across the population. We ended up with \(£ 450\) billion of QE by the Bank of England. So massive economic damage.
Q. Professor, I'm very sorry to interrupt you again. That wasn't an invitation for an impressively fluent --
A. No --
Q. Please forgive me -- retrospective view of the entirety of the Covid pandemic.
A. No, 2020.
Q. I asked you: why does it matter in March 2020 that the government, and you showed us the SAGE minutes where they still pursued the mitigation strategy, why does it matter then that they go for mitigation rather than suppression if they had no practical means by which to mitigate properly?
A. Because you were going to need a find, test, trace, isolate and support system.
Q. All right.
A. Because what happened was, without an effective one, the first lockdown ended, we got it right down to nearly 500 cases per day, and then it just came back up again, 160
because we never had an effective find, test, trace and isolate.

So even if we were late, it was better to develop one and save subsequent infection, transmission and deaths than to not do anything at all.
Q. So the answer, then, Professor --
A. Yeah.
Q. -- is this, isn't it: that for those people in the government who in March were saying, "We must suppress the sombrero, we must reduce the level of the outbreak, to avoid suppressing one wave -mitigating one wave and then being hit by a second wave", in order to be able to deal with that second wave when it surely re-emerged --
A. Yeah.
Q. -- they would have had to have, they needed to have a proper test, trace, isolate, support system in place --
A. Correct.
Q. -- by the time of the second wave --
A. Yeah.
Q. -- which of course struck in the late autumn?
A. Yeah.
Q. That's what you're saying?
A. Yeah.

161
A. Effectively, because they -- I think Chris Whitty, in
the -- 5 March, when he was giving evidence to
the Health Select Committee, indicated that they were on the cusp of moving to a delay phase.

Can I just add one small point?
Q. Please.
A. This plan, contain, delay, research, mitigate, what confuses me is that both Sir Jeremy Farrar and John Edmunds have both said that this was never discussed at SAGE.
Q. Yes. My Lady's received evidence, and will receive further evidence, on that, Professor, thank you.
A. Thank you.
Q. Herd immunity --
A. Yeah.
Q. -- is a related issue, again of which you are -- you have much to say in your statement.

If you have a system, Professor, as the government, on your evidence, appeared to have, that the only thing that could be done with the virus was chop off the top level, mitigate it, suppress it, but allow a significant body of it to pass through the population, is herd immunity simply a recognition that that is a byproduct of such a strategy? If you don't suppress a virus completely, it will pass through the population and
Q. So the absence of a test and trace system resulted in a lockdown because there was no alternative, it resulted in the virus getting away from the United Kingdom, spreading uncontrollably in March, and it also ensured that we were hit by a second wave?
A. Correct
Q. All right.

You are critical of the government's strategy document that was published on 3 March, which is the contain, delay document.

We'll just have that on the screen, INQ000237322.
You'll recall, Professor, this is the document in which the government sets out its strategy, if we go forward to the first page, of containing, delaying, mitigating, researching -- perhaps one more page -I'm afraid I can't remember, I think it may be page 4. Let's try page 10, at 3.9. Ah, yes. The overall phases are: contain, delay, research, mitigate.

So as at 3 March, step 1 of the government's strategy was detect early cases, follow up close contacts and prevent the disease taking hold in this country for as long as is reasonably possible.

By 3 March, in the absence of a scaled-up test system, had containment of the disease already been lost?

162
eventually that part of the population through which it passes will gain immunity, hence herd immunity. Is that what this argument is? Is that what this issue is about?
A. Well, that only depends upon whether the virus induces persisting immunity. So if you, for example, with rubella, German measles as it's sometimes called, before vaccination many children would get this, and it would give them pretty much lifelong immunity, but this -coronaviruses are well known for not inducing such effective immunity, rather like flu, so the ideal is to get to a point where herd immunity is brought about by vaccination, given however frequently you need to boost the level of immunity. But herd immunity does mean that the virus has got nowhere else to go.
Q. So are you saying that an additional concern at this time was not just the wisdom of the strategy, but you were unclear as to whether or not -- or what the degree of immunity that allowing the virus to pass through the population --
A. Yeah.
Q. -- would engender?
A. Exactly. And there was the work of, you know, Sunetra Gupta and others who put forward this view that in fact most people had been infected and that actually 164
everything was going to die out very quickly, and the problem was that when the testing for antibodies came in, they did not find that.
Q. It became apparent that, relatively speaking --
A. Yeah.
Q. -- a very small part of the population --
A. Exactly.
Q. -- by the summer --
A. \(5 \%, 6 \%\) or something. Yeah.
Q. All right.

Now, two documents which you produced at the time, around this time, which is now mid-March, please,
Professor, you wrote to Chris Whitty, Professor Sir
Chris Whitty, on 15 March, INQ000282428, and you copied it to Richard Horton, the editor of The Lancet?
A. Yeah.
Q. And to a couple of other --
A. I think to David Nabarro, to Devi Sridhar and Jason Hickel.
Q. Who are all scientists?
A. Of varying descriptions.
Q. "Dear Chris,
"I know you must be incredibly busy and under great pressure. I quite understand the need to stagger some measures around social distancing ..."
A. Correct.
Q. -- isolation, support? All right.

Another document I want to ask your view on so that we can be clear about your position is the tweet that you sent on 13 March, two days before, INQ000268213:
"Doesn't this herd immunity strategy conflict with WHO Policy?"

Then you refer to Dr Tedros' remarks?
A. Yeah, yeah.
Q. Is that a reference to what you've just told us, which
is that you were challenging the wisdom of this
byproduct of herd immunity because it conflicted
directly with what Dr Tedros had himself recommended, which is --
A. Yeah.
Q. -- don't mitigate, don't chop the top level off --
A. Yeah.
Q. -- don't allow herd immunity as a byproduct, but
suppress, suppress, suppress?
A. Correct.
Q. All right.

In your statement, another area of concern is that of -- expressed by you -- behavioural fatigue?
A. Yeah
Q. The Inquiry has heard evidence, Professor, that at 167

Pausing there, by this time, Professor, the UK Government had announced the imposition of certain relatively limited social distancing measures --
A. Yeah.
Q. -- correct?
"... but many of us are at a loss to understand why the government has abandoned intensive population surveillance, contact tracing and quarantine nationwide, which is the bedrock of WHO advice on epidemic control."

Then you refer to South Korea, by implication, Japan, Taiwan, Hong Kong and China. And then you say this, in the last sentence of the second paragraph:
"... without it [that is to say population surveillance], I fail to see how you can really delay a huge epidemic in the next month which could totally overload the health system."

And of course, in the absence of a lockdown, the overloading of the health system is exactly what would have happened.

By that reference to population surveillance, although you don't use the word, did you mean testing as part of a surveillance contact, trace, isolation system?
A. Ideally, yes.
Q. Right. Because without testing there can be no proper surveillance, contact tracing -166
a press conference in early March and in COBR, the Chief Medical Officer said something along the lines of, "If we go too early with stringent measures, people will understandably get fatigued", and you have been very critical of the notion that people would, over time, decline to comply, to conform to non-pharmaceutical interventions, saying that there is no forensic or epidemiological basis for that idea; is that the nub of it?
A. Yes, I mean, I was drawing upon the psychologists who were on Independent SAGE and helping to advise us, and who actually -- one of whom was on SPI-B, Dr -Professor Stephen Reicher, and he made it clear that, you know, some of the statements coming out, "There is a risk if we go too early people will understandably get fatigued" and "The British would not accept Wuhan-style measures", that actually this was not correct and in fact the evidence showed that we did abide by lockdown measures to a great extent. And also that if you get the support right, as later happened in New York, where they were given generous support for self-isolation, you got \(94 \%\) compliance, whereas in this country many poor people did not comply with self-isolation simply because they couldn't afford to do so, and our -- the -- we were not generous with sick pay, we spent \(£ 54\) million in 2020 168
on sick pay, and we ended up, as I said earlier, spending vast billions on a furlough scheme.

So if we had got that right, there is no reason why there would have been behavioural fatigue, especially as isolation was the nub of the control policy.
Q. You are critical in your statement of a particular body in the Cabinet Office called the Behavioural Insights Team, BIT, or at least you suggest that its director was the genesis, the origin of behavioural fatigue as a notion.

Could I just ask you, please, to look at some minutes from SAGE on 13 March.

That's INQ000109142, page 4 of 5.
Paragraph 30 says this, under the heading, Professor, of "Behavioural science considerations", so this is 13 March, social restrictions have been in place but we're short of the lockdown so far:
"Difficulty maintaining behaviours should not be treated as a reason for not communicating with the public about the efficacy of the behaviours [and this] and should not be taken as a reason to delay implementation where that is indicated epidemiologically."

So my question for you is this, and it's the last question: do you accept that, regardless of the public 169

Covid Bereaved Families for Justice. Just on one topic, please, and that is a press conference, 26 March 2020, hosted by the then Chancellor, Rishi Sunak, and Professor Dame Jenny Harries. I think you might have seen some YouTube footage of that press conference in preparation for your evidence today; is that right?
A. Mm .
Q. And you remember it?
A. I have seen it, but I haven't seen it recently, but I think I know what you're going to say.
Q. Thank you.

My Lady, a copy of it is going to be disclosed on Relativity. I'm afraid, for technical reasons, I can't take the Professor to a video now, so I'm going to have to summarise it for him.

It's a press conference that causes the families that I represent some significant concern, and it was 26 March, as I say, it's after you'd written an article yourself, 20th March, called "The United Kingdom is flying blind on Covid-19", and Professor Dame Jenny Harries responded to a question about the WHO guidance called "Test, test, test". Is that the guidance you mentioned in your evidence a moment ago, 24 February, or did it come a little later?
A. Her "Test, test" -- the guidance from --
debate about behavioural fatigue and its validity, SAGE recognised that difficulty maintaining behaviour should not be taken as a reason to delay the implementation, the imposition of non-pharmaceutical interventions?
A. Yes, and I would also actually withdraw that statement about David Halpern, given that I read his own witness statement and presence here last week in which he said he clearly did not support that view. So since he's said that, I would take that back. I heard that from other people.

So, yes, I would agree with that.
Can I just say one thing or have you got to finish now?
MR KEITH: It's a matter for my Lady. There are some further Rule 10 questions, I believe.
LADY HALLETT: There are some questions to come. Let's see what happens when --
A. Okay.

LADY HALLETT: -- Ms Morris has asked the questions,
Professor, and we'll, if necessary, come back to the point you wish to make.

Ms Morris.

\section*{Questions from MS MORRIS KC}

MS MORRIS: Thank you, my Lady.
Professor Costello, I ask questions on behalf of the 170
Q. The WHO guidance.
A. Well, they -- I was going to say in response to that, because she said the WHO didn't apply to --
Q. I'm going to come to that, but just to get some dates clear, if I can. Was that guidance at the end of February?
A. Yes.
Q. Thank you. Okay, so just to give you some context Professor Dame Jenny Harries says this:
"The clue for WHO was in its title, it's the World Health Organisation, and it's addressing all countries across the world, with entirely different health infrastructures and particularly public health infrastructures. We have an extremely well developed public health system in this country", and then she talks about training other countries and offering expertise and experience. So the point there is that they're all addressing every country, including lower middle-income countries, so encouraging all countries to test of some type.
"When you come to the UK we've made it very, very clear there has been a plan right the way through this, which is entirely consistent with the science and epidemiology. We started with a containment phase and every early case of this disease was followed through, 172
every contact was traced exactly as we would do for other diseases but particularly noticing this one, and of course the viewers will be very familiar with the fact that we had some very strict and very successful containment facilities. But there comes a point in the pandemic where that's not an appropriate intervention and that is the point really where we moved, we moved into delay, and although we still do do some contact tracing and testing, for example in high-risk areas like prisons or care homes, that is not an appropriate mechanism as we go forward. At that point what we need to do is focus on the clinical management of the patients first and foremost and then additionally, as I have said earlier, on our health and care staff and first responders staff. So obviously if there was an infinite testing facility, and we are growing them at pace and we will have them, then it moves to the public, but we need to be very careful about focusing where it is clinically most valuable."

I've just read that out so you have the context and my Lady has the direct quotation from the relevant part of the video.

So, having regard to what you've said this afternoon about what should have happened, in your view, by 26 March, my first question is: is this press conference 173
nursing homes, preventative measures in workplaces and schools, importation risks are managed and communities educated, engaged and empowered. They put that out to every country in the world.

I would argue that we didn't do much of that.
Q. Understood, thank you.

My second question relating to the reference in the
press conference to the plan of containment and delay being entirely consistent with the science and epidemiology, do you agree with that statement?
A. No, I don't.
Q. And, thirdly, was there any evidence that contact tracing in vulnerable locations, for example care homes, was happening in a meaningful way in March 2020?
A. I don't think so.

MS MORRIS: Thank you very much, Professor, those are my questions.

Thank you, my Lady.
LADY HALLETT: Thank you very much indeed, Ms Morris. Is that it?
MR KEITH: My Lady, thank you.
LADY HALLETT: Thank you very much indeed,
Professor Costello.
THE WITNESS: Thank you.
LADY HALLETT: I'm very grateful for your help.
an example of the United Kingdom promoting itself as world class or exceptional to other countries?
A. Well, yes. I disagree with almost everything that was stated there. As you know, there was an assessment of pandemic preparedness where USA was 1 and we were number 2 -- this was by Johns Hopkins in 2019 -- and we ended up with five times the death rates of the East Asian states. So we've had 228,000 people die with Covid-19 on death certificates, 208,000 excess deaths, and that is a huge public health disaster. And if we'd had the South Korean, for example -- and remember South Korea, Japan are not poor countries, they have the same life expectancy if not better, same age, same GDP, and similar health systems to us, they took a different policy, and if we had followed their policy I would argue we could have stopped upwards towards 150,000 deaths.

So I disagree with her on that point.
I think she also made a comment about WHO only being appropriate for poor countries, or something similar to that. Can I just say one thing about that? The WHO put out, on February 3, a strategic preparedness and response plan and they said there are six priority actions: control transmission, do find, test, trace, isolate, outbreaks minimised in health facilities and 174

\section*{(The witness withdrew)}

MR KEITH: The next witness will be examined by Mr Keating. LADY HALLETT: Thank you.

Mr Keating.
MR KEATING: Thank you, my Lady, may I call
Professor Andrew Hayward, please.

\section*{(Pause)}

LADY HALLETT: I'm sorry you have been kept waiting for so long, Professor.
THE WITNESS: No problem.

\section*{PROFESSOR ANDREW HAYWARD (affirmed) Questions from COUNSEL TO THE INQUIRY}

MR KEATING: Thank you. Could you give us your full name, please.
A. Sorry, could you repeat that?
Q. Yes. Could you provide us with your full name, please.
A. Professor Andrew Hayward.
Q. Thank you, Professor, probably a good illustration that we should both keep our voices up. I will do that. Equally, if we can avoid speaking over each other and speaking at pace, to aid the stenographer who sits to my left.

Thank you very much for attending today. Can I echo the apologies as well for keeping you waiting, but we've sufficient time to cover the key parts of your evidence 176
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    today.
        Firstly, if we could just deal with the formalities
        and look at your statement, please, which is dated
        4 September of this year. It's in front of us, and if
        we could go to page 43, please, we see that is dated
        4 September, and you can confirm that you've signed the
        statement of truth?
    A. I have.
MR KEATING: Thank you.
My Lady, if we could have permission for that to be
formally published, please.
LADY HALLETT: Certainly.
MR KEATING: In terms of professional background, it's
correct you're here in a personal capacity, but you are
a professor in epidemiology and public health at the
University College London, UCL; is that correct?
A. That's correct.
Q. And that's where you were working full-time during the
pandemic?
A. Yes.
Q. Your employment has changed to an extent since then; you
now are primarily employed by the UK Health Security
Agency, and you spend 80% of your time there now?
A. Correct.
Q. In terms of epidemiology, just to assist the layperson,
1 7 7
make on the impact of transmission; and, lastly, lessons
learned.
So dealing with that first topic, and perhasps we
could turn to paragraph 5.1 of your statement and your
membership of NERVTAG.
We've heard already what NERVTAG is but briefly, as
set out there, it was originally an expert committee of
DHSC, but in due course it was designated as a subgroup
for SAGE; is that correct?
A. That's correct.
Q. And your role on the group was a scientist with
expertise in epidemiology of acute respiratory
infections; is that correct?
A. That's right.
Q. You've set out in your statement a number of examples of
the type of work NERVTAG was involved in, and that
included advice on border control measures,
hand washing, PPE guidance, face masks, transmission of
new variants; a number of different areas which I'm not
going to touch upon. I'm grateful for that information.
But in relation to that, there was one area which
you do touch upon at paragraph 5.6, which is social
distancing. Do you think this is an area where NERVTAG
should have been utilised more upon?
A. I thought it was an area of extreme importance, and was

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in a sentence or two, what does that mean?
A. Well, epidemiology was originally devised, if you like, as the study of epidemics, of which a pandemic is a major example. It concerns really understanding how diseases spread through populations, what causes people to get diseases, really by looking at patterns of diseases in populations compared to different exposures, lifestyle exposures or exposures to infections. And I'd say there is really sort of two broad branches of it, one of which is what I would call sort of more empirical epidemiology where we're trying to measure these things and draw inferences, and then there's also another side of it which is the mathematical modelling, where we're perhaps more concerned with making predictions about the future.
Q. We'll probably touch upon the first part of that in a moment. But in terms of the areas we want to deal with today, you've provided a comprehensive statement, and I'm not going to deal with every single part, but I'd like to deal with an overview and timeline of your roles.

You were on NERVTAG and SAGE EMG, which we'll turn to in a moment; secondly, you were involved in a number of significant scientific studies, which we will turn to, again briefly; and, thirdly, some observations you 178
very concerned that it should be being looked at, particularly during the run-up to the lockdown, as it became increasingly apparent that other measures were not going to control the epidemic. So at that time I raised whether this should be an issue that NERVTAG could look at, and I think at the time I was informed that this was an area that was largely being considered by another group called SPI-M, the modelling group.
Q. Yes. We've heard about SPI-M. Why was SPI-M sufficient for dealing with this --
A. Well, I'd hope --
Q. -- rather than using NERVTAG? Forgive me.
A. -- that it could be considered from other perspectives than purely modelling perspectives. So, really trying to think through some of the epidemiological evidence for why social distancing might be needed above and beyond the measures that were happening, and thinking about the science of why that might be, in relationship to our understanding of how Covid transmits and the clinical picture of Covid being one that ranges from asymptomatic to mildly symptomatic disease made me think that the current control measures would not be sufficient, and that there was value in NERVTAG or other groups considering this, and I certainly had thoughts about how I would like to approach looking at that. 180
Q. And what do you think the consequence of NERVTAG not being utilised was?
A. I think it's -- I think we could have added to the pressure to introduce social distancing measures earlier than in fact was done. I think we could have rapidly pulled together some of the rationale for why this was needed now, that would have complemented the rationale of the modelling work.
Q. My Lady has already heard about one of the subgroups of SAGE, which was the EMG, Environmental Modelling Group. That was set up, the original subgroup was set up in approximately April/May 2020. You weren't involved in the original subgroup, but then there was another group which flowed from that, which was the EMG group; is that correct?
A. That's correct, the EMG transmission subgroup.
Q. Correct, so you were on a subgroup to the original SAGE subgroup. When were you involved in the transmission subgroup?
A. Well, initially that started as what was called the Public Health England transmission group which was convened, I think, if I remember rightly, in October, and then it was transposed into a subgroup of a subgroup of SAGE, and its remit was really -- rather than the main EMG group, which was looking at sort of theoretical 181
more reactive rather than being proactive?
A. Yes, I would say that's true. And I think related to that there was also an issue that it was difficult within a subgroup to see what was going on in the wide range of other groups that were convened, and it was difficult to see what the discussions were, for example, in main SAGE. Even as a member of a subgroup, one didn't have access to the minutes of those meetings.
Q. And what would the consequence of that be, that you weren't aware of what other colleagues in parallel fields were doing?
A. I think it was that you could -- it was difficult to be certain that things were being picked up that should be being picked up. I mean, often one would assume that they were, because of the wide range of committees and the wide range of expertise on SAGE and its subgroups, but you never quite knew that.
Q. I want to turn, please, to paragraph 4.9, which deals with one of the issues regarding the composition of the subgroups you were involved in and the expertise.

So paragraph 4.9, please. That's on page 9 of your statement. You refer to good clinical advice being provided to NERVTAG, but you also make some observations regarding the advice from public health experts, which is touched upon in that paragraph.
considerations as to how Covid would spread in different environments, understanding things like viral excretion, how it ends up on surfaces, et cetera -- this group was really convened to look at the epidemiological evidence, ie more studies of -- that had measured how Covid was being transmitted in different populations in different settings, et cetera, and to advise on that.
Q. I think we may come back to the work of the transmission group in due course, which is probably related to some of your studies. But in relation to your involvement, that transmission subgroup and NERVTAG, you weren't on the full SAGE group; is that correct?
A. That's correct.
Q. And from your perspective as somebody who was on a subgroup to SAGE, did you have any observations or learnings from your perspective?
A. I think one of my observations was that, as a member of a subgroup, the agendas of those subgroups were very much set for you in terms of: we were asked to consider specific areas of science related to different areas of policy, but there were limited opportunities to sort of set our own agenda or to, if you like, step back and provide advice on what you think an overall response might look like.
Q. So your view was that NERVTAG and your involvement was 182

Perhaps I'm just going to ask you the question: did you think that there was sufficient representation from public health experts in the committees that you were involved in?
A. Well, I think there was -- there was input from academics with public health training and expertise, such as myself, but the way that -- if you like, the ethos of the committees was to provide scientific advice, and so it was very much focused on academics providing this advice rather than on being able to, if you like, stimulate discussions between academics and people who would be responsible for enacting control measures, so local public health people who've spent their lives working closely with communities of varying backgrounds to try to improve their public health. And I think that was, in a sense, a deliberate separation, to have the science then informing the policy, but in general I felt that we didn't have those opportunities for discussions across those divides.
Q. Well, let's develop that a little bit more, because you touch upon this in your statement at paragraph 4.12, and we can look at the last three lines in relation to that. You say this:
" ... greater involvement of service public health colleagues in discussions might have added value in 184
terms of thinking about feasibility of interventions, maximising effectiveness and addressing health inequalities."

How do you say it would have assisted in addressing health inequalities by having those public health colleagues with frontline experience?
A. Well, because I think a major part of the day-to-day role of public health colleagues across the country is working very closely with their local communities, trying to understand the different cultures and groups, trying to form connections with those groups in order to help to improve public health, and so they have a very real lived experience of how inequalities play out, and that would be a useful additional perspective within these groups, and would make you, I think, start to think more concretely about specific issues like if you're doing testing, tracing, isolation, how that's going to play out in different groups of the community.
Q. In your experience and your view, is it that that was something which was absent or lacking in the subgroups that you worked upon, that insight?
A. I felt that there wasn't really a strong focus on thinking about how different interventions would work differentially in different sectors of the population, and also perhaps how it would have differential harms in 185

I think we've been told that SAGE didn't have the directors of public health, people with the practical experience, haven't we, I think?
MR KEATING: That was an issue which was raised, my Lady, yes.
LADY HALLETT: Yes.
Thank you. Sorry, I just wanted to check I had it correctly.
A. Yes.

MR KEATING: I'm going to move on to our second topic, which is scientific studies, and there's four we're going to touch upon: the SAFER programme, which is one of the studies you undertook; secondly, the Vivaldi care home study briefly; thirdly, Virus Watch, and its sister study, Covid health equity study.

So let's deal with the SAFER study, and that was to measure infection in frontline healthcare workers.

I'm doing it in this order because I think you've indicated this is the sort of chronological order, back in 2020, these were undertaken.

So in relation to SAFER study, if we could turn to paragraph 3.11 of your statement, that's at page 7. And in relation to this, this was a study focusing on the infection in frontline healthcare workers, and you produce an exhibit which we're not going to turn to but 187
different groups of the population; how it might be difficult, for example, for people in very precarious positions, people who have jobs that can't be done from home, people in overcrowded households, et cetera, how they were going to -- you know, how the interventions would play out, and then what more we could do to support people in those positions.
Q. Thank you.

LADY HALLETT: I'm detecting two sources of criticism, and just correct me if l've got it right or wrong.

So, one, you don't have on this group, subgroups, subgroups of subgroups, you don't have people with the practical experience?
A. \(\mathrm{Mm}-\mathrm{hm}\).

LADY HALLETT: And, second, that with all the highly specific subgroups of subgroups and separating operation and strategy, you're not confident that things might not have slipped through the cracks?
A. From the position in the committee structure where I was, it felt a bit like that. I'd not -- I think the main committee in terms of SAGE would have had a much better overview of what all of the subcommittees were doing, but as a member of a subgroup it was difficult to see that.
LADY HALLETT: Then, depending upon the membership of SAGE, 186

I can summarise it, and indeed you summarise it yourself. This was focused on measuring rates of infection in frontline healthcare workers in a major London secondary care setting, UCL hospital.

Is this a fair summary, that this included regular testing for Covid-19 as well as antibody testing, and findings were that healthcare workers were at a high risk of developing Covid and may themselves have been contributing to its spread?
A. I think the main finding of that was that healthcare workers were at very high risk. For example, this study started pretty much about the same time as lockdown and already by that time, within Central London, frontline healthcare workers, I think about 20\% of them had evidence of infection.
Q. Well, can I help you in relation to that? Because your article, which I checked, which deals with the study, says this:
"Between 26 March and 8 April 2020 ..."
So very early in the pandemic.
A. Yeah.
Q. "... \(44 \%\) of healthcare workers had Covid at any one time."
A. That's correct.
Q. So a particularly high rate?
A. Well, over that period, by the end of that study, \(44 \%\)--
Q. Yes.
A. -- had been infected, which was higher than we had probably anticipated, and was probably the first study to show such intense transmission within healthcare settings to healthcare workers.
Q. Am I right in understanding that was published, as you say, in The Lancet and it sort of ensured wide readership and was raised at NERVTAG?
A. Yes.
Q. What impact do you consider that study had?
A. I think it had an impact on a number of things, for example, the use of -- widening the use of personal protective equipment to all encounters across healthcare settings. I think it also was critical in leading to the regular testing of healthcare workers, which was an important aspect of control in healthcare workers.
Q. Our second study in time order deals with the Vivaldi care home study report, and I have been invited to summarise that briefly with you.

It's an important topic, care homes, my Lady, and one which of course the Inquiry is going to deal with later by way of a further module.

So I'm going to touch upon it briefly, but at paragraph 3.9 you set out that you were 189
infection, from which we inferred that it was harder for people to not attend work if they were sick, if they were not being paid for that, and that that would contribute to infection.
Q. How significant were the findings of that study in relation to the understanding of transmission in the home care sector?
A. I think they were important directly in releasing central government funds to ensure that sick pay was provided to those working in nursing homes and to drastically reduce the use of agency staff. We also found very high levels of Covid within nursing home staff and nursing home residents which also influenced the regular testing regimes there. So I think, yes, it did have an impact.
Q. So significant in terms of knowledge, insight, but also funding towards agency staff?
A. Yes.
Q. And regular testing, or increased testing?
A. Yep.
Q. Moving on to the third and fourth studies, which are set out at paragraph 3.4, Virus Watch, and that's one which you've mentioned in your statement at considerable length and that you were significantly involved in -and that's at paragraph 3.4, thank you -- you were the
a co-investigator into the Vivaldi nursing home core study, and this was where testing took place between 11 May and 7 June. Do those time periods sound correct?
A. For the initial parts of the study, yes.
Q. Yes, and the outcome of that study -- did you want to previously summarise what the outcome, the headlines of that study was?
A. Yeah, I mean, this was an attempt to do a survey, in the initial parts, of as many care homes as we could across the country to try and identify what the risk factors for outbreaks in those care homes had been. What we identified, I'd say the main headlines was really the importance of staff in the transmission of Covid in those homes --
Q. I think we see those at paragraph 3.10 , if we move on one paragraph, just to complement what you were saying, Professor. So you mentioned that one of the issues was staff; do continue.
A. Yeah, so in particular, for example, we found that homes that had greater use of agency staff -- so these would be staff who might be working between nursing homes -had higher risk of outbreaks, from which we inferred that they would have been carrying infection from one nursing home to another. Also that homes that were unable to pay sick pay to staff had higher rates of 190
chief investigator in relation to this.
Am I right in understanding this was aimed to provide information on Covid-19 occurrence and risk factors in a large cohort of members of the public?
A. That's right, eventually in about 50,000 members. So large, but not nearly as large as some of the other community studies that were subsequently funded.
Q. You mentioned that that was related to an analysis of occupational health risks, at paragraph 3.3. Is that right, that it considered occupational health risks?
A. Occupation was one of the key things that we focused on because of the importance of that as a risk factor for Covid.
Q. In terms of the time period when the Virus Watch study was carried out, am I right in understanding this was between June 2020 up until August 2021?
A. Yes, in fact there's elements of the Virus Watch cohort that are still being followed up as well.
Q. In relation to the sister study, as you describe it, the "Covid Health Equity" study, can you briefly explain what that was?
A. The health equity study was really a recognition that most studies tend to have an under-representation of people from ethnic minority groups, and so we aimed to deliberately go as hard as we could to recruit many 192
people from ethnic minority groups so that we could start to draw some inferences from there.
Q. And roughly at what stage did the Covid Health Equity study commence?
A. It was a little bit later, but certainly it meant by -we were actively over-recruiting people from ethnic minority groups probably from about October.
Q. So the position was the first study which we mentioned, the Virus Watch, commenced around June 2020 and that additional work to have a wider perspective and knowledge in relation to those from certain ethnic groups was October 2020.

You mention in your statement the background, by May 2020, that there was reports and information to suggest that there was a greater risk of mortality in certain ethnic groups; isn't that correct?
A. That's correct. We had seen within the NERVTAG committee there had been -- we'd been examining some of the reports of hospitalisation from Covid from the national studies of hospitalisation, and it appeared from those reports that there was an over-representation of people from black and Asian ethnic minority groups amongst those hospitalised, that they tended to be being hospitalised at a much younger age, and were more likely to end up in intensive care.
requires linkage of different datasets. For example, most surveillance datasets don't come with ethnicity information within them, so you have to link them to another dataset like the national census or to hospital data to do that, and these take time.
Q. Just pause there for a moment. That was the fourth topic I was going to deal with, but whilst that's fresh in our memory let's deal with that now in terms of your lessons learned; and one of the matters you've discussed really is work in that area to improve surveillance data. Is that right?
A. Yes.
Q. It's touched in your statement just towards the end, if we turn to paragraph 9.20, please, and it's linked to your current employment. Of course you're here speaking in a personal capacity, but one of the areas you're working in, your key learning point is to develop health and surveillance data systems to routinely capture and report on the multiple dimensions of inequalities, and you set out those various inequalities.

If we could draw that out just for a moment, please. If you could just come out into a wider view of the statement, thank you very much, and turn overleaf, thank you.

You mention at the top of the page that UKHSA is 195
developing a health equity and inclusion health surveillance strategy to address these gaps for communicable diseases

Just dealing with that briefly, first of all, was there a gap in identifying the issues you've discussed in terms of impact on certain health inequality areas and ethnicity groups?
A. There -- initially I would say yes, there was a gap, there was work to try and fill that gap fairly quickly, I mean, so by the end of the first wave of the pandemic we had fairly robust data on this. I think if one had been measuring that from the onset, we may have got an earlier signal of that by a few weeks, or possibly more, and that may have drawn attention to those issues and the need to address them earlier.
Q. So pausing there, the fact that you've joined UKHSA in February 2023, and this is your area that you're developing this strategy, does that suggest that there's a need for such a strategy?
A. I think there is. The pandemic has brought into sharp relief the importance of thinking about inequalities among multiple dimensions and the need for us to develop our systems to be robust in that respect, and, yeah, I'm pleased to be working on that now.
Q. And the last point in relation to this is: am I right in 196
understanding that the first part of your work is to review all the different -- your phrase, I think, is -surveillance outputs and to identify where there is gaps with a view to trying to fill those gaps at this second stage of your work?
A. That's correct, and not just for respiratory infections but across all the infections that we conduct surveillance on.
Q. I'm just going to return back to the two studies we were discussing, which was the Virus Watch and the Covid Health Equity study, and the final question in relation to this is how that work impacted any decision-making or improved matters. Can you assist in relation to that?
A. Sorry, could you repeat?
Q. Of course I can. So in relation to your work for those two studies, jumping back in the narrative in relation to the Covid health equity study, and this is the one where you had --
A. Yeah.
Q. -- the 50,000 volunteers, what benefit did that work bring?
A. So I think there were perhaps three main areas of benefit.

One was undertaking studies that looked at the role of occupation, that could show the real importance of 197
important, as there was so many restrictions on different sectors of society, for trying to understand which sectors were important.

And so unfortunately these data take a long time to accrue, so I think perhaps it was more important in informing the -- what was it called -- the roadmap out of the second wave of the pandemic. But I think this early information on, really, the critical importance of the difference between those who could work from home and those who couldn't was important in being able to advocate for stay at home advice.
Q. Thank you.

The final area -- and l'm very grateful for your patience -- is really to draw upon your perspective and expertise as an epidemiologist. And you mention -- you make a number of comments regarding transmission of the virus and the effect on social distancing, and perhaps we could turn to paragraph 7.9, please, of your statement in relation to this. You make a few comments regarding the likelihood of a sizeable winter wave. Where we are in the time period is mid-2020, coming out of lockdown 1, and can you help us in relation to the work you did in preparing for, preparing awareness for the winter of 2020?
A. Well, I think one of the important parts of that was
people being involved in frontline workforces, healthcare and other service industries or ones where we had public contact in driving the risk of infection, and the big differential infection rates between those who could work from home and those who couldn't work from home, and we were able to raise those which I think stressed the importance of the value of work from home interventions, but also the value of protecting people who couldn't work from home through other non-pharmaceutical interventions in the workplace.

The other area that we really looked at was different settings, and so trying to understand where people were catching Covid, and so, for example, we looked at, during the second lockdown, we could see clearly the importance of leaving home for work, using public transport to go for work, and at that stage also just going to the shops were important risk factors for Covid.

As soon as we saw the opening up of society, we started to see that things like going to pubs, going to restaurants, going to other public spaces was also becoming increasingly important in transmission of Covid, and so we were able to feed that into the picture about trying to understand which settings were important. And I think that became particularly 198
there was a report commissioned from the Academy of Medical Sciences that was entitled "Preparing for a challenging winter", that was really aimed to raise awareness of the fact that it was extremely likely that we would have another large wave of infection over the winter period that could potentially be even larger than the wave that we'd already seen, and the need for intense preparation for that, including --
Q. So -- forgive me.
A. Yeah.
Q. You continue, I spoke over you.
A. -- including both how the health service should prepare itself for it, but also there was a particular emphasis on the need to work closely with communities to develop the interventions for non-pharmaceutical interventions, for example, and how we can gain insights from that to help to reduce inequalities.
Q. So we've touched upon this report already briefly, the Academy of Medical Sciences report, "Preparing for a challenging winter 2020/21", and that was dated 14 July 2020. How high profile was that report during the summer of 2020 ?
A. Well, I think it was, would have been widely known about amongst the advisory groups and the government, as well as it was reported in the media fairly considerably as
well.
Q. And you were involved, of course, in that report; isn't that correct?
A. Yes.
Q. We've got paragraph 7.9 in front of us, and it says this, your view:
"I thought that after the first wave of the pandemic it was virtually inevitable that, without widespread social distancing measures, there would be a very sizable winter wave."

And you express the reasons why you formed that view. Is that correct?
A. That's correct.
Q. What was your view regarding the implementation of restrictions in autumn 2020? Were you someone in favour of further restrictions?
A. What we could see in autumn 2020, as expected, was that the case numbers were starting to increase. We had extraordinarily good surveillance data by that time from the Covid infection study that allowed us to measure exactly how they were increasing over time, and we could see these early signals.

What we'd learnt from the first wave was that it was really important not to wait until those infections had reached such high levels that you started to see big 201
A. That's the point. So it means that they'll not only have a bigger impact on preventing hospitalisations and deaths, but they potentially also have a less severe impact on the economy; and so we really felt that earlier intervention was much preferable to later intervention.
Q. You've spoken publicly about this, and I've been invited just to raise this, that you've spoken publicly on 2 November in relation to the impact that delay had in relation to not introducing any circuit breaker as recommended by SAGE in September 2020; and why did you speak publicly in relation to this?
A. I felt it was important for the public to understand the value of early intervention, to try and explain the scientific rationale for that early intervention. I also thought it was important for politicians to understand that. I felt that that was also a direct way of communicating with both the public and politicians.
Q. And what was the message that you spoke publicly about in November 2020?
A. The message was really about the importance of intervening early and harder to suppress transmission at a stage when it was at low levels. I may have also at that -- certainly in other interviews I would have discussed the tier system, which were basically the --
increases in hospitalisations and deaths, but to act before that in order to reduce transmission; and my view was that by acting earlier you could suppress it to the extent that you would not need to then be as severe or as long in lockdown, and so I felt that it was really important

There was advice at the time from SAGE along those lines, for example, the recommendations for a circuit break was going to be planned as a limited period of lockdown to coincide with the school holidays, so taking advantage of the fact that already schools would be closed at that time, and it was felt that that could help to suppress the virus. That was not taken up.

We moved, I think, instead into what was called the tier system --
Q. Just pausing there in relation to that.

So at paragraph 7.13 -- the penultimate points, my Lady, in relation to this -- so if we could turn overleaf, please. Thank you. You really make the point that when intense restrictions are introduced at high levels of infection, they are likely to need to be more intense and of a longer duration than if they were introduced at a lower level of infection. That's the point you've just been making; isn't that correct? 202
even though rates would have been going up across the country, what we were doing was we were waiting for rates to reach quite high levels in certain areas before intervening, and that meant that we were missing opportunities to prevent those hospitalisations and deaths.
Q. And I think the headline was, you were quoted as saying, "Number 10 could have saved thousands of lives if it followed SAGE advice and issued a circuit-breaker lockdown on September 21st".
A. That was my feeling, that was a conservative estimate, and I think that the thing that, even despite the first wave, that people had failed to appreciate is, because of the mathematics of exponential growth, that once you wait for a later stage then you will have -- even short delays can make very major differences to the eventual number of hospitalisations and deaths.
MR KEATING: Professor Hayward, I'm very grateful for your attendance today.

I've got no further questions, my Lady.
LADY HALLETT: I have no further questions.
Thank you very much for your help, Professor.
THE WITNESS: Thank you.
LADY HALLETT: Very grateful.
(The witness withdrew)
204

1
\begin{tabular}{|c|c|}
\hline LADY HALLETT: Right, I think that completes the evidence for today. & 1
2 \\
\hline I'm sorry to everyone that it was a long day with & 3 \\
\hline obviously some quite intense evidence, but obviously & 4 \\
\hline also extremely interesting. & 5 \\
\hline 10 o'clock tomorrow, I think. & 6 \\
\hline MR KEATING: Yes, my Lady. Thank you. & 7 \\
\hline LADY HALLETT: Thank you. & 8 \\
\hline (4.55 pm) & 9 \\
\hline (The hearing adjourned until 10 am & 10 \\
\hline on Tuesday, 17 October 2023) & 11 \\
\hline & 12 \\
\hline & 13 \\
\hline & 14 \\
\hline & 15 \\
\hline & 16 \\
\hline & 17 \\
\hline & 18 \\
\hline & 19 \\
\hline & 20 \\
\hline & 21 \\
\hline & 22 \\
\hline & 23 \\
\hline & 24 \\
\hline & 25 \\
\hline 205 & \\
\hline
\end{tabular} 205
```

```
            INDEX
```

```
            INDEX
PROFESSOR MARK WOOLHOUSE (affirmed) .......... 1
PROFESSOR MARK WOOLHOUSE (affirmed) .......... 1
    Questions from COUNSEL TO THE INQUIRY ........
    Questions from COUNSEL TO THE INQUIRY ........
    Questions from MS MORRIS KC ................. }7
    Questions from MS MORRIS KC ................. }7
PROFESSOR ANTHONY COSTELLO (affirmed) ........ }7
PROFESSOR ANTHONY COSTELLO (affirmed) ........ }7
    Questions from LEAD COUNSEL TO THE INQUIRY ..79
    Questions from LEAD COUNSEL TO THE INQUIRY ..79
APPLICATION .................................. }9
```

APPLICATION .................................. }9

```
Submissions on behalf of
``` \(\qquad\)
```

Sir Patrick Vallance by MR HILL
Submissions on behalf of Scottish Covid
Bereaved by MS MITCHELL KC
Families for Justice and Covid Bereaved Families for Justice Northern Ireland by MS MORRIS KC

```
Questions from MS MORRIS KC ..... 72
PROFESSOR ANTHONY COSTELLO (affirmed) ..... 79
Questions from LEAD COUNSEL TO THE INQUIRY .. 79
APPLICATION ..... 96
```Submissions on behalf of ..................... 96Sir Patrick Vallance by MR HILL
```

105

```Bereaved by MS MITCHELL KC
```

Submissions on behalf of Covid Bereaved

```Families for Justice and Covid BereavedMS MORRIS KC
```961

Submissions of the UK Health Security ............. 109
Agency by MS DOLAN KC

Submissions by LEAD COUNSEL TO THE INQUIRY 116

PROFESSOR ANTHONY COSTELLO (continued) ...... 123

Questions from LEAD COUNSEL TO THE INQUIRY 123
(continued)

Questions from MS MORRIS KC171

PROFESSOR ANDREW HAYWARD (affirmed) ......... 176

Questions from COUNSEL TO THE INQUIRY . 176

\section*{LADY HALLETT:}
[49] 1/3 10/16 11/5 11/9 11/17 50/11 50/13 51/1 51/7 51/12 72/8 79/3 79/11 79/14 95/21 96/4 96/8 105/16 107/25 108/23 109/3 109/11 109/16 111/23 116/9 122/15 122/21 123/10 139/7 147/20 147/23 148/1 148/5 170/16 170/19 175/19 175/22 175/25 176/3 176/8 177/12 186/9 186/15 186/25 187/6 204/21 204/24 205/1 205/8
MR HILL: [1] 96/14
MR KEATING: [8]
176/5 176/13 177/9
177/13 187/4 187/10 204/18 205/7
MR KEITH: [15]
79/20 95/19 95/25
96/9 116/12 122/18
123/8 123/13 139/11
147/22 147/24 148/7
170/14 175/21 176/2
MR O'CONNOR: [9]
1/4 1/8 11/6 11/8 11/19 51/5 51/13 72/3 79/16
MS DOLAN: [2] 109/20 112/2
MS MITCHELL: [1] 105/25
MS MORRIS: [8]
72/10 78/25 108/5
109/1 109/9 109/13 170/24 175/16
THE WITNESS: [6]
79/10 79/13 96/3
175/24 176/10 204/23
\begin{tabular}{|c|}
\hline \\
\hline \multirow[t]{3}{*}{'flattening [1] 88/9 'rollercoaster' [1] 75/22} \\
\hline \\
\hline \\
\hline 'Safe [1] 85/17 \\
\hline 0 \\
\hline 0.1 [1] 13/7 \\
\hline 1 \\
\hline 1.02 pm [1] 96/5 \\
\hline 10 [23] 31/1 31/7 \\
\hline 31/20 31/25 32/2 32/5 \\
\hline 32/13 32/15 32/20 \\
\hline 93/12 100/9 100/23 \\
\hline 103/21 106/3 113/22 \\
\hline 113/23 114/15 119/16 \\
\hline 119/17 156/10 162/17 \\
\hline
\end{tabular}

170/15 204/8
10 am [1] 205/10
10 March [1] 42/23
10 o'clock [1] 205/6
10,000 [1] 58/9
10,000 times [1] 58/11
10.30 am [1] \(1 / 2\)

100 [4] 28/1 28/2
32/6 40/4
100,000 [3] 74/8 74/9
75/10
100,000 target [1] 75/5
100,000 tests [1] 74/1
100,000 words [1] 104/15
105 [1] 34/15
107 [1] 36/20
11 [1] 101/8
11 March [1] 43/12
11 May [1] 190/3
11 million [1] 151/20
11.40 am [1] 51/9
11.55 [1] 51/8
11.55 am [1] 51/11

12 [1] 81/5
12 March [3] 81/9
156/7 158/1
12 May [1] 88/11
12 May 2020 [1] 87/25
12.4 [1] 119/19

12th [1] 156/21
13 January [1]
125/10
13 March [3] 167/5
169/12 169/16
14 days [1] 152/25
14 July 2020 [1] 200/21
15 [5] 101/11 102/17 104/7 132/2 143/12
15 August [1] 1/20
15 cases [1] 145/19
15 March [1] 165/14 15,000 [1] 151/17 15,000 tests [1] 151/16
150 [1] 152/13
150,000 deaths [1] 174/17
16 [1] 101/14
16 October 2023 [1]
1/1
160 [2] 47/18 47/23
169 [1] 55/7
17 [1] 143/16
17 countries [1]
131/4
17 October [1] 64/20
17 October 2023 [1]

18 February [3]
145/14 151/4 151/13
18 months [1] 80/16
18,000 tests [1]
92/10
187 [1] 63/10
19 [20] 2/17 3/23 4/3
34/15 36/24 58/10
60/24 63/17 63/23
74/3 77/8 87/24 96/24 22 January [2] 126/5 114/19 114/22 136/21
171/20 174/9 188/6
192/3
2
2 feet [2] 45/6 45/24
2 November [1]
203/9
2 o'clock [2] 95/23
96/1
2-3 months [1] 27/3
2.00 pm [1] 96/7
2.30 [1] 96/2
2.8 [1] 94/19

20 [3] 136/24 139/1
188/14
20 January [1]

\section*{125/13}

20,000 [1] 152/20
2003 [3] 16/8 23/14
39/25
2004 [2] 89/9 146/10
2006 [1] 89/9
2009 [4] 37/22 38/1
38/11 38/17
2011 [3] 92/25
137/15 141/15
2013 [1] 135/20
2014/15 [1] 143/12
2018 [1] 80/13
2019 [2] 144/13
174/6
2019-nCoV [1]
125/18
2020 [46] 3/4 4/12
17/12 34/4 37/7 38/4
39/11 39/13 42/3 51/1
51/3 52/15 55/3 60/6 63/13 63/13 63/14
63/21 63/21 73/25
75/2 75/21 81/4 87/25 94/8 160/13 160/14
168/25 171/2 175/14
181/12 187/20 188/19
192/16 193/9 193/12
193/14 194/10 199/21
199/24 200/21 200/22 3 February [2] 144/8
201/15 201/17 203/11
203/20
2020/21 [1] 200/20
2021 [4] 74/14 75/21
85/17 192/16
2022 [1] 3/10
2023 [4] 1/1 80/1

196/17 205/11
208,000 [1] 174/9
20th [2] 3/6 171/19
21 [2] 139/20 200/20
21 January [4] 5/7
19/4 125/16 125/19
21st [1] 204/10
22 February [2]
148/7 151/15

22/23 January [1]
128/12
228,000 people [1]
174/8
22nd [1] 127/4
23 January [2]
129/24 143/25
23rd [3] 47/22 49/9
143/8
24 February [2]
148/23 171/24
24 January [1]
124/19
24/25 January [1] 129/5
24th [4] 94/18 127/8 129/19 152/16
25 September 2023
[1] 80/1
25-person [1] 149/5
250,000 [1] 152/18
250,000 cases [1]
143/15
25th [1] 19/7
26 [1] 150/16
26 March [3] 171/18
173/25 188/19
26 March 2020 [1]
171/2
270 [1] 152/1
273 [1] 4/15
27th [2] 129/21 131/3
28 [2] 133/11 142/9
28 January [1]
150/10
281 [2] 70/12 70/13
282 [1] 125/14
28th [5] 88/22 129/11
129/20 133/1 134/9
29 [2] 47/18 85/16
29 January [2] 29/3
142/25
29 May [1] 86/14
3

144/19
3 March [3] 162/9
162/19 162/23
3.10 [1] 190/15
3.11 [1] 187/22
3.15 pm [1] 148/2
3.3 [1] 192/9
3.30 [1] 148/1
3.30 pm [1] 148/4
3.4 [2] 191/22 191/25
3.9 [2] 162/17 189/25

30 [2] 132/3 169/14
30 January [1] 143/7
300 years [1] 160/3
309 [1] 135/21
30th [2] 143/21 144/1
31 [1] 55/7
31 January [1] 25/2
31st [1] 29/6
34 [2] 63/9 86/15
36 [2] 72/21 75/13
37 [2] 73/1 73/5
4
4 February [3]
145/18 146/18 150/16
4 May [1] 87/4
4 September [2]
177/4 177/6
4.12 [1] 184/21
4.55 pm [1] 205/9
4.9 [2] 183/18 183/21

400 [6] 134/2 135/4
135/13 136/6 150/11
150/14
400,000 people [1]
147/12
407 billion [1] 160/4
43 [1] 177/5
44 [2] 188/22 189/1
44 molecular [1]
136/3
450 billion [1] 160/6 471 [1] 97/3
5
5 March [1] 163/2
5,000 environmental
[1] 155/12
5.1 [1] 179/4
5.6 [1] 179/22

50 [2] 70/12 122/6
50,000 [2] 192/5
197/20
500 [9] 134/2 135/4
135/13 136/6 150/11
150/14 156/9 156/10
160/25
54 million [1] 168/25
6
60 [2] 128/23 132/14
64 [1] 75/13
66 [2] 73/2 73/5
7
7 June [1] 190/3
7.13 [1] 202/18
7.9 [2] 199/18 201/5

75 [2] 58/9 122/6
750,000 [1] 152/19
\begin{tabular}{|c|c|c|c|c|}
\hline 8 & 128/9 132/10 133/3 & & & afternoon [2] 72/ \\
\hline \[
8 \text { April } 2020 \text { [1] }
\] &  & & & \\
\hline 188/19 & & & & \\
\hline 8 January 2021 [1] & 149/19 151/15 152/13 & achieved [2] & 96/15 109/4 109/20
196/2 196/15 & 4 \\
\hline 85/17 & 152/20 153/21 153/23 & 100/4 & ssing [4] & 38/12 38/19 45/22 \\
\hline 8.2 [2] 106/11 112/18 & 154/2 156/8 156/10 & achieving [1] & (172/11 172/18 185/2 & 57/9 57/12 79/6 80/21 \\
\hline 80 [1] 177/23 & 159/7 159/15 164/4 & acknowledge [1] & 185/4 & 96/2 123/1 150/10 \\
\hline 800 contacts [2] 151/6 151/10 & 164/12 167/4 169/20 & 83/16 & adequate [1] 31/15 & 150/12 160/8 160/25 \\
\hline \[
\begin{array}{|c|}
15 \\
8 t l
\end{array}
\] & 170/1 170/6 171/21 & ac & adjourned [1] 205/10 & 163/16 1 \\
\hline & 172/16 173/18 173/24 & & adjournment [1] 96/6 & against [3] 89/1 89/2 \\
\hline 9 & 174/19 174/21 178/14 & acronym [3] 44/ & adjust [1] 65/7 & 110/8 \\
\hline 9 January [1] & 180/9 180/18 180/25 & 82/13 130/5 & ad & age [9] 58/15 58/16 \\
\hline 9,000 people [1] & & & & \\
\hline 151/20 & 185/23 188/12 188/14 & 81/16 95/21 152 & administratively [1] & 1/13 61/18 174/13 \\
\hline 9.20 & 192/5 193/7 196/21 & 154/22 154/22 160/ & 116/6 & 193/24 \\
\hline 94 [1] 168/2 & 198/24 200/23 203/7 & 172/12 184/19 185/8 & admitted [1] & aged [1] 63/16 \\
\hline 95 [1] 94/4 & 203/19 203 & 189/14 190/9 19 & adolescent [1] 80/14 & agency [7] 109 \\
\hline & above [4] 68/5 104/7 & 20 & [1] 40/ & 109/22 177/23 190/20 \\
\hline A & 0/16 & act [6] & d [2] 59/4 & 191/11 191/17 \\
\hline aba & abridge [1] & 119/20 132/23 145 & 104/9 & agenda [1] \\
\hline abide [1] & abridging [1] & & adopting & agendas [1] 182 \\
\hline able [22] 9/23 24/7 & abridgment [1] 116/5 & acting [2] 24/19 & 103/25 & ages [1] 62/2 \\
\hline 26/4 53/22 57/6 73/15 & abroad [1] 72/24 & 202/3 & advance [1] 103/9 & ago [3] 15/8 41/22 \\
\hline 89/21 90/10 102/20 & absence [5] 16/12 & action [14] 39/7 39/8 & advantage [1] 202/11 & 171/24 \\
\hline 114/16 121/5 121/8 & 141/23 162/1 162/23 & 50/6 50/6 71/15 71/15 & advice [17] 22/25 & agree [15] 9/15 12/23 \\
\hline 121/13 121/23 132/21 & 166/17 & 71/19 80/21 98/15 & 23/1 69/14 69/16 & 13/25 36/7 46/6 56/9 \\
\hline 148/19 153/15 161/13 & absent [1] 185/20 & 133/24 139/7 140/6 & 74/12 89/1 120/11 & 63/20 73/22 76/3 86/3 \\
\hline 184/10 198/6 198/23 & absolute [1] 52/24 & 140/6 140/8 & 166/9 179/17 182/23 & 100/19 108/13 110/25 \\
\hline 199/10 & absolutely [16] 13/18 & actions [4] 139/8 & 183/22 183/24 184/9 & 170/11 175/10 \\
\hline about [167] 2/20 3/6 & 14/20 16/7 30/13 53/2 & 140/12 141/2 174/24 & 184/10 199/11 202/7 & agreed [11] 7/5 10/8 \\
\hline 3/13 3/24 4/10 4/20 & 74/3 74/16 77/1 83/23 & activation [1] 126/16 & 204/9 & 31/2 31/17 64/5 73/21 \\
\hline 6/6 9/10 9/11 9/16 & 87/6 89/25 91/13 & active [1] 129/7 & advise [4] 139/8 & 97/23 98/4 101/2 \\
\hline 11/10 12/6 14/17 & 116/22 134/11 145/ & actively [1] 193/6 & 140/11 168/11 18 & 136/25 144/25 \\
\hline 14/23 15/10 15/17 & 149/22 & actual [3] 31/16 & advised [2] 60/25 & agreeing [1] 15 \\
\hline 17/11 17/17 18/2 & abundantly [1] 110/9 & 41/14 50/18 & 147/18 & agreement [2] 33/24 \\
\hline 18/12 18/14 20/1 20/3 & academics [3] 184/6 & actually [47] 5/23 & Adviser [5] 29/14 & 137/3 \\
\hline 20/4 20/8 20/10 21/5 & 184/9 184/11 & 7/12 13/11 14/18 & 84/1 84/14 85/23 & Ah [1] 162/17 \\
\hline 21/18 23/6 23/7 26/1 & Academy [2] 200/1 & 15/17 16/20 17/14 & 153/11 & ahead [2] 32/25 \\
\hline 27/9 28/20 29/11 & 200/19 & 17/24 20/16 21/2 & advisers [5] 71/9 & 52/23 \\
\hline 31/16 32/5 32/14 & accept [12] 62/13 & 23/24 31/8 32/3 41/3 & 82/25 88/8 122/6 & aid [1] 176/21 \\
\hline 32/15 33/13 33/19 & 64/17 66/8 83/16 85/1 & 42/1 42/4 45/2 45/14 & 129/23 & aim [1] 40/23 \\
\hline 34/13 35/1 37/5 38/3 & 85/7 101/19 108/17 & 46/7 46/17 49/13 & advising [1] 141/2 & aimed [6] 85/7 \\
\hline 38/5 38/24 39/3 40/23 & 112/22 142/7 168/16 & 52/16 53/3 53/7 54/12 & advisory [10] 3/23 & 100/23 156/18 192/2 \\
\hline 41/17 42/6 42/16 & 169/25 & 54/18 56/4 58/23 & 4/3 74/3 81/21 81/23 & 192/24 200/3 \\
\hline 42/24 43/16 43/24 & acceptance [1] 106/2 & 59/19 66/19 71/9 75/5 & 82/2 82/15 129/14 & aiming [1] 116/25 \\
\hline 45/2 45/9 46/10 47/5 & accepted [1] 155/15 & 77/12 77/16 83/11 & 142/9 200/24 & alarm [2] 129/9 150/2 \\
\hline 47/10 51/1 51/5 52/11 & accepts [3] 104/24 & 83/24 84/2 88/21 89/9 & advocate [1] 199/11 & alarmed [1] 5/24 \\
\hline 53/18 54/23 55/16 & 104/25 106/6 & 92/18 95/14 128/11 & affect [1] 96/19 & albeit [2] 103/13 \\
\hline 56/5 57/4 62/7 62/9 & access [7] 48/10 & 140/19 164/25 168/12 & affirmed [6] 1/6 & 141/2 \\
\hline 63/7 63/18 64/7 64/14 & 50/11 68/21 114/1 & 168/17 170/5 & 79/18 176/11 206/3 & alert [1] \\
\hline 65/11 65/12 65/18 & 125/25 149/4 183/8 & acute [1] 179/12 & 206/9 207/13 & alerted [2] 21/23 \\
\hline 66/14 67/20 68/1 68/6 & accommodate [1] & adapted [3] 77/6 & afford [1] 168/24 & 21/24 \\
\hline 69/7 70/4 73/8 74/24 & 68/17 & 103/12 137/2 & afraid [9] 47/7 63/2 & alerting [1] 11/11 \\
\hline 75/6 75/7 75/16 76/17 & according [4] 62/19 & add [2] 108/14 163/5 & 72/18 78/23 108/23 & aligned [1] 23/1 \\
\hline 77/13 81/3 81/7 81/10 & 86/11 93/9 99/1 & added [5] 102/7 & 109/10 109/15 162/16 & all [110] 3/20 4/22 \\
\hline 81/14 90/7 91/17 94/7 & accordingly [1] 52/4 & 102/8 102/21 181/3 & 171/13 & 9/20 11/19 11/19 \\
\hline 94/9 95/18 96/17 & account [3] 90/8 & 184/25 & after [21] 6/4 19/6 & 18/16 20/15 22/1 \\
\hline 103/11 109/6 111/9 & 94/22 120/16 & addendum [2] & 19/8 20/2 33/19 50/14 & 23/11 28/8 29/23 \\
\hline 111/11 111/15 113/12 & accrue [1] 199/5 & 133/13 133/15 & 50/15 51/16 51/17 & 32/22 33/3 34/14 \\
\hline 114/7 114/12 115/21 & accumulate [1] 64/9 & additional [9] 61/4 & 81/9 88/12 89/8 91/6 & 36/15 43/12 52/6 \\
\hline 116/4 116/4 118/17 & accurate [1] 91/11 & 61/24 101/20 102/2 & 92/17 127/4 143/8 & 53/12 54/11 54/13 \\
\hline 123/14 125/20 126/7 & accurately [3] 14/21 & 102/23 113/9 164/16 & 146/6 148/11 171/18 & 56/20 61/9 62/2 63/5 \\
\hline & 17/20 101/17 & 185/14 193/10 & 194/18 201/7 & 63/9 63/13 67/24 \\
\hline
\end{tabular}
(54) 8 April 2020 - all

A
all...[83] 68/10 68/14 68/22 69/17 69/18 69/20 72/4 77/21 78/9 82/18 84/17 84/20 84/25 86/5 87/18 88/5 88/24 89/2 91/24 92/11 98/4 102/20 103/7 104/11 105/3 105/10 108/14 110/18 110/21 110/23 111/10 115/1 115/2 115/17 117/21 118/4 121/24 126/24 128/13 128/15 129/9 135/1 135/20 135/23 140/4 141/9 141/10 142/2 142/22 143/22 144/7 145/4 145/8 147/5 148/1 148/5 148/17 149/11 149/15 153/24 154/16 155/1 156/2 156/5 156/6 157/12 157/18 160/22 161/5 162/7 165/10 165/20 167/2 167/21 172/11 172/18 172/19 186/15 186/22 189/14 196/4 197/2 197/7
All right [20] 18/16 22/1 32/22 63/5 67/24 84/17 84/25 128/15 140/4 142/22 143/22 144/7 148/1 155/1 156/2 156/5 160/22 162/7 167/2 167/21
Allan [1] 154/11
Allan Wilson [1] 154/11
allow [5] 97/24
107/16 137/7 163/21 167/18
allowed [5] 16/11 46/24 76/9 125/24 201/20
allowing [3] 65/19 142/6 164/19
allows [1] 101/16
almost [7] 9/3 41/11
61/14 64/4 81/10
93/22 174/3
alone [3] 10/21 46/3 139/25
along [6] 21/9 57/3 70/20 71/8 168/2 202/7
alongside [2] 116/20 123/17
already [28] 6/3 11/2 15/25 17/6 21/24
23/21 31/10 31/20
34/25 49/17 62/22
74/1 93/24 110/15

113/10 114/23 115/6 Andrew [4] 176/6 143/19 144/24 145/15 153/2 162/24 179/6 181/9 188/13 200/7 200/18 202/11
also [63] 2/8 3/13 3/22 3/24 7/20 10/12 14/5 25/14 36/20 41/3 43/18 44/1 59/24 61/19 62/19 66/10 79/11 80/22 84/23 86/25 91/22 92/5 94/17 97/2 98/13 100/10 102/5 102/11 103/22 104/10 107/3 111/17 117/13 117/15 117/17 122/25 127/14 127/24 131/7 142/15 162/4 168/19 170/5 174/19 178/12 183/3 183/23 185/25 189/15 190/24 191/11 191/13 191/16 194/15 198/8 198/16 198/21 200/13 203/3 203/16 203/17 203/23 205/5
also independent [1] 84/23
alternative [4] 82/7
155/9 155/9 162/2 alternatives [1] 71/10 although [7] 48/9 117/19 118/22 122/4 150/17 166/21 173/8 always [6] 27/6 40/10 56/22 57/13 59/6 74/6 am [19] 1/2 1/16 2/7 2/10 11/20 15/10 33/21 33/24 51/9 51/11 56/11 56/12 72/17 123/2 189/7 192/2 192/15 196/25 205/10
ambivalence [1] 88/7
amend [1] 97/8
America [1] 42/1
among [1] 196/22
amongst [6] 15/13
29/14 131/14 131/20
193/23 200/24
amount [6] 28/4 49/9 98/7 103/1 104/18 129/2
amounted [2] 137/4 155/13
analogy [2] 45/4 121/25
analysis [6] 9/17 9/19 9/21 13/15 54/18 192/8
analytical [1] 104/16
Anderson [2] 93/25 146/6 Angela McLean [1] 64/19
Angela's [1] 67/9 announce [1] 52/2 announced [1] 166/2 anonymously [1] 48/19
another [30] 4/25 5/3 17/14 22/10 22/15 28/23 45/4 51/5 51/21 57/23 102/21 114/10 115/20 117/22 123/23 127/14 138/14 145/2 147/24 150/25 151/23 158/12 167/3 167/22 178/12 180/8 181/13 190/24 195/4 200/5
answer [7] 11/8
51/21 81/2 130/25
136/13 136/15 161/6
ANTHONY [5] 79/18 79/23 123/11 206/9 207/6
Anthony Costello [1] 79/23
antibodies [1] 165/2 antibody [2] 146/2 188/6
anticipated [2] 30/7 189/4
anticipating [2]
25/13 52/9
anxious [1] 21/8 any [64] \(3 / 186 / 25\) 21/7 22/2 23/8 25/12 26/25 27/3 27/22 27/24 32/9 41/17 45/8 45/9 47/12 48/6 49/13 53/22 54/17 60/18 68/23 78/6 81/8 84/22 91/19 92/12 92/13 96/19 103/20 103/25 104/15 107/9 107/11 107/11 107/17 108/8 109/6 111/10 112/6 112/17 113/18 114/8 114/9 114/14 115/14 115/15 116/16 117/3 117/10 124/23 138/3 203/10
anybody [8] 105/21
109/18 112/10 114/9 116/10
anyone [7] 55/20
69/20 97/19 105/4

114/8 115/14 118/7 176/11 176/17 207/13 anything [9] 9/16 anecdotal [1] 131/8 \(27 / 25\) 43/23 44/25 Angela [2] 64/19 66/4 81/7 114/16 114/17 138/12 138/12 139/16 approaches [2] 143/23 144/20 147/6 \(40 / 13\) 123/25 149/23 149/23 175/12 appropriate [6] 17/5 182/15 188/22 197/12 \(102 / 12\) 105/13 173/6 114/13 114/18 115/16 April [4] 81/4 86/23

125/20 161/5
anyway [4] 12/24
42/15 43/5 52/1
anywhere [2] 28/1
68/13
apologies [1] 176/24 apologise [5] 11/5 45/5 47/4 116/23 122/19
apparent [7] 25/17
51/15 75/24 127/2
142/16 165/4 180/3
Appeal [3] 98/13
110/7 122/2
appear [5] 111/14
111/21 111/24 114/19
138/3
appeared [2] 163/19 193/20
appearing [2] 86/1 121/11
appears [4] 9/13
44/13 110/2 115/25
application [5] 96/12
96/24 105/11 115/13
206/13
applied [5] 106/8
106/10 106/17 120/18 129/3
applies [3] 98/13
102/6 120/19
apply [2] 117/20 172/3
applying [3] 88/14
100/14 140/2
appreciate [1]
204/13
appreciating [1] 40/22
appreciation [1] 122/16
approach [22] 39/6
39/15 40/14 47/3 81/15 81/17 88/18 89/5 89/7 98/2 101/6 101/10 102/15 102/17 103/25 104/8 105/12 106/7 107/5 110/19 120/17 180/25 173/10 174/20
approximately [2]
152/1 181/12 181/12 188/19
April 2020 [1] 81/4
April/May 2020 [1]

181/12
are [161] 2/5 2/6 2/11 6/5 6/10 8/11 8/14 9/25 10/10 18/11 20/14 20/23 21/19 25/9 25/10 25/17 31/4 33/19 34/4 37/13 40/17 40/25 41/4 43/11 44/2 46/12 48/17 49/2 49/3 49/3 49/4 51/1 53/6 53/11 53/14 53/21 54/6 54/6 54/8 54/22 56/13
56/14 57/6 66/9 66/12 67/14 68/2 71/4 74/21 74/22 76/12 77/18 78/6 78/13 78/13 79/2 80/3 80/5 80/20 82/11 84/11 87/6 87/24 91/8 91/11 92/24 93/24 94/4 94/5 99/3 99/4 99/6 99/6 99/9 99/22 100/18 100/19 100/22 101/8 101/21 102/4
102/10 102/15 102/24 105/14 106/12 108/22 110/1 110/9 111/10 111/17 112/20 113/5 113/6 113/9 114/5 115/4 115/8 115/10 115/18 115/20 116/1 117/14 117/21 118/12 118/20 119/22 120/12 120/24 121/9 121/10 121/14 121/16 121/16 122/9 123/22 124/6 124/14 126/20 128/7 129/13 129/18 130/11 130/15 130/17 133/3 133/4 133/8 133/17 133/19 134/5 135/9 139/15 143/3 143/15 146/16 147/6 153/12 154/21 162/8 163/16 164/10 164/16 165/20 166/6 169/6 170/14 170/16 173/16 174/12 174/23 175/2 175/16 177/14 177/22 191/21 192/18 194/19 199/21 202/21 202/22
are: [1] 162/18
are: contain [1]
162/18
area [11] 6/24 20/21
167/22 179/21 179/23 179/25 180/7 195/10 196/17 198/11 199/13 areas [17] 49/3 49/10 63/7 76/24 76/24
92/11 151/23 157/22 173/9 178/17 179/19 182/20 182/20 195/16 196/6 197/22 204/3
aren't [1] 54/14
argue [5] 47/2 67/8
124/14 174/16 175/5
argued [1] 136/7
arguing [3] 46/15
46/16 47/2
argument [18] 41/2 55/25 66/5 66/14 67/23 71/2 71/3 96/1
103/20 116/13 116/23 117/24 119/4 119/15 119/24 152/11 152/20 164/3
argument's [1]
151/10
arising [1] 73/19
arose [1] 75/23
around [23] 3/6
11/10 15/14 23/15
23/22 29/3 29/18
54/11 60/1 65/6 66/11
71/6 92/3 94/25
128/16 132/13 136/3
148/22 151/10 156/8
165/12 165/25 193/9
arrival [1] 129/8
arriving [1] 135/6
art [2] 126/9 132/17
article [40] 34/16 34/17 98/9 98/22 99/18 99/23 100/9 103/21 106/3 106/6 106/11 106/13 106/16 107/22 108/17 110/1 110/4 110/15 110/21 110/25 111/5 112/12 112/16 112/18 113/18 113/22 113/23 114/15 118/2 119/16 119/16 119/17 120/12 120/19 122/8 122/13 127/14 127/15 171/18 188/17
Article 10 [7] 100/9
103/21 113/22 113/23
114/15 119/16 119/17
Article 8 [24] 98/9
98/22 99/18 99/23
106/3 106/6 106/11 106/13 106/16 107/22 108/17 110/1 110/4 110/15 110/21 110/25 111/5 112/12 113/18 118/2 119/16 120/19 122/8 122/13
Article 8.2 [1] 112/18 articles [2] 81/13 87/1
as [273]
As I say [1] 18/16 ascertained [1] 145/20
Asian [12] 89/3 89/15

90/7 91/16 129/13 141/11 142/2 145/3 145/12 147/16 174/8 193/22
ask [30] 23/7 27/9 29/11 34/13 34/17 38/24 42/16 43/24 46/10 48/23 60/4 63/7 67/25 68/6 70/4 72/11 88/12 101/21 102/15 111/11 112/13 113/12 114/6 114/9 126/7 147/23 167/3 169/11 170/25 184/1
asked [23] 6/4 6/20 60/15 62/19 69/23 77/13 78/8 78/18 78/19 81/12 104/12 109/11 111/9 111/15 112/8 115/14 115/15 115/21 141/4 141/5 160/14 170/19 182/19 asking [13] 4/9 32/15 33/19 53/5 74/24 90/7 96/21 112/6 140/11 153/23 154/2 159/6 159/15
asks [2] 105/10 106/7 aspect [3] 66/16 70/3 189/17
aspects [2] 91/8 120/24
aspired [1] 53/1
assess [1] 101/3
assessment [2] 106/6 174/4
assist [5] 104/12 105/14 109/14 177/25 197/13
assistance [2] 93/10 109/22
assisted [1] 185/4 associated [4] 76/7 110/8 122/1 141/14
Associated Newspapers [1] 122/1
associates [1] 99/16 assume [3] 94/23 147/8 183/14
assumed [1] 25/10 assuming [1] 138/19 assumptions [1] 29/25 assurances [1] 102/13
assured [1] 111/23 assures [1] 117/1 asymptomatic [28] 16/1 16/5 16/23 17/1 199/23 200/4 18/11 24/1 24/6 25/18 away [1] 162/3 25/24 26/7 26/11

29/15 94/4 94/5 124/8 B 134/6 145/20 145/24 146/7 146/17 146/19 148/21 148/25 180/21

\section*{at [275]}
at emails [1] 18/18 attached [2] 14/8 14/12
attack [2] 8/18 27/19 attempt [3] 78/17
158/6 190/8
attempts [1] 97/9
attend [3] 3/14 3/18 191/2
attendance [1] 204/19
attended [3] 3/17 33/5 84/12
attendees [2] 133/16 133/17
attending [1] 176/23
attention [5] 28/3
28/4 32/7 121/15 196/14
attenuated [2]
117/23 122/12
attracted [1] 110/25
August [2] 1/20 192/16
August 2021 [1] 192/16
authorities [2] 148/18 155/5 authority [6] 5/24 12/19 98/10 99/21 135/22 135/24
automatically [2] 119/12 120/13 autumn [3] 161/22 201/15 201/17 autumn 2020 [2] 201/15 201/17 avail [1] 136/20
available [23] 22/11 25/23 48/11 48/21 49/1 49/5 50/21 51/3 51/16 63/22 65/10 75/1 78/6 93/3 104/8 116/21 120/2 120/22 134/12 136/19 152/8 155/4 194/11
average [3] 58/14 58/16 152/14 avoid [4] 69/22 71/18 161/11 176/20
avoidable [1] 54/3
avoided [1] 55/1
aware [7] 21/21
60/16 65/5 92/24
151/18 183/10 194/15
awareness [2]
baby [1] 62/24
back [40] 2/2 3/10
5/4 5/22 9/13 9/19 12/17 14/5 15/2 15/7 18/17 19/13 20/13 21/10 22/23 24/24 36/10 38/11 42/9 47/6 47/17 69/10 74/5 75/8 77/12 78/3 83/13 89/8 90/3 133/25 136/18 148/9 160/25 170/9 170/20 182/8 182/22 187/19 197/9 197/16
backed [1] 142/20 background [3]
96/16 177/13 193/13
backgrounds [1] 184/15
backwards [1] 22/21
backyard [1] 154/15 bad [6] 23/20 33/12
33/16 33/17 37/8 38/1
balance [3] 100/5
101/16 122/11
balanced [2] 69/6 110/16
balancing [3] 44/22
56/12 112/21
ball [2] 109/12
159/17
ballpark [2] 9/3 9/10
Bangladeshi [1] 194/7
Bank [3] 100/2
120/17 160/6
Bank Mellat [2]
100/2 120/17
bar [1] 121/24
barriers [1] 78/6
Barrington [2] 62/9 62/13
base [1] 137/1
based [9] 12/3 12/4
12/15 29/25 49/16
64/21 80/21 92/24 127/11
bases [1] 83/9
basic [5] 25/6 123/14
123/22 128/18 147/11
basically [4] 11/3
141/7 149/11 203/25
basis [8] 52/18 53/8 67/8 99/22 126/12 126/15 146/4 168/8
bathwater [1] 62/25 be [299]
be 10 [1] \(32 / 5\)
be effective [1] 128/24
bear [3] 26/12 26/13 26/14
bearings [1] 133/12
beautifully [1] 56/7 became [14] 22/11 49/5 51/16 56/8 59/13 62/15 65/5 75/24 76/7 78/22 142/15 165/4 180/3 198/25
because [104] 12/25 15/4 16/25 18/4 20/9 22/20 23/25 27/18 30/6 30/12 33/20 38/6 44/16 45/15 47/1 47/4 50/23 53/13 53/21 59/20 60/17 64/17 65/12 67/17 71/20 74/24 76/9 77/5 77/7 77/10 77/18 78/9 81/11 82/15 82/25 83/3 83/16 84/6 86/25 87/7 88/20 91/10 91/20 92/11 94/3 98/25 101/21 105/7 108/24 110/16 110/21 111/10 111/13 111/22 112/15 115/25 117/9 117/18 117/21 118/8 119/6 120/19 125/23 128/24 130/24 131/12 135/7 137/20 138/14 138/19 139/25 140/8 140/19 141/4 141/13 144/24 146/14 148/17 156/20 156/21 156/22 157/2 157/8 157/15 157/19 158/25 160/4 160/20 160/23 161/1 162/2 163/1 166/24 167/12 168/23 172/3 183/15 184/20 185/7 187/18 188/16 192/12 194/24 204/13
become [8] 5/21 13/4 42/5 48/11 63/21 93/6 112/15 137/20
becoming [3] 123/24 127/8 198/22
bedrock [1] 166/9
been [115] 3/2 16/17 19/3 19/23 20/6 21/23 22/21 23/25 24/1
25/10 26/25 29/4 29/7 31/2 38/1 38/25 49/21 49/24 50/1 52/23
53/23 53/24 53/24
53/25 54/4 57/2 65/16 65/21 67/4 69/12 72/2 74/6 74/22 76/1 78/7 78/9 78/15 79/6 79/20 81/4 81/6 81/10 86/25 92/24 97/15 97/20
98/4 98/20 102/11 103/18 103/18 103/18 105/16 106/14 107/23 110/15 111/22 114/23 115/1 116/19 116/25
been... [54] 118/20 119/5 119/23 120/7 120/22 121/19 122/5 123/4 125/23 125/24 126/13 127/6 127/11 128/12 129/7 131/20 133/3 140/2 143/11 143/24 143/25 148/14 149/2 149/22 150/1 152/21 152/23 154/8 154/17 155/3 155/7 155/10 158/6 162/24 164/25 168/4 169/4 169/16 172/22 176/8 179/24 187/1 188/8 189/3 189/19 190/11
190/23 193/18 193/18 196/12 200/23 202/25 203/7 204/1
before [38] 1/13 1/25 3/2 3/2 4/13 5/4 11/22 13/21 15/2 19/3 22/22 24/20 25/9 25/13 25/17 42/18 49/12 49/21 51/13 53/4 71/14 86/14 86/19 92/17 95/22 96/1 108/11 108/23 109/5 123/14 134/17 145/25 147/1 147/6 164/7 167/5 202/2 204/3
beforehand [2] 25/20 27/10
beg [6] 36/13 48/25
66/23 94/13 130/7
154/1
begin [1] 93/7
beginning [7] 13/22
19/14 71/21 86/5
124/13 144/8 149/7
behalf [13] 72/12
85/5 96/10 96/13
105/19 105/23 108/2
108/5 108/12 170/25
206/15 206/18 206/21
behave [3] 16/22 53/6 53/14
behaved [1] 58/24
behaving [1] 50/23
behaviour [6] 50/2 52/1 52/4 52/20 83/12 170/2
behavioural [9] 44/5
53/9 133/23 167/23 169/4 169/7 169/9 169/15 170/1
behaviours [3] 50/18 169/18 169/20
being [77] \(8 / 1110 / 10\) 12/6 12/9 17/18 17/19 20/5 23/6 23/24 25/6 30/7 35/9 35/22 37/16

38/21 40/23 41/1 bias [1] 37/20 41/16 44/12 50/3 55/5 big [10] 13/2 13/3 61/25 62/1 63/18 65/15 65/20 67/4 67/6 68/15 70/7 70/23 81/17 87/8 92/8 93/19 101/1 108/21 111/2 111/6 111/9 111/9 111/15 112/8 113/2 113/6 113/19 113/20 114/12 116/1 120/14 120/21 132/1 134/3 135/9 138/17 140/6 145/20 151/1 155/19 161/12 174/19 175/9 180/1 180/7 180/20 181/2 182/6 183/1 183/13 183/14 183/22 184/10 191/3 192/18 193/23 198/1 199/10 believe [17] 1/18 7/2 19/4 26/7 27/15 63/2 74/24 81/22 88/13 88/17 126/22 129/6 132/22 155/12 155/19 157/17 170/15
believed [1] 36/20 bells [1] 129/9 beloved [1] 122/19 below [5] 26/16 76/8 133/24 139/14 145/16 below 1 [1] 145/16 benefit [2] 197/20 197/23
benefits [1] 159/21
bereaved [11] 72/12 105/23 108/2 108/3 108/5 108/6 108/14 171/1 206/19 206/21 206/22
best [9] 48/4 50/24 59/22 62/18 69/4 101/11 103/10 109/1 138/1
better [13] 39/7
40/18 41/3 41/4 41/7 50/16 52/7 90/9 90/13 127/25 161/3 174/13 186/22
between [32] 14/16 18/18 29/5 40/13 42/17 43/3 90/1 93/6 93/19 94/15 95/1 95/3 99/11 100/6 119/16 122/6 122/11 127/18 127/21 127/22 127/23 128/25 129/19 146/7 147/4 184/11 188/19 190/2 190/21 192/16 198/4 199/9
between 3 [1] 94/15 beyond [6] 39/12 59/10 64/24 144/6 151/16 180/17

40/13 44/24 66/15 131/1 149/5 154/21 198/4 201/25
bigger [4] 25/12 69/2 75/10 203/2
biggest [1] 160/2
billion [2] 160/4 160/6
billions [1] 169/2
bills [1] 149/17
biological [1] 136/3
biomedical [2]
154/12 154/21
bit [14] \(4 / 225 / 1\)
26/16 56/2 67/16 82/2 84/15 104/3 135/25 156/24 169/8 184/20 186/20 193/5
bite [1] 114/22
black [3] 83/5 193/22 194/6
black/minority [1] 83/5
blind [1] 171/20
block [1] 128/23
board [4] 7/5 148/12 148/14 148/15
bodies [1] 82/11
body [4] 45/22 85/6 163/22 169/6
book [1] 56/5
boost [1] 164/13
boots [2] 95/17 141/20
border [1] 179/17 borders [2] 23/12 124/1
both [22] 2/14 7/19 14/19 34/24 40/20 65/1 66/4 69/15 72/23 79/7 82/1 98/1 106/1 124/4 124/20 143/4 156/20 163/8 163/9 176/19 200/12 203/18 bothering [2] 19/15 32/11
bottom [6] 13/22 18/25 19/2 43/10 85/20 140/5
bounds [1] 84/9
box [1] 147/25
brain [1] 97/5
branches [1] 178/9
breach [1] 122/7
breaches [1] 124/1
break [7] 51/7 51/10 51/13 91/14 95/24 148/3 202/9
breaker [2] 203/10 204/9
breaking [2] 123/20 147/4
breaks [2] 132/25 148/5
brief [1] 68/1
briefing [2] 22/10 22/25
briefly [16] 2/4 15/2
21/4 23/7 34/13 64/17
97/1 109/21 178/25
179/6 187/14 189/20
189/24 192/20 196/4
200/18
bring [4] 16/15 128/9
132/11 197/21
Britain [1] 85/22
British [3] 91/6
159/23 168/16
broad [3] 49/2 63/7 178/9
broader [1] 4/6
broadly [1] 112/18
brought [5] 16/8
144/4 151/20 164/12 196/20
BSIs [2] 44/3 44/5
build [2] 71/11 71/25
build-up [2] 71/11 71/25
building [1] 150/17
built [1] 50/17
Bunting [6] 99/19
105/19 108/12 108/24 109/9 113/23
burden [5] 27/1
69/15 101/20 102/8 113/4
businesses [1] 53/14
busy [1] 165/23
but [253]
byproduct [3] 163/23
167/12 167/18
C
Cabinet [1] 169/7
Cabinet Office [1] 169/7
calculate [1] 194/3
calculation [3] 9/22
12/3 36/10
calculations [2]
13/15 20/14
calculator [1] 10/12
Calderwood [7] 15/1
18/21 21/17 25/3 29/6
33/2 35/19
call [13] 9/19 20/13
54/9 56/18 67/16 74/2
79/5 82/20 82/23
150/2 152/16 176/5 178/10
called [22] 16/20
36/10 50/17 59/25
72/19 73/1 82/12
85/17 92/20 92/25
133/13 140/14 141/10

154/14 164/7 169/7
171/19 171/22 180/8
181/20 199/6 202/15
calling [5] 22/13
81/19 83/17 86/25 141/19
calls [1] 143/13
came [15] 1/25 18/1 52/15 65/6 66/18
84/22 88/22 109/5
110/13 110/16 126/15
135/20 148/8 160/25 165/2

\section*{campaigning [1]} 46/15
Campbell [1] 108/7
can [120] 4/13 4/17 4/22 5/18 6/11 7/10 7/12 7/13 10/9 11/24 15/2 15/7 16/2 19/20 20/1 20/10 21/10 21/14 21/17 24/17 24/24 25/23 26/16 28/2 28/19 28/25 29/8 29/9 31/24 33/1 33/20 34/14 34/23 35/23 36/19 37/18 39/7 39/9 41/9 42/20 45/23
46/10 47/17 48/19 48/23 50/6 50/24 52/22 56/21 57/1 57/9 58/23 60/11 60/13 61/6 61/21 63/3 63/8 64/24 67/9 67/16 67/16 68/8 68/16 69/15 70/10 70/13 71/15 72/19 73/1 76/5 79/5 90/3 90/23 90/24
100/4 103/11 103/13 103/16 105/14 107/8 107/10 107/15 109/14 110/22 114/15 123/6 123/21 125/6 128/4 128/8 128/9 129/15 133/12 135/16 139/16 144/17 145/10 150/6 152/4 155/17 163/5 166/14 166/24 167/4 170/12 172/5 174/21 176/20 176/23 177/6 184/22 188/1 188/16 192/20 197/13 197/15 199/22 200/16 204/16
can't [14] 27/25 32/9
45/7 46/3 47/7 47/9
51/4 55/24 78/23
138/14 146/3 162/16 171/13 186/3
cannot [12] 27/7
27/13 59/19 78/21
94/2 94/3 137/11
138/19 139/1 145/21 146/19 150/20
capability [1] 150/18

C
capable [1] 153/8
capacity [12] 27/3
134/2 134/13 135/4 135/13 135/17 150/14 150/20 150/20 153/14 177/14 195/16
capture [3] 6/19 35/5 195/18
captured [1] 37/16 care [27] 27/1 59/20
59/21 59/22 76/15
76/21 77/17 77/24
78/13 78/20 87/15
102/2 102/12 105/13
133/22 156/16 173/10 173/14 175/13 187/13 188/4 189/19 189/21 190/9 190/11 191/7 193/25
care home [2]
187/13 189/19
care homes [10]
76/15 76/21 77/17 77/24 78/13 78/20 173/10 175/13 190/9 190/11
care sector [1] 191/7
career [1] 2/4
careful [2] 27/23 173/18
carefully [1] 122/24
carers [1] 59/23
caricature [2] 41/11 62/21
carried [4] 33/4
106/14 106/20 192/15 carry [4] 11/9 77/23 106/23 154/4
carrying [1] 190/23
case [73] 6/17 8/11
8/22 12/3 12/4 12/6 12/8 12/10 12/13 12/25 13/5 13/5 14/17 17/17 20/3 20/10 26/21 26/23 27/16 27/20 27/22 28/22 30/1 30/22 30/23 31/9 31/14 31/18 31/19 32/5 32/16 32/20 33/12 33/17 37/6 37/9 37/17 38/9 38/15 40/6 40/6 57/19 90/23 98/11 98/13 98/13 99/15 100/2 100/14 106/9 109/4 110/8 112/18 119/21 119/22 119/25 120/3 120/11 120/15 122/1 122/13 125/11 126/3 126/25 131/8 131/13 131/17 132/9 137/1 149/6
154/17 172/25 201/18
cases [34] 16/6 17/11 18/5 18/9 18/11 24/1 25/17 41/15 57/24 67/19 67/21 77/17 98/4 107/22 124/6 125/8 128/13 130/11 131/15 135/2 135/8 135/11 136/23 139/14 143/2 143/15 144/13 145/8 145/19 147/7 151/6 156/9 160/25 162/20
cast [1] 142/9
catch [1] 5/4
catching [2] 63/23 198/13
categorically [1] 47/7 chapter [1] 26/4 categories [1] 49/3 characterising [1] category [1] 102/11 Catherine [6] 15/1 18/21 21/17 25/3 29/6 35/19
Catherine
Calderwood [6] 15/1 18/21 21/17 25/3 29/6 35/19
caught [1] 62/12 cause [5] 37/2 37/4 37/24 38/6 65/11 caused [7] 49/19 49/19 51/17 53/19 66/17 83/18 85/3 causes [5] 34/13 38/7 69/24 171/16 178/5
causing [1] 23/16 ceased [1] 3/8 census [1] 195/4 cent [1] 31/1 central [4] 12/5 16/10 188/13 191/9
centres [1] 49/4
certain [13] 21/2
61/14 76/17 93/24
143/9 144/3 144/23
166/3 183/13 193/11
193/16 196/6 204/3
certainly [16] 26/10 33/16 37/9 41/2 42/3 62/2 62/4 77/8 78/18 127/8 129/9 149/25 177/12 180/24 193/5 203/24
certainty [1] 134/8 certificates [1] 174/9 cetera [4] 87/1 182/3 182/7 186/4
chain [5] 10/17 19/11 22/20 24/25 91/14
chains [1] 123/20
chair [2] 80/20 85/23
chaired [3] 2/24 2/24 29/8
challenge [1] 66/16
challenged [1] 111/2 challenges [1] 97/13
challenging [5] 78/9
141/25 167/11 200/3 200/20
chance [3] 23/23
73/18 127/25
Chancellor [1] 171/3
change [1] 53/21
changed [5] 50/2 68/17 94/16 97/8 177/21
changing [5] 52/1
52/3 52/4 52/19 127/3 channel [2] 70/20 71/8 58/13
characteristic [1] 58/20
Charles [1] 122/1 check [5] 4/17 7/5
111/23 155/17 187/7
checked [1] 188/17
checking [1] 13/16
chief [17] 5/14 11/2
11/11 11/21 12/18 20/18 21/2 21/15 29/13 84/1 84/14 85/23 109/7 153/10 153/11 168/1 192/1 child [2] 80/13 82/4
children [19] 63/8
63/16 63/22 63/25
64/1 64/6 64/8 64/9 64/10 64/15 65/2 65/2 65/3 65/15 65/20 65/22 67/3 67/4 164/8
China [29] 17/8 17/19 30/3 30/7 30/15 30/19 94/17 124/16 125/9 125/12 125/15 125/24 126/23 126/24 127/4 127/17 130/20 140/1 143/3 143/19 144/14 145/8 145/10 145/15 145/19 149/5 157/18 159/3 166/11 choose [1] 82/8 chop [2] 163/20 167/16
chose [1] 83/8
Chris [12] 14/2 21/19 21/23 23/1 29/23 31/5 132/10 142/21 163/1 165/13 165/14 165/22 Chris Whitty [11]
14/2 21/19 21/23 23/1 29/23 31/5 132/10 142/21 163/1 165/13 165/14
chronological [1] 187/19
chronology [2] 125/2
\(21 / 13\)
125/6
CMOs [1] 21/18 co [4] 2/24 3/6 105/7 190/1
co-chaired [1] 2/24 co-operated [1] 105/7
co-opted [1] 3/6
coalesced [1] 71/6
COBR [3] 28/24
126/16 168/1
COBRA [1] 14/3 cocooning [4] 57/4
59/25 62/16 62/18
cohort [2] 192/4
192/17
coincide [1] 202/10 cold [1] 22/13
collateral [1] 41/6
colleague [1] 7/25
colleagues [6] 10/19 21/13 183/10 184/25 185/6 185/8
collected [1] 127/12
College [3] 7/24
128/16 177/16
combined [2] 91/12 95/11
come [31] 4/16 12/17
17/25 20/18 41/8
41/12 42/9 51/22
51/22 52/17 54/6
59/24 61/7 62/8 83/1
83/13 90/3 95/21
118/4 130/2 136/18
137/8 145/17 170/16
170/20 171/24 172/4
172/21 182/8 195/2
195/22
comes [8] 13/11 31/7
32/3 32/12 69/10 75/8
98/11 173/5
coming [12] \(2 / 2\)
12/21 24/20 42/25
60/3 89/24 94/17
103/3 132/23 136/12
168/14 199/21
CoMix [2] 50/17 50/19
commence [2] 79/21 193/4
commenced [2]
88/12 193/9
comment [4] 19/16
32/2 73/20 174/19
comments [3] 109/6
199/16 199/19
commissioned [1]
200/1
commit [1] 121/5
commitment [1]
143/20
committee [18] 2/22
3/3 3/5 3/9 3/10 3/14
committee... [12]
16/19 69/2 129/24 130/1 130/2 141/24 143/18 163/3 179/7 186/19 186/21 193/18 committees [3]
183/15 184/3 184/8
common [4] 82/13
82/14 98/10 105/9
commonplace [1] 82/1
communicable [1] 196/3
communicate [3]
20/18 34/20 85/8
communicated [2]
70/9 71/20
communicating [3]
46/22 169/19 203/18 communication [1] 86/7
communications [4]
27/24 31/10 44/20 45/12
communities [4]
175/2 184/14 185/9 200/14
community [18]
23/16 65/23 77/20
78/2 90/19 100/7
100/8 129/16 156/6
156/12 157/2 157/8
157/12 157/14 157/25
158/4 185/18 192/7
comorbidities [1]
64/1
comparative [1]
120/14
compared [1] 178/7
comparison [1]
124/7
compiled [1] 118/5
complacency [2]
30/14 36/21
complement [1]
190/16
complemented [1] 181/7
complete [3] 17/7 33/24 42/24
completely [8] 9/7
27/2 36/7 39/25 56/9 136/4 138/20 163/25
completes [1] 205/1 compliance [1] 168/22
complicated [2] 9/16
54/1
comply [2] 168/6
168/23
component [1] 69/4
composition [5] 68/7

68/10 83/2 83/13 183/19 comprehensive [2] 178/18 194/16 concentrated [1] 58/21
conceptual [1] 90/5 concern [17] 5/20
8/7 12/1 14/23 28/20 34/16 34/18 35/5 55/19 66/17 69/1 83/18 129/25 143/24 164/16 167/22 171/17 concerned [19] 5/21 6/6 13/13 28/21 31/11 32/14 33/15 34/4 35/1 35/4 38/5 38/11 45/2 45/9 55/4 65/18 68/12 178/14 180/1
concerns [10] 6/10
7/6 31/12 33/7 61/22 68/18 81/9 81/14 119/15 178/4
conclude [4] 118/16
119/13 120/23 123/22 conclusion [4] 80/2 104/6 107/20 145/1 conclusions [2] 54/6 144/11
concretely [1] 185/16 conditions [1] 58/19 conduct [1] 197/7 conducts [1] \(2 / 13\) conference [9] 81/5 81/9 149/10 168/1 171/2 171/5 171/16 173/25 175/8
confidence [3] 94/21 100/12 122/7
confident [10] 12/11 18/12 18/14 25/24 28/1 28/2 32/5 32/6 73/17 186/17 confidential [1] 118/9
confidentiality [8] 99/2 118/15 118/21 118/25 119/2 120/8 121/1 121/4
confined [2] 30/3 30/15
confirm [1] 177/6 confirmation [1] 11/14
confirmed [5] 10/6 62/23 131/15 144/13 144/15
confirms [1] 73/14 conflict [1] 167/6 conflicted [1] 167/12 conform [1] 168/6 confuses [1] 163/8 confusing [1] 82/9 confusion [3] 83/18

85/3 89/25 connected [2] 8/17 8/21 connections [1] 185/11
conscious [1] 101/22 consensus [8] 27/1 70/4 70/6 70/16 71/2 144/10 144/16 144/19 consequence [3] 17/24 181/1 183/9 conservative [1] 204/11 consider [8] 62/5 100/3 102/25 111/2 113/21 115/12 182/19 189/11
considerable [3] 61/1 107/5 191/23 considerably [3] 17/25 194/7 200/25 consideration [1] 112/19
considerations [4] 100/10 117/20 169/15 182/1
considered [8] 30/2
62/4 63/4 89/7 112/5
180/7 180/13 192/10
considering [2]
147/3 180/24
considers [1] 103/13
consistent [5] 20/21
27/19 67/13 172/23 175/9
constructive [1] 98/2
construed [1] 114/20
consulted [1] 154/24
consulting [1] 145/3
contact [38] 5/19
59/24 73/9 73/16
90/20 91/13 92/14
92/20 95/12 123/18 129/16 138/22 139/18 142/4 144/18 145/11 151/7 151/8 151/18 152/1 152/2 152/3 152/4 152/13 152/24 155/11 155/12 155/13 158/21 159/1 159/16 166/8 166/22 166/25 173/1 173/8 175/12 198/3
contacted [3] 6/20 29/5 143/5
contacts [10] 21/7 59/20 90/24 90/24 128/8 135/10 151/6 151/9 151/10 162/21 contain [7] 23/15 24/7 137/9 142/14 162/10 162/18 163/7 contained [7] 16/24 16/24 24/8 30/8 30/9

144/17 145/10
containing [4] 5/25
23/11 101/12 162/14 containment [8] 23/8 75/19 128/9 156/19
162/24 172/24 173/5 175/8
content [4] 108/8 109/13 114/17 194/10 contents [4] 1/15 1/19 80/3 118/11 context [13] 5/17 10/3 16/5 17/7 35/8 42/21 43/2 56/2 57/9 97/1 108/20 172/8 173/20
continue [5] 39/1 66/16 123/3 190/18 200/11
continued [8] 22/14
33/2 102/16 123/11
123/12 143/2 207/6 207/9
continues [3] 105/11
106/7 106/16
continuing [3] 31/12 47/2 159/24
Contrary [1] 96/23
contribute [1] 191/4
contributed [1] 51/20
contributing [1] 188/9
contribution [4]
29/12 66/13 66/15 154/25
control [45] 16/8
16/15 17/2 55/12
57/15 88/6 90/23
115/6 123/15 123/17 123/22 124/11 124/25 128/22 129/4 135/22 135/23 135/24 136/5 136/22 136/22 137/1 137/11 137/13 137/19 138/1 138/4 138/15 138/17 139/4 139/13 139/21 145/2 147/11 147/16 147/17 154/18 166/9 169/5 174/24 179/17 180/4 180/22 184/12 189/17
controlled [1] 17/3
controlling [4] 40/21
40/23 74/4 128/24
controversial [1]
82/9
convened [4] 126/13
181/22 182/4 183/5
convenience [3]
113/3 113/16 113/19
convenient [3] 51/6
147/20 147/25
Convention [3] 98/9
110/5 119/20
conversations [1] 67/10
conveying [1] 35/15
convinced [3] 40/5
41/23 157/19
cope [3] 44/3 111/20 151/5
copied [3] 21/14
122/4 165/14
copy [3] 5/23 115/9 171/12
cord [1] 150/2
core [35] 61/7 76/19
80/16 96/20 97/25
98/20 99/12 101/23
104/1 104/25 106/12
107/11 107/17 110/18
110/24 111/10 112/6
114/11 115/2 115/21
116/14 116/24 118/19
118/20 119/5 119/8
119/10 119/11 120/8
120/22 121/15 121/23
122/9 123/16 190/1
core participant [2] 111/10 112/6
core participants
[21] 96/20 97/25
98/20 99/12 101/23
104/1 104/25 106/12
107/17 110/18 114/11
116/24 118/19 118/20
119/5 119/8 119/10
120/8 120/22 121/15 121/23
core participants' [1] 107/11
coronavirus [15] 6/7
89/8 89/10 90/11 91/5
94/14 125/17 129/12
132/1 133/3 138/5
138/15 140/20 144/14
151/5
coronaviruses [2] 89/24 164/10
correct [75] 2/16
2/23 3/12 7/9 8/13 9/8 19/19 23/5 27/18
76/22 76/23 80/7 80/8
80/12 80/18 80/19 80/24 84/24 86/17
87/11 87/21 89/19
97/9 101/16 116/3
128/1 128/14 130/14
130/23 131/16 131/21
131/23 135/11 135/12 137/25 140/3 146/11 153/18 155/11 155/23 156/4 157/4 158/8
158/10 158/22 158/23
159/2 161/19 162/6
166/5 167/1 167/20
168/17 177/14 177/16
177/17 177/24 179/9
correct... [17] 179/10 179/13 181/15 181/16 181/17 182/12 182/13 186/10 188/24 190/3 193/16 193/17 197/6 201/3 201/12 201/13 202/25
correctly [1] 187/8 correctness [1] 140/22
correspondence [2] 11/16 21/22
correspondents [1] 10/23
corresponding [1] 129/2
Costello [10] 79/17
79/18 79/23 122/22
123/11 123/13 170/25 175/23 206/9 207/6 costs [1] 145/5 could [121] 1/8 4/25 7/16 13/10 16/13 16/14 17/24 18/25 19/16 27/2 28/7 28/8 31/18 36/19 43/7 45/1 45/3 48/13 50/7 51/22 52/11 55/6 56/13 58/13 61/13 66/18 68/25 69/6 69/16 69/17 71/12 71/18 73/17 75/3 75/14 79/21 85/14 88/1 88/3 89/13 90/20 92/3 93/3 93/14 95/8 95/12 95/14 96/1 97/15 102/21 103/20 103/23 104/11 107/1 107/17 121/19 124/24 130/16 133/7 133/20 133/25 134/7 136/8 136/21 139/8 140/13 141/3 142/12 147/17 150/8 150/15 151/5 151/11
152/23 154/4 154/8 154/15 154/17 154/20 154/24 155/7 156/15 157/16 157/21 163/20 166/15 169/11 174/16 176/13 176/15 176/16 177/2 177/5 177/10 179/4 180/6 180/13 181/3 181/5 183/12 186/6 187/21 190/9 192/25 193/1 194/5 195/21 195/22 197/14 197/25 198/5 198/14 199/9 199/18 200/6 201/17 201/21 202/3 202/13 202/19 204/8 couldn't [17] 16/23 18/5 44/2 50/1 50/8

50/23 52/12 69/20 92/12 92/13 122/21 130/19 142/7 168/24 198/5 198/9 199/10 counsel [15] 1/7 79/19 96/20 104/1 108/12 111/9 116/11 123/6 123/12 176/12 206/5 206/11 207/4 207/8 207/15
Countdown [1] 80/20 counterfactual [1] 54/1
countries [17] 9/4
23/11 30/8 34/8 123/25 126/24 131/4 143/16 145/12 145/12 172/11 172/16 172/19 172/19 174/2 174/12 174/20
country [24] 41/18 48/3 64/4 75/21 91/10 123/24 132/13 136/3 147/15 149/12 149/14 149/20 152/9 154/21 158/5 160/3 162/22 168/22 172/15 172/18 175/4 185/8 190/10 204/2
couple [3] 25/19 58/19 165/17 course [66] 1/24 2/17 2/20 2/24 3/13 6/25 7/22 10/5 21/21 24/17 28/4 28/25 34/24 35/23 40/24 43/16 45/7 46/17 47/16 48/4 48/5 51/7 52/15 53/9 54/21 60/17 63/6 64/3 66/5 80/15 81/7 89/17 94/19 107/12 111/1 111/17 113/8 113/21 114/3 115/4 115/11 117/6 117/16 117/19 118/7 118/10 118/12 119/24 120/4 120/9 120/10 121/8 122/10 128/10 134/25 142/13 143/3 161/22 166/17 173/3 179/8 182/9 189/22 195/15 197/15 201/2
Court [5] 98/12 98/13
110/7 120/18 122/2 courts [1] 104/24 CoV [1] 16/17 cover [7] 83/8 107/9 107/15 132/24 135/18 157/21 176/25
coverage [3] 151/19 152/12 152/13
covered [3] 2/4 51/19 149/10
covering [1] 83/10

Covid [51] 2/17 3/23 cusp [1] 163/4 4/3 36/24 57/17 58/10 cut [1] 113/13 58/15 58/21 61/23 61/25 63/17 63/23 65/16 72/12 77/8 87/24 105/23 108/2 108/3 108/5 108/6 113/8 148/13 160/12 171/1 171/20 174/9 180/19 180/20 182/1 182/5 187/15 188/6 188/8 188/22 190/13 191/12 192/3 192/13 192/20 193/3 193/19 197/10 197/17 198/13 198/18 198/23 201/20 darkest [1] 33/13 206/18 206/21 206/22 data [54] 8/9 10/24 Covid Inquiry [1] 113/8
Covid-19 [12] 2/17
3/23 4/3 36/24 63/17 63/23 77/8 87/24 171/20 174/9 188/6 192/3
cracks [1] 186/18 crashing [1] 102/22 create [3] 113/9 134/19 134/20 created [4] 78/8 110/6 110/11 110/13 creating [1] 97/14 creation [1] 101/12 criminal [1] 120/4 crisis [4] 31/16 53/8 53/16 152/17 critical [8] 12/24 54/7 149/22 162/8 168/5 169/6 189/15 199/8 criticised [1] 143/11 criticism [1] 186/9 criticisms [1] 68/3 crucial [8] 14/20 14/24 16/7 17/4 17/13 17/14 50/22 148/16 crude [3] 9/18 9/20 9/21
cruise [3] 148/8
148/10 148/16
crying [1] 38/18
Crystal [1] 15/22
Crystal clear [1] 15/22
CTI [2] 116/14 121/15
cultures [1] 185/10
cumbersome [2]
75/4 75/9
current [3] 151/1 180/22 195/15 currently [5] 80/20 111/6 134/5 139/21 144/15
curtailing [1] 114/14
curve [2] 45/4 142/16
curve' [1] 88/9

\section*{D}

Daegu [1] 151/23
daily [1] 6/16
dairies [5] 117/14 121/1 121/3 121/9 121/20
damage [3] 91/20
160/2 160/7
Dame [3] 171/4
171/20 172/9
dangerous [1]
156/20
data [54] \(8 / 9\) 10/24
\(12 / 2012 / 2112 / 23\)
17/8 17/9 20/22 24/20
25/4 27/11 27/18 31/8 47/25 48/11 48/15 48/21 48/21 49/1 49/5 49/7 49/16 50/11
50/17 50/20 50/25
51/2 51/16 52/7 52/25 53/4 53/18 64/22 65/1
65/10 65/19 66/25
67/10 78/6 78/12
94/17 127/11 127/13
140/1 194/2 194/9
194/11 194/20 195/5
195/11 195/18 196/11
199/4 201/19
dataset [1] 195/4
datasets [2] 195/1 195/2
date [9] 1/20 29/2
48/7 88/11 102/12
103/18 105/12 123/4 148/24
dated [7] 64/20 80/1
85/16 150/16 177/3
177/5 200/20
dates [3] 63/15 125/5 172/4
David [4] 85/22 86/4 165/18 170/6
David Halpern [1] 170/6
David Nabarro [1] 165/18
day [29] 18/21 21/12 22/16 74/1 74/11 74/15 84/4 86/24 87/2 92/10 94/25 97/13 112/4 125/16 127/4 134/3 135/4 135/13 138/9 150/11 150/14 151/16 151/17 156/17 159/10 160/25 185/7 185/7 205/3
days [13] 7/18 18/19 33/13 42/18 51/25

93/17 95/4 97/6 127/6 degree [9] 83/18 85/3

\section*{D}
degree... [7] 106/4 107/6 124/7 126/25 145/24 146/17 164/18 delay [12] 137/9 142/15 162/10 162/18 163/4 163/7 166/14 169/21 170/3 173/8 175/8 203/9
delaying [1] 162/14 delays [1] 204/16 deliberate [1] 184/16 deliberately [1] 192/25
delicate [1] 44/22
delineate [1] 89/14 delineating [1] 109/23
demand [1] 120/5 demands [2] 116/14 120/1
dementia [1] 58/20
Department [2]
133/22 155/15
depend [1] 28/5
depending [2]
146/17 186/25
depends [2] 23/11 164/5
deploying [1] 134/17
deputy [2] 21/15 33/3
derogation [1]
106/10
describe [12] 23/19
24/3 24/10 25/5 37/3
55/9 56/25 138/16
140/6 141/20 158/13
192/19
described [5] 43/19
57/2 68/2 104/7
137/19
describes [3] 4/15
97/10 100/24
describing [2] 44/12 52/7
description [1] 9/15 descriptions [1] 165/21
designated [1] 179/8
desirability [1] 146/9
desire [1] \(85 / 11\)
despite [4] 66/8 98/3 125/25 204/12
detail [9] 4/9 5/18 6/9 20/15 28/18 33/21 43/1 92/18 194/2
detailed [3] 4/5 22/12 106/24
detailing [1] 124/17
details [3] 2/3 81/3 149/11
detect [3] 16/13 88/7 162/20
detecting [1] 186/9 detection [1] 136/23 determine [1] 110/1 determining [1] 115/13
detriment [1] 103/19 develop [5] 161/3
184/20 195/17 196/22 200/14
developed [5] 34/21
60/2 87/14 159/10 172/14
developing [7] 24/17
28/20 93/19 136/9
188/8 196/1 196/18
development [1]
80/6
Devi [1] 165/18
Devi Sridhar [1] 165/18
devised [1] 178/2 devotion [1] 83/21 DHSC [1] 179/8 diagnostic [3] 150/17 150/19 159/10 Diagnostics [1] 134/1
diagram [2] 94/2 146/5
Diamond [1] 148/8 Diamond Princess [1] 148/8
diaries [1] 99/18
diary [9] 110/12 116/19 117/12 117/13 118/4 118/9 118/14 121/12 121/21
diction [1] 122/18 did [82] 2/18 3/14 3/18 3/23 5/19 10/16 10/17 10/19 10/21 11/12 14/7 22/8 22/15 32/23 34/20 36/4 38/19 40/2 42/9 45/10 45/12 47/19 47/22 50/11 52/6 57/16 58/2 59/7 62/5 63/21 64/4 64/4 64/9 65/6 65/11 68/24 69/3 72/16 77/13 77/19 77/25 78/1 81/13 81/22 82/10 82/23 82/25 83/8 86/21 88/13 88/16 88/25 89/20 91/18 91/19 97/8 99/16 111/23 125/20 131/25 141/6 143/6 154/13 157/9 157/17 157/18 159/13 159/23 165/3 166/21 168/18 168/23 170/8 171/24 182/15 184/1 190/5 191/15 193/3 197/20 199/23 203/11
didn't [52] \(3 / 16\) 11/13 \(\quad 24 / 20\) 66/9 100/24 12/23 16/22 17/19 167/13 191/8 18/4 18/13 18/15 21/21 33/15 33/16 35/2 35/4 35/13 37/8 38/23 44/25 45/19 48/6 48/6 49/13 49/25 50/8 54/3 56/10 56/17 60/18 62/20 62/20 67/12 67/17 69/24 72/17 74/19 76/20 77/10 81/7 82/8 83/3 112/24 130/19 132/1 141/10 149/12 149/23 153/14 159/4 172/3 175/5 183/8 184/18 187/1
die [10] \(8 / 2455 / 24\) 58/10 124/7 130/12 131/14 131/20 142/9 165/1 174/8
difference [6] 20/1 40/13 40/16 58/12 143/23 199/9

\section*{differences [1]}

204/16
different [47] 4/2 5/2 7/12 9/11 12/7 17/6 24/18 27/12 29/11 37/10 37/14 39/5 40/2 42/12 44/8 57/2 62/11 77/25 78/13 85/6 85/13 89/11 91/5 92/15 117/20 146/9 146/15 154/22 172/12 174/15 178/7 179/19 182/1 182/6 182/6 182/20 185/10 185/18 185/23 185/24 186/1 194/4 194/21 195/1 197/2 198/12 199/2
differential [2]
185/25 198/4
differentially [1] 185/24
difficult [18] 14/21
17/22 26/6 32/18 53/11 53/13 56/9 59/15 61/2 78/15 136/13 144/2 144/6 183/3 183/6 183/12 186/2 186/23
difficulty [5] 102/8
103/24 107/6 169/18 170/2
dimensions [2]
195/19 196/22
direct [2] 173/21
203/17
directed [2] 114/23 140/8
directing [1] 45/5
directives [1] 52/10
directly [7] 8/17 8/21
director [6] 5/11
80/13 125/23 143/1
154/11 169/8
director general [1] 143/1
directors [1] 187/2
disagree [2] 174/3 174/18
disagreed [2] 73/21 81/11
disagreeing [1]
57/15
disapprove [1] 62/12
disaster [1] 174/10
disciplines [1] 83/10
disclosed [14] 97/25
98/20 98/25 102/3
104/25 107/18 110/22
113/6 119/5 119/6
119/10 120/6 122/6 171/12
disclosure [4] 99/11
99/15 106/5 115/7
discover [1] 83/1
discuss [2] 11/1 22/2
discussed [12] 32/17
35/18 36/3 36/15 60/9
65/10 68/15 71/12
163/10 195/9 196/5
203/25
discussing [6] 11/2
21/22 36/15 38/9 56/6
197/10
discussion [12]
14/16 17/10 20/10
24/22 28/23 37/5
42/24 43/5 47/12
78/22 78/24 149/23
discussions [5]
144/5 183/6 184/11
184/19 184/25
disease [11] \(2 / 5\)
30/12 58/18 58/22
65/23 93/20 162/21
162/24 172/25 180/21
194/20
diseases [7] 2/14 93/24 173/2 178/5 178/6 178/7 196/3
disgruntled [1] 122/5 display [4] 111/3 112/20 113/14 113/15 116/19
displaying [1] 112/3 dispose [1] 117/10 disproportionality [1] 55/14
disputed [1] 111/4
disruptive [1] 40/9
distancing [9] 44/10
dis displayed [5] 96/18 7/13 7/16 11/23 22/19 111/13 112/23 115/18 28/23 85/14 92/25

68/19 165/25 166/3 179/23 180/16 181/4 199/17 201/9
distinction [3] 39/14 99/11 99/21
distinguish [1] 82/5
distressing [1] 55/25
distribution [1] 83/5
district [4] 135/23
152/10 152/11 152/14
districts [2] 135/21
135/21
disturbing [1] 143/4
divided [1] 17/21
divides [1] 184/19 do [112] \(3 / 810 / 11\) 11/8 11/12 11/13 11/22 12/14 12/19 14/11 14/16 15/2 17/9 20/25 21/4 22/14
24/15 25/25 27/23
33/21 37/4 37/21
38/17 41/3 41/12
48/14 50/24 52/9
52/12 53/5 53/16
54/13 55/11 56/20
56/21 57/17 57/18
57/18 57/19 59/22
62/20 63/20 66/8 69/7
69/9 69/17 69/18
69/20 71/6 75/3 77/23
83/16 85/1 90/20
93/22 94/2 94/12
98/19 101/20 104/3
105/2 107/3 107/13
109/1 109/6 109/25
110/20 115/3 115/23
123/2 126/22 129/5
134/15 137/3 138/2
139/25 140/8 141/6
141/18 142/12 146/23 147/23 150/24 152/8
152/20 153/6 153/16
154/9 154/25 155/16
157/10 161/5 168/24 169/25 173/1 173/8
173/8 173/12 174/24 175/5 175/10 176/19 179/22 179/23 181/1 185/4 186/6 189/11 190/3 190/8 190/18 194/23 195/5
doctors [1] 151/22

101/12 103/23 107/18
111/21 113/13 115/9
119/23 162/9 162/10
162/12 167/3
documents [10]
102/1 102/5 102/6
106/10 106/12 113/5
113/11 114/25 115/4
documents... [1]
165/11
does [28] 6/19 6/20
12/10 13/4 28/5 32/10 43/20 44/5 69/3 71/7 96/19 103/8 105/21 114/22 135/18 138/3 138/11 139/1 144/2 145/23 150/23 159/22 160/14 160/16 164/14 178/1 194/24 196/18
doesn't [10] 9/15
12/13 45/20 54/13 66/9 114/4 114/18 117/9 139/7 167/6 doing [14] 68/25 69/2 69/3 69/21 74/14 77/15 102/18 141/11 142/5 183/11 185/17 186/23 187/18 204/2
DOLAN [2] 109/19 207/2
doll [1] 106/17
doll-type [1] 106/17 domain [1] 118/12
don't [57] 1/13 14/5 14/15 15/19 20/15 30/11 31/7 31/8 32/2 32/24 35/6 37/4 40/12 43/1 50/14 54/13 55/23 55/23 62/15 67/8 69/6 69/14 71/15 71/19 76/11 76/11 78/15 85/7 85/7 86/7 92/12 92/13 94/5 95/14 108/17 109/4 109/16 113/4 121/12 123/5 128/6 145/12 146/2 153/21 155/5
155/18 155/19 163/24
166/21 167/16 167/16 167/18 175/11 175/15 186/11 186/12 195/2
done [25] 34/6 38/25 39/25 41/25 49/17 50/6 56/13 67/17 71/18 74/17 92/12 103/18 103/18 103/18 104/11 107/1 107/22 113/20 116/7 135/7 154/6 154/20 163/20 181/5 186/3
double [2] 4/17 66/21
double-check [1]
4/17
doubles [1] 132/21
doubling [3] 9/5 20/8 47/25
doubt [7] 28/19 52/22 65/5 65/14 102/20 105/3 147/24
doubts [1] 14/23
down [36] 4/18 10/13 15/18 17/25 18/2 20/2 26/16 28/14 33/1 40/14 40/15 41/4 41/7 41/9 41/12 60/23 71/14 71/16 76/11 76/12 77/17 77/20 81/10 95/16 102/22 108/23 127/25 128/2 128/4 128/8 132/11 139/9 139/11 140/13 141/4 160/24
Dr [8] 125/24 129/22 129/22 143/14 156/17 167/8 167/13 168/12
Dr Gauden Galea [1] 125/24
Dr Peter Singer [1] 129/22
Dr Tedros [3] 143/14
156/17 167/13
Dr Tedros' [1] 167/8
Dr Tedros's [1] 129/22
drafted [1] 60/5
drastic [5] 39/8 41/13 50/6 71/15 76/5
drastically [1] 191/11
draw [6] 49/18
138/16 178/12 193/2 195/21 199/14
drawing [2] 23/21 168/10
drawn [2] 121/14 196/14
drip [1] 6/6
drive [3] 76/11 76/12
77/20
driven [1] 77/8
driver [4] 47/24
52/16 67/6 88/17
drivers [1] 86/11
driving [13] 65/22
66/1 66/6 66/9 66/12 66/15 66/19 67/14 67/23 77/16 88/18 146/14 198/3
dropped [1] 159/17 due [4] 63/6 117/15 179/8 182/9
dump [1] 97/5
duration [2] 61/14 202/23
during [26] 2/1 2/19 3/15 8/20 9/6 34/11 35/8 35/11 36/3 38/23 38/25 44/14 47/13 50/21 51/24 55/3 56/25 58/1 80/15 96/18 115/5 150/21 177/18 180/2 198/14 200/21
dwelling [1] 97/13 dying [5] 124/16

130/20 147/13 157/10 \(\quad 165 / 15\)
Edmunds [8] 42/17 43/3 43/11 47/13 64/19 103/4 124/20 163/9
Edmunds's [2] 46/1 46/14
educate [1] 81/1
educated [1] 175/3 education [1] 85/18 educational [1] 68/2
Edward [1] 1/9
effect [8] 20/5 54/10
56/16 70/6 78/1 80/3 123/15 199/17 42/10 50/6 50/7 51/19 effective [13] 40/21 52/8 70/5 71/15 71/22 \(50 / 1\) 50/3 73/9 74/19 75/25 76/5 90/8 130/8 137/15 137/19 148/14 169/1 173/14 181/4 196/13 196/15 202/3 203/5
earliest [1] 50/2
early [52] 14/3 14/21
17/11 26/7 33/7 33/13
38/8 39/2 39/18 40/3 40/7 40/10 40/12 40/15 40/17 41/10 41/13 42/2 42/7 44/14 58/3 63/12 63/21
71/19 74/21 74/25
76/20 79/12 95/15
128/6 132/23 134/4
145/14 155/24 158/20 159/3 159/7 159/15 162/20 168/1 168/3 168/15 172/25 188/20 194/5 194/14 194/18 199/8 201/22 203/14 203/15 203/22
early 2020 [1] 63/21 early-ish [1] 63/12 easier [2] 71/4 128/3 East [12] 89/3 89/15 89/18 90/7 91/16 129/13 141/11 142/2 145/3 145/12 147/16 174/8
East Asian [8] 89/15
90/7 91/16 129/13 142/2 145/3 145/12 147/16
easy [2] 78/14 105/2
Ebola [1] 143/12
echo [1] 176/23
economic [5] 68/20
75/19 91/20 160/2 160/7
economy [1] 203/4
edge [1] 55/5
Edinburgh [2] 2/6 2/12
Edinburgh's [1] 2/9
editor [2] 56/4

77/15 88/20 91/25 128/24 158/21 160/23 161/1 164/11
effectively [3] 142/6 159/9 163/1
effectiveness [2]
72/23 185/2
efficacy [1] 169/20
efficient [1] 91/9
efficiently [1] 89/21
effort [2] 16/9 16/11
eight [5] 95/3 103/5
108/12 122/3 136/2
either [12] 44/2 44/16
44/23 48/4 55/22
68/13 68/25 78/21
114/20 134/19 134/19 139/11
elderly [3] 58/7 58/21 59/14
element [4] 20/12
20/17 43/4 53/15
elements [2] 89/6 192/17
eliminating [1] 40/24
elimination [1] 90/1
else [11] 13/2 59/7
68/13 68/25 69/6 97/19 105/18 105/21 116/10 132/21 164/15
elsewhere [2] 9/22 13/10
email [33] 5/6 5/17 7/11 7/14 7/18 8/4 9/22 15/1 15/3 15/3 15/5 15/9 15/18 18/17 18/20 19/1 19/11 19/13 21/20 22/20 22/23 24/25 25/1 25/19 27/9 27/15 29/7 36/9 42/16 43/9 45/17 45/20 46/10
emailing [1] 43/11 emails [21] \(4 / 114 / 13\) 4/21 10/3 11/21 14/16 15/14 17/9 18/18 19/8 23/4 24/12 24/16

24/19 28/18 29/4 32/10 32/14 33/3
35/18 45/22
emanating [1] 86/2
emerge [1] 42/15
emerged [1] 161/14
Emergencies [2]
81/21 82/16
emergency [4] 80/17
129/25 143/24 194/23
emerging [5] 2/14
10/25 126/1 130/9 130/10
EMG [5] 178/22
181/10 181/14 181/16
181/25
eminent [1] 83/9
eminently [2] 68/9 101/15
emphasis [5] 38/14
41/21 70/15 85/9
200/13
emphasise [2] 28/14
90/22
emphasising [1]
85/10
empirical [1] 178/10
employed [3] 152/2
152/23 177/22
employment [2]
177/21 195/15
empowered [1]
175/3
enable [3] 95/10
119/10 138/24
enabled [2] 91/25 95/13
enables [2] 91/9 124/5
enacting [1] 184/12
encapsulating [1]
29/17
encounters [1]
189/14
encourage [1] 107/4
encouraging [1] 172/19
end [34] 1/17 4/12
17/11 18/1 25/2 40/14 44/3 44/16 45/7 45/24
46/13 46/20 47/15
47/20 54/10 60/8
66/22 67/23 70/10
86/22 92/8 97/5 134/2
143/15 149/7 150/13
151/1 151/2 153/18 172/5 189/1 193/25 195/13 196/10
ended [10] 46/21
46/21 61/16 160/1
160/2 160/3 160/5
160/24 169/1 174/7
endemic [1] 42/4
endorse [1] 108/13
(62) documents... - endorse

(63) endorsed - extradition
\begin{tabular}{|c|c|c|c|c|}
\hline E & 100/13 143/8 19 & 35/ & fine [1] 47/11 & \\
\hline [6] & & 37/3 37/7 38/4 38/21 & finish [2] 24/2 & \\
\hline 100/25 112/4 112/20 & fair & & & 174/15 192/18 204/9 \\
\hline 113/2 115/15 115/24 & fake [1] 130/5 & 44/14 92/9 125 & firmed [1] 36/16 & wing [8] \\
\hline & fall [1] 49/13 & 142/2 144/8 144/8 & first [65] 1/4 4/22 & /6 100/19 12 \\
\hline 201/19 & fallacy [1] 140 & 144/19 145/14 145/18 & 15/7 19/4 23/8 24/25 & 25/16 137/10 150/ \\
\hline rc & fallen [1] 49/1 & 146/18 148/7 148/2 & 27/15 29/23 30/2 30/5 & 194/1 \\
\hline extraordin & falling [2] 44/2 & 15 & 30 & food [1] \\
\hline extreme [2] 51/20 & 92/10 & 151/13 151/15 155/20 & 40/14 42/18 43/1 & footage [2] 102 \\
\hline \[
\begin{gathered}
\text { extreme } \\
179 / 25
\end{gathered}
\] & false [5] & 155/21 171/24 172/6 & 51/17 61/9 63/9 63/13 & 171 \\
\hline extremely [12] 6 & 134/19 134/20 & 174/22 196/17 & 64/25 68/7 73/25 & footing [ \\
\hline 79/7 81/18 99/9 & & Feb & 76 & otnotes [1] \\
\hline 2/19 113/10 122 & falsely [1] & 34/4 37/7 38/4 39/11 & 76/10 78/21 78/24 & forced [1] 44 \\
\hline 122/18 123/8 172/ & familiar [6] & 39/13 & 84/4 86/24 86/24 87/2 & forcefully [1] 45 \\
\hline 200/4 205/5 & 64/20 85/25 & Fe & 87/9 87/23 88/20 & \\
\hline & & & 1 & \\
\hline \[
\text { F-A-K-E [1] } 1
\] & & & & \[
3 \text { 160/1 }
\] \\
\hline \begin{tabular}{l}
face [6] 9/2 31/ \\
53/6 66/11 14
\end{tabular} & 2 206/23 & & 140/14 160/1 160/24 & 200/9 \\
\hline 179/18 & fa & fed [1] & 162/14 173/13 173/15 & forgotten [1] \\
\hline facilitate [2] 100/1 & 127/18 127/22 128/3 & feed [2] & 173/25 178/16 179/3 & form [7] 6/25 6 \\
\hline facilate [2] 100/16 & far [10] 31/20 & feel [5] 10/17 10/19 & 189/4 193/8 196/4 & 97/12 97/22 117 \\
\hline facilities [7] 136/19 & 55/4 58/8 63/3 & 10/21 35/3 98/2 & 196/10 197/1 201 & 117/19 185/11 \\
\hline 154/16 154/23 155/10 & 71 & feeling [2] & 201/23 204/12 & al [2] \\
\hline 156/16 173/5 174/25 & 194 & & first few hundred [1] & 126/16 \\
\hline facility [1] 173/16 & Farrar [18] & feet [2] & 13 & formalities [1] \\
\hline facing [2] 38/16 & 6/ & fell & fir & formally [2] 126/1 \\
\hline 130/9 & 15/4 18/10 18/19 19/9 & felt [14] 40/25 70/22 & 91/9 117/9 123/18 & 177/11 \\
\hline fact [43] 3/18 4/25 & 19/24 20/7 21/25 23/2 & 83/1 83/6 89/5 9 & & rmed [2] \\
\hline 5/3 15/16 18/25 22/15 & 25/19 34/24 124 & /22 & five [6] 89/4 94/25 & 201/11 \\
\hline 22/21 25/25 29/4 & 163/8 & 202/5 202/12 203/4 & 127/6 151/5 151/9 & ormer [2] \\
\hline 32/10 39/ & fashion [1] & 203 & 17 & rtune [1] \\
\hline 44/11 48/12 53/19 & fast [7] & Ferguson [17] & five days [1] & [1 \\
\hline 53/23 60/18 63/23 & 127/3 127/7 142/3 & 7/20 10/5 14/17 18/1 & five-day [1] 94/25 & 22/18 38/21 61/8 \\
\hline 64/14 71/16 86/15 & 145/5 147/9 & 19/9 19/24 20/7 21/25 & flashing [1] 129/1 & /12 89/2 \\
\hline 87/4 91/24 103/7 & faster [2] 25/13 & 23/3 26/3 34/25 46/24 & flatten [1] 44/12 & /3/1 113/20 \\
\hline 7/17 111/24 116/22 & 122 & 47/1 94/1 103/4 14 & flattening [2] 43/ & 62/14 164/24 17 \\
\hline 126/11 129/1 129/20 & fatal [4] & Ferguson's [1] 13/19 & 471 & ound [3] \\
\hline 141/15 143/19 143/21 & 138/18 140/7 158 & few [9] 7/18 8/14 & flew [1] 66/10 & 190/19 191/12 \\
\hline 146/10 153/12 164/25 & fatality [23] 8/12 8/22 & 10/12 15/8 18/19 & flow [1] 74/25 & founder [1] 80/2 \\
\hline 8 173/4 18 & 12/4 12/25 13/5 13/5 & 135/10 147/17 196/13 & flowed [1] 181/14 & four [3] 102/23 \\
\hline 192/17 196/16 200/4 & 14/17 17/17 20/3 & 199 & flu [24] 16/3 16/25 & 125/14 18 \\
\hline 2 & 20/10 27/20 38/9 & fewer [1] 156/8 & 3/20 24/9 36/24 & fourth [3] 103/25 \\
\hline factor [4] & 38/15 124/5 131/8 & field [2] 10/20 148/22 & 37/22 37/25 38/8 77/9 & 191/21 195/6 \\
\hline 26/14 94/3 & 131/13 131/17 131/22 & fields [1] & 77/9 92/22 92/23 & on [1] 101/2 \\
\hline factors [3] & 131/25 132/2 132/8 & figure [6] & 92/25 93/7 93 & rail [1] 58/7 \\
\hline \[
192 / 4 \text { 198/17 }
\] & 132/9 132/22 & 31/7 32/2 94/19 121/7 & 132/5 133/6 137/1 & rankly [1] 10 \\
\hline [ 1 & fatigue [4] & figures [2] 69/25 & 137/17 141/14 142/ & ee [1] 59/24 \\
\hline & 169/4 169/9 & 145/18 & 164/1 & edom [3] 119 \\
\hline factual [1] & fa & & [1] & 9/18 12 \\
\hline  & & final [4] 63/7 1 & fluent [1] 160/9 & 3] 83/20 \\
\hline failed [3] 5 & & 7/11 199/13 & flying [1] 171/20 & 14/15 114/17 \\
\hline \[
204
\] & 108/20 201/ & finally [4] 2/11 3/22 & focus [8] 77/7 97/ & frequently [1] \\
\hline & fear [3] 33/9 38 & 67/25 87/2 & 120/13 138/11 156/1 & fresh [1] 195/7 \\
\hline failsafe [1] & & financially [1] 138/25 & 157/5 173/12 185/2 & Friday [4] 25/2 29/6 \\
\hline failure [3] 55/10 & feared [1] 38/2 & find [9] 40/10 69/20 & focused [5] 73/2 & 86/14 108 \\
\hline 56/19 69/10 & \begin{tabular}{l}
fearing [1] 33/18 \\
feasibility [1] 185
\end{tabular} & \[
\begin{array}{lll}
69 / 23 & 71 / 4 & 144 / 11 \\
160 / 20 & 161 / 1 & 165 / 3
\end{array}
\] & 157/9 184/9 188/2
192/11 & \[
\begin{aligned}
& \text { friend [2] } 7 / 2 \\
& 110 / 14
\end{aligned}
\] \\
\hline fair [10] 26/10 & feasibility [1] 185 & 160/20 161/1 165/3 & 192/11 & 110/1 \\
\hline 37/22 48/2 55/9 75/5 & feature [2] 16/10 & 174/24 finding [2] 57/19 & focusing [5] 8/11 9/9 & 29/8 69/19 \\
\hline 76/25 100/5 145/6 & features [1] 122/9 & finding [2] 57/19 & \begin{tabular}{l}
141/22 173/18 187/23 \\
follow [5] 45/10
\end{tabular} & front [6] 29/8 69/19 69/24 144/12 177/4 \\
\hline 188/5
fairly [7] \(68 / 185 / 9\) & \[
\begin{aligned}
& \text { features [1] 122/9 } \\
& \text { February [39] } 3 / 10 \\
& 33 / 534 / 334 / 434 / 22
\end{aligned}
\] & findings [2] 188/7 & \[
\begin{aligned}
& \text { follow [5] 45/10 } \\
& 88 / 23 \text { 114/5 136/13 } \\
& 162 / 20
\end{aligned}
\] & \[
\begin{aligned}
& \text { 69/24 144/12 } 177 / 4 \\
& 201 / 5 \\
& \text { frontline [6] } 185 / 6
\end{aligned}
\] \\
\hline
\end{tabular}
(64) extraneous - frontline
frontline... [5] 187/17 187/24 188/3 188/13 198/1
frustrated [1] 62/15
full [13] 1/8 72/1
79/22 92/19 97/22
98/6 104/16 104/21
113/25 176/13 176/16 177/18 182/12
full-time [1] 177/18
fullest [1] 108/20
fully [6] 10/4 10/23
13/25 37/15 45/20 75/1
function [1] 68/23 functionally [1] 84/12
fundamentally [1] 90/8
funded [1] 192/7
funding [1] 191/17 funds [1] 191/9 furlough [2] 160/4 169/2
further [22] 25/4 25/4 32/9 32/25 49/13 53/22 58/13 59/18 61/15 95/14 105/14 106/21 107/7 111/4 133/23 156/2 163/12 170/15 189/23 201/16 204/20 204/21
furthering [1] 99/5
future [1] 178/15

\section*{G}
gain [3] 86/8 164/2 200/16
gained [1] 149/4
Galea [1] 125/24
gap [4] 93/5 196/5
196/8 196/9
gaps [4] 147/4 196/2 197/3 197/4
gathering [1] 50/20 Gauden [1] 125/24 gave [8] 1/25 17/13 37/11 37/14 72/24 83/20 106/2 124/20
GCSA [1] 87/22
GDP [1] 174/14
gender [1] 83/6
general [5] 33/23
89/20 120/11 143/1 184/18
generally [2] 64/5 127/21
generate [1] 151/10
generated [1] 157/21
generates [1] 151/9
generating [1] 151/6
generation [1] 25/7
generous [2] 168/21 168/25
genesis [3] 92/22 142/14 169/9
Geneva [1] 80/15 genome [1] 16/17 genuine [1] 55/19 German [1] 164/7
get [32] 9/3 26/6 43/1 50/11 55/15 57/4 74/20 90/18 92/9 93/23 98/18 101/23 106/18 122/21 129/15 133/12 139/13 140/22 142/3 143/18 143/20 149/15 152/12 155/24 164/8 164/12 168/4 168/15 168/19 172/4 178/6 194/16
gets [2] 23/15 31/8 getting [12] 9/4 11/12 17/7 23/16 52/20 64/12 90/22 103/10 151/16 152/18 162/3 194/24

\section*{Ghebreyesus [1]} 143/1
give [19] \(1 / 8\) 2/2 26/4 31/21 35/15 35/23 42/25 49/1 56/2 57/9 73/7 73/20 75/15 84/4 108/19 123/2 164/9 172/8 176/13
given [24] 1/24 41/21 43/14 48/2 50/4 69/16 71/5 71/25 72/2 72/17 76/16 102/13 110/5 118/7 118/18 119/23 120/7 120/21 146/18 159/16 159/19 164/13 168/21 170/6
giving [8] 7/22 22/25 27/20 27/21 31/24 45/18 79/22 163/2
Glasgow [1] 92/6 global [8] 6/15 15/12 15/20 16/9 80/5 80/6 80/10 80/17
globally [2] \(2 / 1534 / 5\) gloss [1] 99/19 go [88] 4/13 4/20 4/22 4/25 5/4 6/8 6/11 7/10 7/12 7/13 7/16 9/20 10/13 11/7 13/21 14/5 14/16 14/25 15/2 15/7 15/20 18/16 18/25 21/10 22/18 23/10 24/24 25/25 26/16 29/9 30/17 33/3 36/20 37/18 39/6 39/18 39/18 39/18 39/20 40/7 40/7 40/7 40/12 40/12 40/15 40/15 41/10 41/10

41/10 42/4 42/20 43/8 43/10 48/8 53/22 55/18 58/13 59/18 60/13 60/18 61/6 63/9 64/24 69/14 70/10 79/16 88/3 95/14 106/20 111/1 122/25 127/8 128/7 133/20 147/11 149/5 151/22 154/13 155/17 160/17 162/13 164/15 168/3 168/15 173/11 177/5 192/25 198/16
go hard [1] 40/7 goal [1] 105/9 goes [5] 8/19 39/12 39/13 102/8 151/7 going [94] 5/22 6/15 11/1 11/20 13/2 13/3 14/25 15/12 19/21
20/12 22/2 22/4 28/6 33/3 33/5 33/21 34/17 36/11 36/13 38/14 39/2 39/2 39/6 39/24 40/4 40/6 40/7 40/8 40/9 40/17 40/18 41/20 41/23 41/24 42/10 43/5 45/17 47/4 47/17 49/15 51/22 53/6 53/11 53/14 53/15 59/5 66/1 67/25 73/3 74/5 79/16 81/4 86/7 88/22 88/24
92/16 108/24 122/17 126/7 130/2 132/4 132/8 144/5 144/10 144/24 146/13 147/9 160/20 165/1 171/10 171/12 171/14 172/2 172/4 178/19 179/20 180/4 183/4 184/1 185/18 186/5 187/10 187/11 187/25 189/22 189/24 195/7 197/9 198/17 198/20 198/20 198/21 202/9 204/1 gone [4] 31/10 44/7 89/17 120/3
good [21] 1/4 10/22
24/21 25/5 29/19 39/22 40/1 43/22 54/17 63/17 71/16 72/11 79/20 83/7 95/19 114/5 114/24 146/3 176/18 183/22 201/19
Google [5] 48/18 49/7 50/11 50/25 51/1 got [36] 5/1 7/9 11/15 19/4 21/7 45/22 55/22 62/12 62/24 65/14 81/4 92/10 93/11 93/22 93/23 94/6 94/23 94/24 132/10

132/12 134/16 134/22
134/24 135/9 145/15 152/18 158/5 160/24 164/15 168/22 169/3 170/12 186/10 196/12 201/5 204/20
government [58] 7/3 28/2 29/13 32/6 52/2 52/9 52/10 52/11 52/19 67/17 69/13 71/13 71/23 71/25 82/15 82/25 83/15 83/25 84/13 84/22 85/5 85/21 85/23 86/3 86/10 86/18 87/19 88/5 88/14 92/23 95/10 123/21 124/9 124/10 129/6 130/19 135/6 135/25 145/23 146/22 148/11 149/3 153/11 156/6 156/11 156/18 156/21 158/14 158/16 159/23 160/15 161/9 162/13 163/18 166/2 166/7 191/9 200/24
government's [8] 4/3 81/20 81/23 88/8 88/18 157/1 162/8 162/19
governmental [2] 7/1 59/12
GPs [1] 152/22
Graham [2] 36/4 124/20
Graham Medley [2] 36/4 124/20
grant [1] 122/2
granted [1] 107/4
graphic [1] 102/7
grateful [7] 96/14
102/15 175/25 179/20
199/13 204/18 204/24
great [9] 62/9 62/13 64/6 83/20 85/22
120/24 131/2 165/23 168/19
Great Barrington [1] 62/13
Great Britain [1] 85/22
greater [3] 184/24 190/20 193/15 greatly [2] 5/24 8/2 Gregor [1] 21/14 Gregor Smith [1] 21/14
grim [1] 67/16 grip [1] 44/3 gross [2] 9/5 20/5 ground [4] 95/17 141/20 151/20 152/23 group [39] 2/12 3/23 4/1 4/3 56/24 62/3
\(71 / 574 / 381 / 1981 / 21\) 81/23 82/3 82/16 82/19 83/5 83/8 83/12 83/17 99/16 99/19 138/21 140/23 141/1 142/10 153/19 154/19 179/11 180/8 180/8 181/10 181/13 181/14 181/21 181/25 182/3 182/9 182/12 186/11 194/1
groups [26] 3/25
49/7 61/13 61/18 117/18 118/23 129/14 145/3 146/24 180/24 183/5 185/10 185/11
185/15 185/18 186/1 192/24 193/1 193/7 193/12 193/16 193/22 194/4 194/7 196/7 200/24
growing [3] 73/11 129/19 173/16
growth [1] 204/14 guarantee [1] 45/25 Guardian [2] 86/22 119/25
guess [1] 15/11
guesses [1] 146/3 guidance [12] 134/3
137/1 137/19 138/4 138/17 149/21 171/22 171/23 171/25 172/1 172/5 179/18
guiding [1] 149/22
Gupta [1] 164/24
H
habits [1] 52/4
had [152] 3/2 4/6 5/21 8/15 15/3 15/14 16/17 19/3 19/3 19/23 20/6 20/10 20/22 21/6 21/23 23/4 23/25 25/10 25/19 27/10 31/2 35/10 38/1 42/9 42/12 45/10 47/12 47/20 49/11 49/19 49/21 49/24 51/13 51/15 53/23 62/16 62/17 65/16 65/21 67/4 69/5 69/19 71/18 72/15 74/9 77/6 77/9 77/21 81/4 81/6 81/10 86/14 86/16 86/18 86/25 88/12 88/16 89/15 89/17 90/13 90/15 91/24 92/4 92/6 92/24 96/4 97/18 97/19 99/18 101/13 110/11 113/10 116/17 122/5 125/23 125/24 126/13 127/5 127/11 128/12 131/3 132/2
(65) frontline... - had
\begin{tabular}{|c|c|c|c|c|}
\hline H & 85/16 94/6 111/13 & 14 & healthy [1] & high-risk [1] 173/9 \\
\hline & & 86/5 97/7 97/8 97/8 & hear [8] 2/17 3/23 & higher [11] 13/1 \\
\hline 136/2 136/3 140/1 & hard [14] 17/2 39/2 & 97/9 97/10 97/10 & 28/5 39/1 55/25 72/16 & 14/18 25/9 27/19 \\
\hline 143/5 143/11 143/24 & 39/18 40/7 40/12 & 97/18 97/23 98/22 & 109/5 126/9 & 27/19 27/20 144/1 \\
\hline 144/19 145/15 147/8 & 40/15 40/18 41/10 & 99/18 99/21 104/12 & heard [22] 2/25 3/13 & 189/3 190/22 190/25 \\
\hline 148/13 148/15 148/2 & 101/22 104/19 113/ & 104/14 104/20 104/23 & 3/17 9/10 12/6 39/1 & 194 \\
\hline 149/4 149/13 151/25 & 122/19 192/25 194/16 & 104/24 104/25 105/7 & 39/4 43/16 58/14 70/7 & highest [1] 121/3 \\
\hline 152/2 152/7 152/10 & hard-working [1] & 105/8 105/10 106/7 & 70/8 70/23 92/7 & highly [2] 103/6 \\
\hline 152/11 153/18 156/13 & 122/19 & 118/7 118/17 121/7 & 100/17 122/23 & \\
\hline 156/22 157/2 157/2 & & 121/19 121/22 132/10 & 15 & Hill [4] 96/10 \\
\hline 157/7 157/8 157/9 & harder [5] 39/20 & 132/10 143/13 148/1 & 179/6 180/9 & 105/16 206/16 \\
\hline 157/14 157/16 157/22 & 42/10 71/21 191/1 & 154/14 163/2 168/13 & hearing [3] 100/22 & him [14] 5/19 6/4 6/5 \\
\hline 158/5 158/6 159/1 & 20 & 170/7 170/8 & 119/25 205/10 & \\
\hline 160/18 161/1 161/16 & harmful [2] 54/25 & he'll [1] & hearings [5] 2/1 99/7 & 36/5 46/11 104/12 \\
\hline 162/24 164/25 166/2 & 69/25 & he's [3] 6/24 3 & 105/2 114/2 115/16 & 104/17 114/9 11 \\
\hline 16 & ha & & heart [3] 77/5 116/12 & 171/15 \\
\hline 174/8 174/11 174/15 & & & & hi \\
\hline 180/24 182/5 186/21 & 69/ & ng [1] & held [8] 66/2 66/4 & \\
\hline 187/7 188/14 188/22 & 85/19 185/25 & headline [1] 204/7 & /16 102/1 118 & hindsight [1] 48/10 \\
\hline 189/3 189/3 189/11 & Harries [3] 17 & headlines [2] 190/6 & 8/21 149/8 149/9 & his [34] \\
\hline 189/12 190/11 190/20 & 171/21 172/9 & 190/12 & help [15] 16/4 20/11 & 13/22 15/23 35/10 \\
\hline 190/22 190/25 & has [50] 15/25 21 & health [109] 2/9 5/14 & 21/17 25/23 37/2 79/9 & 39/3 72/15 72/16 \\
\hline 193/18 196/11 196/11 & 26/25 41/5 48/11 & 5/24 9/7 12/15 12/21 & 152/17 152/23 175/25 & 72/17 72/24 73/2 \\
\hline 197/18 198/3 201/18 & 53/19 93/4 93/16 & 16/9 24/21 27/1 34/2 & 185/12 188/16 199/22 & 73/21 75/20 97/4 97 \\
\hline 201/24 203/9 204/13 & 98/21 98/22 103/20 & 35/21 55/10 55/10 & 200/17 202/13 204/22 & 97/9 97/24 99/17 \\
\hline 201/24 203/9 204/13 & 104/11 104/13 104/20 & 56/15 56/19 56/20 & helped [2] 82/3 97/12 & 99/17 99/19 100/23 \\
\hline & 105/6 105/12 106/9 & 64/23 68/10 68/23 & helpful [7] 33/22 & 01/8 104/14 104/20 \\
\hline \(72 / 22\) 73/12 75 & 106/14 107/21 107/23 & 69/4 69/11 69/15 & 69/12 78/25 79/7 & 105/12 107/14 110/11 \\
\hline & 108/19 110/15 114/23 & 75/18 75/24 80/5 80/7 & 100/23 105/16 123/9 & 115/17 118/2 118/16 \\
\hline & 115/9 116/14 116/17 & 80/10 80/14 80/14 & helping [1] 168/11 & 118/18 121/5 122/7 \\
\hline & 118/5 118/7 119/5 & 80/21 81/3 81/15 82/4 & hence [2] 131/17 & 70/6 \\
\hline & 119/14 119/23 120/3 & 83/4 83/10 87/16 & 164 & hit [5] \\
\hline & 120/7 120/12 120/22 & 90/16 95/18 97/6 & her [13] 19/3 19/4 & 92/6 161/12 162/5 \\
\hline & 121/4 131/20 140/5 & 109/19 109/21 125 & 20/23 21 & therto [1] 86/16 \\
\hline & 147/15 148/9 154/13 & 125/11 125/13 125/16 & 21/13 22/10 22/25 & HIV [2] 94/3 94/4 \\
\hline & 164/15 166/7 167/25 & 125/20 126/5 129/25 & 27/24 33/2 72/25 & hm [1] 186/14 \\
\hline & 170/19 172/22 173/21 & 133/22 135 & 17 & hold [4] 37/16 40/1 \\
\hline & 177/21 181/9 & 135/18 135/19 135/22 & her Lad & 155/18 162/21 \\
\hline ha & hasn't [1] & 135/23 135/24 136/5 & & holding [3] 22/9 45/6 \\
\hline & hastily [1] 105 & 42/24 143/24 & herd [8] & 45/ \\
\hline & have [275] & 144/3 148/23 151/4 & 3/22 164/2 16 & holidays [1] 202/10 \\
\hline & haven't [5] 5 & 152/10 152/21 153/3 & 164/14 167/6 167/12 & home [19] 54/11 \\
\hline \[
10
\] & 56/21 134/22 171/ & 155/13 155/15 163/3 & 167/18 & 54/17 77/21 138/7 \\
\hline & 187/3 & 166/16 166/18 172/11 & here [36] 2/1 7/18 & 186/4 187/13 189/19 \\
\hline \[
105 / 12
\] & having [21] 31/5 35/2 & 172/12 172/13 172/15 & 11/4 17/10 19/21 20/4 & 190/1 190/24 191/7 \\
\hline & 44/18 44/24 47/5 & 173/14 174/10 174/14 & 20/13 22/23 24/3 & 191/12 191/13 198/5 \\
\hline & 60/25 95/2 95/3 & 174/25 177/15 177/22 & 24/15 24/18 27/11 & 98/6 198/7 198/9 \\
\hline & 100/12 101/2 122/23 & 181/21 183/24 184/3 & 29/23 37/25 38/2 & 198/15 199/9 199/11 \\
\hline \[
\begin{gathered}
\text { ha } \\
12
\end{gathered}
\] & 129/10 137/20 139/21 & 184/6 184/13 184/15 & 43/19 43/20 46/19 & homes [17] 76/15 \\
\hline & 140/24 147/11 148/13 & 184/24 185/2 185/5 & 47/4 61/25 62/24 72/7 & 76/21 77/17 77/24 \\
\hline \[
28 / 736 / 1338 / 23
\] & 158/3 173/23 185/5 & 185/5 185/8 185/12 & 75/16 98/17 100/18 & 78/13 78/20 173/10 \\
\hline  & 194/23 & 187/2 187/15 192/9 & 108/25 109/24 111/2 & 175/1 175/13 189/21 \\
\hline 127/23 129/20 141/21 & Hayward [5] 176/6 & 192/10 192/20 192/22 & 114/22 119/22 129/8 & 190/9 190/11 190/14 \\
\hline 147/9 & 176/11 176/17 204/18 & 193/3 194/15 195/17 & 141/19 151/19 170/7 & 190/19 190/21 190/24 \\
\hline happened [9] & 207/13 & 196/1 196/1 196/6 & 177/14 195/15 & 191/10 \\
\hline 38/23 91/16 92/18 & he & 197/11 197/17 200/12 & Hi & [2] 148/14 \\
\hline 157/13 160/23 166 & 6/25 \(7151 / 22\) & 20 & high [20] 13/8 13 & \\
\hline 168/20 173/24 & 13/19 13/24 14/5 14/6 & healthcare [17] & 14/24 32/1 38/10 & Hong Kong [2] \\
\hline happening [10] 31/2 & 14/7 14/7 14/11 15/13 & 59/21 68/21 90/19 & 38/10 61/12 75/17 & 14 \\
\hline 32/6 32/16 38/12 & 15/14 15/16 15/17 & 87/2 & 31/9 & /2 \\
\hline 74/16 126/2 127/22 & 21/16 26/3 29/14 & 188/3 188/7 188/10 & 173/9 188/7 188/11 & 53/7 98/1 109/22 \\
\hline 129/13 175/14 180 & 29/23 30/17 30/25 & 188/14 188/22 189/5 & 188/25 191/12 200/21 & 128/8 180/11 \\
\hline & 31/8 35/9 35/10 46/2 & 189/6 189/14 189/16 & 201/25 202/21 204/3 & hoped [2] 6/4 21/4 \\
\hline happens [5] 13/3 & 46/9 46/15 46/16 56/5 & 189/17 198/2 & High Court [1] 98/13 & hopefully [1] 57/24 \\
\hline
\end{tabular}
(66) had... - hopefully

128/21 143/3 143/3
hoping [3] 20/25 57/8 73/1
Hopkins [1] 174/6
horrible [1] 91/23
Horton [1] 165/15
hosepipe [2] 45/6 45/24
hospital [5] 76/21 77/22 131/9 188/4 195/4
hospitalisation [2] 193/19 193/20
hospitalisations [6]
48/1 194/21 202/1
203/2 204/5 204/17
hospitalised [2] 193/23 193/24
hospitals [6] 76/16 77/18 78/20 156/15 157/5 157/9
hosted [1] 171/3 hotspot [3] 92/11 151/22 157/22
hotspots [3] 92/2 92/3 92/4
hour [3] 2/21 13/20 14/12
household [1] 90/24 households [2] 128/4 186/4
how [68] 8/20 8/23
14/24 17/20 22/8 25/24 28/6 29/20 31/4 42/12 50/1 50/1 50/23 53/6 53/11 53/13 53/14 55/25 59/22 66/14 68/16 69/6 69/14 69/22 69/25 94/4 96/17 96/19 97/7 101/22 102/13 102/14 104/3 105/3 106/23 110/5 124/6 124/7 129/15 129/15 131/1 131/1 131/2 132/20 132/21 148/19 151/14 166/14 178/4 180/19 180/25 182/1 182/3 182/5 185/4 185/13 185/17 185/23 185/25 186/1 186/4 186/5 191/5 197/12 200/12 200/16 200/21 201/21
however [8] 26/19
46/6 61/4 85/2 85/3 101/24 104/10 164/13
huge [4] 11/15
149/19 166/15 174/10
human [16] 98/9
119/19 124/17 124/17 125/21 125/21 126/2 126/2 127/9 127/9 127/17 127/17 128/21
humans [3] 125/22
125/22 127/21
hundred [2] 135/10 155/14
hung [1] 57/4
hurry [1] 21/8
hybrid [1] 16/2

\section*{I}

I actually [1] 32/3
I agree [1] 46/6
I already [1] 62/22
I also [1] 203/16
I am [9] 1/16 2/7 2/10
11/20 33/24 56/11
56/12 72/17 123/2
I apologise [4] 11/5
45/5 116/23 122/19
I ask [2] 72/11
170/25
I asked [1] 160/14 I became [1] 62/15
I beg [5] 36/13 48/25
66/23 130/7 154/1
I believe [7] 7/2 19/4
27/15 74/24 155/12
157/17 170/15
I call [2] 74/2 176/5 I came [3] 52/15 66/18 109/5
I can [12] 28/2 57/9
58/23 67/16 67/16 68/8 105/14 109/14 155/17 172/5 188/1 197/15
I can't [7] 27/25 47/7
51/4 55/24 78/23 138/14 162/16
I cannot [1] 78/21 I certainly [2] 129/9 180/24
I checked [1] 188/17 I completely [2] 36/7 56/9
I contacted [1] 6/20
I continue [1] 66/16
I continued [1] 22/14
I could [3] 58/13
68/25 71/12
I couldn't [1] 122/21
I did [8] 11/12 32/23
36/4 40/2 45/12 47/22
81/13 111/23
I didn't [12] 3/16
11/13 12/23 21/21
35/2 37/8 44/25 48/6
54/3 72/17 82/8
149/23
I disagree [2] 174/3 174/18
I disagreed [1] 81/11
I do [5] 15/2 37/4
38/17 66/8 105/2

I don't [24] 14/5
157/18
79/16 80/15 82/9 87/5 87/12 87/24 90/14
90/21 94/16 94/19
111/23 122/15 127/13 127/24 133/1 136/2
142/20 142/20 142/22
144/4 145/6 148/12
151/15 151/25 156/10
156/13 156/18 156/24
162/16 163/1 165/18
171/4 171/10 174/19
180/6 181/3 181/3
181/5 181/22 182/8
182/17 183/2 183/12
184/5 184/16 185/7
185/15 186/20 187/1
187/18 188/10 188/14 189/12 189/15 190/15 191/8 191/14 194/19 196/11 196/20 197/2 197/22 198/6 198/25 199/5 199/7 199/25 200/23 202/15 204/7 204/12 205/1 205/6
I thought [6] 26/14 30/15 32/19 132/9 179/25 201/7
I understood [1] 36/5
I used [3] 12/24 20/17 45/4
I valued [1] 6/23
I very [2] 7/7 73/22
I want [21] 4/9 7/8
12/19 28/23 29/11
34/13 38/20 38/24
40/19 42/16 43/9
54/20 55/16 57/12
59/5 60/8 63/7 68/6
88/12 167/3 183/18
I wanted [7] 18/7
40/15 45/14 70/4 72/5
73/20 74/10
I was [54] \(3 / 63 / 6\)
11/1 11/10 13/12
18/14 21/8 21/21
22/12 24/19 27/15
27/23 27/25 28/14
28/21 31/10 33/13
33/14 35/1 35/21
36/14 37/15 38/11
40/5 40/9 41/23 45/2
45/9 46/12 46/22 47/6 47/8 52/7 55/25 57/13
60/21 64/13 71/14
74/5 74/11 81/12 82/1
84/5 84/5 109/5
\begin{tabular}{l|l} 
I mean [15] \(9 / 14\) & \(43 / 243 / 744 / 2046 / 12\)
\end{tabular}
26/10 31/23 44/7 45/7
45/23 74/8 89/25
112/10 138/8 147/8
168/10 183/14 190/8
196/10
I meant [1] 22/19
I must [1] 27/6
I need [2] 57/9

46/19 51/19 51/21
52/5 53/17 54/24 55/9
56/18 58/1 58/2 58/14 \(180 / 6\) 186/20 195/7
60/18 61/6 62/9 62/10 I wasn't [7] 11/15
64/7 64/17 66/4 67/2 \(\quad 21 / 2\) 22/11 27/20
67/20 69/1 69/3 69/18 27/21 72/17 78/19
69/23 71/25 72/6 I went [2] 47/5 84/4
73/13 73/24 78/9 I were [1] 14/1
(67) hoping - I were

I will [4] 40/5 108/14 123/2 176/19
I won't [2] 96/15 98/6 I worked [1] 152/12
I would [28] 8/2 9/23 12/20 29/20 32/21 40/1 56/17 76/5 107/2 107/20 109/9 124/14 125/4 144/25 145/2 147/18 153/17 154/23 170/5 170/9 170/11 174/16 175/5 178/10 180/25 183/2 196/8 203/24
I wouldn't [2] 9/19 32/2
I wrote [2] 56/5 81/9 I'd [14] 5/22 18/21 21/3 35/17 60/4 72/20 74/1 122/25 155/17 178/8 178/20 180/11 186/20 190/12
I'II [5] 43/24 73/7
75/15 109/1 109/16
I'm [89] 1/14 7/8 11/4 12/18 14/7 14/25 15/10 19/21 22/22 26/2 30/14 32/6 34/16 35/11 36/12 36/12 37/7 38/5 39/6 40/4 46/19 47/4 47/7 47/10 50/12 51/5 57/15 59/5 60/15 62/7 63/2 65/9 66/3 67/25 70/25 73/1 73/3 73/23 77/4 78/12 78/23 79/4 79/20 84/7 90/7 95/24 105/25 107/24 108/7 108/23 108/23 109/1 109/10 109/11 109/13 109/15 126/7 136/11 144/10 146/13 146/14 147/20 150/24 151/2 153/23 154/2 159/6 159/6
159/15 160/8 162/16 171/13 171/14 172/4 175/25 176/8 178/19 179/19 179/20 184/1 186/9 187/10 187/18 189/24 196/23 197/9 199/13 204/18 205/3
I'm afraid [6] 47/7
63/2 78/23 108/23
109/15 162/16
I'm not [2] 7/8 179/19
I've [13] 5/1 6/15 7/9
8/1 11/5 68/1 71/14
137/7 153/17 173/20 186/10 203/7 204/20
idea [12] 39/1 39/17 45/3 47/19 54/25 55/2 67/14 81/15 88/9

88/22 141/25 168/8 ideal [1] 164/11 ideally [2] 136/22 166/23 identifiable [1] 121/11 identified [2] 59/19 190/12 identify [6] 47/7 135/10 138/1 152/4 190/10 197/3
identifying [2] 106/25 196/5
ie [1] \(182 / 5\)
if [182] 6/11 8/4 8/10 8/19 9/2 9/13 10/9 10/13 11/5 11/24 12/13 12/17 13/2 13/14 13/15 13/19 14/15 16/4 16/13 16/22 16/22 17/22 20/1 21/24 23/25 24/5 26/16 28/25 29/9 29/22 30/14 32/10 32/19 32/23 33/23 36/19 37/4 37/18 38/15 40/11 41/8 42/20 46/1 47/9 47/17 50/4 50/6 50/7 52/17 52/23 54/14 55/1 55/6 55/17 55/17 55/23 56/16 60/13 61/6 61/11 64/2 64/18 66/6 67/12 67/16 67/16 68/8 69/13 69/18 70/10 70/13 71/4 71/18 75/8 75/13 76/11 78/3 78/7 79/6 86/20 88/1 88/2 90/23 91/11 91/12 92/6 92/8 Imperial [3] 7/24 93/4 93/11 95/11 84/18 128/16 95/15 96/9 97/8 103/6 Imperial College [2] 103/16 103/17 103/22 104/4 104/4 107/4 107/12 108/8 108/16 109/11 109/14 110/10 110/25 112/16 112/24 113/10 114/22 118/17 122/20 123/4 123/16 126/16 127/8 127/21 127/25 128/3 128/8 129/18 132/12 132/22 133/20 133/25 136/8 137/10 138/2 138/19 139/15 143/23 143/23 144/19 144/20 146/2 146/4 147/20 152/11 153/17 153/18 154/23 157/7 159/22 160/18 161/3 162/13 163/18 163/24 164/6 168/3 168/15 168/19 169/3 170/20 172/5 173/15 174/11 174/13 174/15 important [44] 13/4

176/20 177/2 177/4 177/10 178/2 181/22 182/22 184/7 184/10 185/16 186/10 187/21 190/15 191/2 191/2 195/13 195/21 195/22 196/11 202/19 202/23 204/8
If we [1] 168/3
ignores [2] 99/20 99/21
ill [1] 130/12
illness [1] 134/5
illustration [1]
176/18
immediately [3] 21/6 28/12 78/14
immense [1] 104/18 immensely [1] 97/6 immunisation [1] 82/3
immunity [15] 61/13 163/14 163/23 164/2
164/2 164/6 164/9
164/11 164/12 164/14 164/14 164/19 167/6
167/12 167/18
immunology [1]
87/15
impact [15] 41/6 54/5
139/22 140/2 141/5 149/1 149/2 179/1 189/11 189/12 191/15 196/6 203/2 203/4 203/9
impacted [4] 30/20 38/3 38/6 197/12
impacts [3] 40/25
68/14 75/18

7/24 128/16
impinged [1] 103/20 implementation [3] 169/22 170/3 201/14 implemented [1]
76/7
implements [1] 80/9
implication [3] 139/3
140/12 166/10
implications [1]
144/3
implied [2] 36/9
128/22
implies [1] 38/22
implying [1] 91/24
importance [14]
17/17 105/8 119/18
120/14 120/25 179/25
190/13 192/12 196/21 197/25 198/7 198/15 199/8 203/21

24/4 26/12 39/14 43/4 incredibly [2] 50/19 43/6 47/14 52/16 165/23
57/25 59/6 61/5 65/13 incubation [4] 91/1
66/24 77/16 90/21 93/16 93/18 94/24
90/21 93/4 100/9 indeed [14] 11/20
119/20 121/2 122/11 \(79 / 3\) 79/4 105/17
128/2 140/19 152/24 107/25 116/9 118/6
155/2 189/17 189/21 \(147 / 16\) 152/16 175/19
191/8 198/17 198/22 \(175 / 22\) 188/1 \(194 / 5\)
198/25 199/1 199/3
199/5 199/10 199/25
201/24 202/6 203/13 203/16
importantly [2]
138/23 149/16
importation [1] 175/2
impose [1] 42/18
imposed [7] 47/21
53/20 53/23 53/25
54/15 54/16 67/18
imposition [2] 166/2 170/4
impress [2] 86/2 96/2
impression [4] 21/7
32/12 77/4 86/8
impressive [2] 16/9 81/18
impressively [1] 160/9
improve [4] 105/9 184/15 185/12 195/10 improved [1] 197/13 inaction [1] 157/19 inadequate [1] 74/9 incidence [1] 158/17 incidentally [1] 112/25
inclined [2] 31/21 31/22
include [2] 100/8 100/10
included [3] 68/23
179/17 188/5
includes [1] 114/10 including [11] 2/14 89/9 100/185/21 83/11 individual [3] 100/6
89/9 100/18 101/17 117/16 121/10
172/18 200/8 200/12 individual's [1]
inclusion [1] 196/1
income [1] 172/19
inconvenience [1] 116/2
inconvenient [1]
116/6
incorporate [1] 20/15 increase [4] 55/19
129/2 143/2 201/18
increased [3] 61/5
150/21 191/19
increases [1] 202/1 increasing [2] 6/16 201/21
increasingly [3] 6/6
indicators [1] 26/20
194/17
indefinite [2] 41/17 41/19
independence [1] 83/19
independent [36]
33/25 80/23 80/25
81/1 81/19 81/20
81/24 82/7 82/8 82/20
82/21 82/22 82/23
83/4 83/17 83/22 84/3
84/5 84/12 84/19
84/20 84/23 85/2
85/15 85/24 86/1 86/9
87/9 87/12 88/13
88/17 141/23 143/17
149/5 154/19 168/11
Independent SAGE
[14] 80/23 80/25
81/1 81/19 81/20
82/22 83/17 85/2
85/24 86/1 87/12
88/13 88/17 168/11
Independent SAGE's
[1] \(87 / 9\)
index [2] 135/8
205/12
indicate [2] 127/24
138/12
indicated [5] 108/9
128/21 163/3 169/22 187/19
indicating [1] \(1 / 18\)
indication [1] 124/13
indicator [1] 50/3

113/18
individually [1] 117/4
individuals [6] 16/2 48/19 126/20 134/6 145/22 153/21
induces [1] 164/5
5 inducing [1] 164/10 industries [1] 198/2
inequalities [7] 185/3
185/5 185/13 195/19
195/20 196/21 200/17
inequality [1] 196/6
inevitable [2] 129/7 201/8
inevitably [1] 144/22
infect [7] 93/7 93/14
94/9 128/19 128/25 132/21 137/21
infected [18] 8/20 8/24 64/12 64/15 65/15 65/20 67/4 93/6 93/19 130/16 130/17 130/21 131/20 137/21 151/7 152/4 164/25 189/3
infecting [1] 125/22 infection [42] \(8 / 19\) 9/4 23/23 42/5 58/10 64/8 74/5 74/7 76/10 77/8 123/14 123/17 123/22 124/1 124/5 124/10 128/2 131/22 131/24 132/2 132/8 132/22 135/9 136/22 136/25 137/13 139/4 148/17 161/4 187/17 187/24 188/3 188/15 190/23 191/1 191/4 198/3 198/4 200/5 201/20 202/22 202/24
infections [10] 17/21
94/4 94/5 125/14
127/17 178/8 179/13 197/6 197/7 201/24
infectious [6] 2/5
2/13 16/1 16/5 58/22 126/21
infects [2] 93/13 132/14
inference [1] 49/18
inferences [2]
178/12 193/2
inferred [2] 190/22 191/1
infinite [1] 173/16
infirm [1] 58/7
influence [1] 37/21
influenced [2] 49/15
191/13
influenza [28] 13/6
13/6 13/7 26/22 30/24
31/11 31/15 31/17
31/19 36/23 37/12
37/17 53/3 77/5 77/6
77/7 88/23 89/12 91/2
94/2 136/25 137/10
137/13 138/5 138/17
139/3 140/14 150/21
influenza-like [1]
31/19
inform [1] 98/1
informal [2] 4/4
59/22
informally [1] 74/2
information [22] 6/7
10/25 22/11 25/4 49/2
50/19 86/21 87/7

87/10 97/10 110/2 111/4 112/5 112/10 114/8 179/20 192/3 193/14 194/17 194/25 195/3 199/8
informed [3] 53/3 151/5 180/6
informing [2] 184/17 199/6
infrastructure [2] 90/14 90/14 infrastructures [2] 172/13 172/14
infringement [1] 112/15 inhibit [2] 100/20 104/1
initial [4] 15/2 15/9 190/4 190/9 initially [4] 61/12 82/6 181/20 196/8 initiated [1] 42/23 injustice [1] 123/16 input [2] 78/12 184/5 INQ000051925 [1] 150/15
INQ000056226 [1] 28/25
INQ000057492 [2] 133/7 150/9
INQ000061570 [1] 60/12
INQ000103227 [1] 7/13
INQ000103343 [1] 42/20
INQ000103349 [2]
4/22 15/8
INQ000103352 [1] 18/23
INQ000109142 [1] 169/13
INQ000207121 [1] 64/18
INQ000230014 [1] 85/14
INQ000237322 [1] 162/11
INQ000249693 [1] 88/2
INQ000257925 [1] 72/21
INQ000268213 [1] 167/5
INQ000268222 [1] 142/25
INQ000281260 [1] 79/25
INQ000282428 [1]
165/14
INQ000303290 [1] 125/6
inquest [2] 111/7 112/6
inquiries [1] 100/11 inquiry [58] 1/7 1/11 1/25 7/23 35/6 72/16 79/19 97/20 97/22 97/24 98/16 99/5 101/20 102/2 102/12 102/25 103/8 104/12 104/18 104/21 105/7 105/11 106/9 106/23 107/21 108/16 108/18 112/22 113/8 114/1
114/24 115/1 115/10 115/20 116/2 116/2 116/11 117/1 117/15 118/8 118/8 118/18 119/7 120/9 121/20 123/12 130/8 140/7 148/9 155/2 167/25 176/12 189/22 206/5 206/11 207/4 207/8 207/15
Inquiry's [4] 98/7 99/1 104/22 118/13 insight [2] 185/21 191/16
insights [2] 169/7 200/16
insofar [1] 84/22
instead [3] 56/13
152/17 202/15
institute [6] 2/8 5/10 7/3 80/6 80/9 154/11 institutions [2] 53/15 77/18
instruction [1] 54/11 intend [1] 109/20 intended [3] 30/11 70/17 97/18
intense [6] 120/13
189/5 200/8 202/21
202/23 205/4
intensely [1] 104/20 intensive [2] 166/7 193/25
intentioned [1] 141/1 interest [6] 74/9
100/11 106/4 108/15 121/2 121/17
interested [2] 40/10 111/25
interesting [3] 79/8
156/17 205/5
interests [3] 100/6 100/7 100/8
interference [12]
98/7 100/4 106/5
111/4 112/11 112/14
112/16 112/17 113/17
118/2 120/16 122/7
internal [3] 15/14 130/1 143/9
international [4]
16/19 129/25 143/24 144/3
interpretation [1] 10/24
interpreted [1] 134/7
interrupt [3] 84/7
122/21 160/8
interval [2] 95/1 95/1
intervals [1] 94/21
intervening [2]
203/22 204/4
intervention [11] 40/9 40/11 44/6 73/18 193/16 201/2 202/25
74/19 159/20 173/6 85/1190/23 124/24 203/5 203/6 203/14 138/2 139/18 141/6 203/15
interventions [16] 44/10 56/15 57/17 76/5 76/6 76/12 88/24 168/7 170/4 185/1 185/23 186/5 198/8 198/10 200/15 200/15 isolating [1] 149/19 interview [1] 124/20 \(\quad\) isolation [21] 59/14 interviews [1] 203/24 73/9 73/16 90/23 intimately [1] 85/25 \(91 / 14\) 92/20 95/11 into [33] 6/8 20/4 23/16 33/6 42/4 43/1 44/18 44/23 55/18 57/21 67/21 69/14 78/24 81/12 92/21 111/20 112/11 115/4 120/16 140/22 145/13 146/1 147/2 147/12 150/3 151/8 173/8 181/23 190/1 195/22 196/20 198/23 202/15 introduce [2] 5/18 181/4
introduced [9] 49/12 49/21 49/25 50/3 75/23 78/24 132/16 202/21 202/24
introducing [1] 203/10
introductions [1] 23/9
introductions/outbre
aks [1] 23/9
intrusive [4] 100/5
101/4 101/6 104/8
investigator [3] 2/11 190/1 192/1
invitation [2] 146/13 160/9
invited [3] 154/25 189/19 203/7
involved [11] 46/16
82/1 178/23 179/16
181/12 181/18 183/20
184/4 191/24 198/1
201/2
involvement [3]
182/10 182/25 184/24
involves [1] 101/11
Ireland [4] 85/22
108/3 108/7 206/23
irrelevant [6] 111/7
111/12 112/9 112/10 115/14 121/24
irreversible [1] 6/3 is [545]
ish [1] 63/12
isn't [11] 46/5 47/18 83/25 86/13 137/24 157/14 157/24 161/8 193/16 201/2 202/25 85/11 90/23 124/24 147/2 149/16 149/17 150/4 158/21 159/1 159/16 159/21 160/21 161/2 161/17 174/25 isolated [3] 138/24 152/25 152/25 123/18 129/17 133/23 138/6 142/4 144/18 145/10 151/8 166/22 167/2 168/21 168/23 169/5 185/17
issue [24] 51/14
66/25 70/25 73/2 110/15 111/2 111/8 111/12 111/16 112/7 114/12 116/12 117/10 117/25 130/24 136/20
145/2 158/15 163/16
164/3 180/5 183/3 187/4 194/17
issued [4] 125/7
128/16 144/10 204/9
issues [7] 109/23
136/12 183/19 185/16
190/17 196/5 196/14
it [562]
it's [134] 1/13 4/15 4/16 7/10 7/11 7/14 8/5 8/8 8/21 9/18 9/21 9/25 10/3 10/9 10/22
11/6 12/11 12/14 13/10 13/22 14/18 14/20 15/5 17/4 17/13 17/14 17/18 18/25 19/1 19/7 19/8 19/10 19/22 20/12 21/11 21/14 22/19 22/19 22/20 26/2 27/10 27/12 27/13 28/6 28/8 28/13 28/24 29/3 29/4 30/6 30/9 32/10 36/13 39/14 39/15 40/8
40/21 41/3 43/2 45/25
47/18 54/14 55/20
56/20 56/21 57/25
58/2 58/2 58/3 64/14
64/20 64/21 66/16
it's... [61] 72/21 73/1 73/2 73/5 73/7 73/13 75/13 78/9 85/15 85/16 85/17 86/13 88/1 91/5 91/22 93/11 93/19 93/23 94/23 95/21 98/17 98/19 102/1 102/7 102/8 103/18 104/10 106/14 106/19 106/22 107/8 113/12 113/15 113/20 114/18 115/10 116/4 126/9 130/2 133/13 139/3 142/20 143/14 143/14 143/16 144/6 155/1 155/24 164/7 169/24 170/14 171/16 171/18 172/10 172/11 177/4 177/13 181/3 189/21 195/13 195/14 its [35] 3/10 4/4 34/3 34/19 48/20 61/14 68/9 69/12 70/15 87/8 88/7 90/24 90/25 91/1 105/8 108/20 118/8 125/17 128/17 132/19 132/22 142/12 142/19 143/12 158/19 158/25 159/13 162/13 169/8 170/1 172/10 181/24 183/16 187/14 188/9 itself [7] 81/19 86/2 117/13 136/20 158/5 174/1 200/13

\section*{J}

January [42] 3/4 3/6 3/7 4/12 5/7 5/22 16/16 17/12 19/4 25/2 29/3 33/14 34/21 35/20 35/21 36/15 85/17 88/22 94/8 94/18 124/15 124/19 125/5 125/7 125/10 125/13 125/16 125/19 126/5 126/11 126/22 127/12 128/12 129/5 129/24 133/11 142/9 142/25 143/7 143/25 150/10 153/18

\section*{January}

20-something [1] 35/20
January 2020 [4] 3/4 4/12 17/12 94/8
January 20th [1] 3/6
January 24th [1] 94/18
January 28 [1] 142/9
January 28th [1] 88/22
January 8th [1] 5/22

Japan [3] 148/18 166/11 174/12
Japanese [1] 148/11
Jason [1] 165/19 Jason Hickel [1] 165/19
Jenny [3] 171/4 171/21 172/9 Jenny Harries [3] 171/4 171/21 172/9 Jeremy [21] 5/7 5/9 6/21 7/20 10/5 13/25 13/25 15/4 16/25 18/10 18/19 19/6 19/9 19/24 20/7 21/25 23/2 25/19 34/24 124/18 163/8
Jeremy Farrar [16] 5/7 6/21 7/20 10/5 13/25 15/4 18/10 18/19 19/9 19/24 20/7 21/25 23/2 25/19 34/24 124/18 Jeremy's [1] 7/7 jet [1] 45/5
Jinping [1] 143/20
job [2] 49/17 152/8 jobs [1] 186/3 John [6] 1/9 43/11 66/4 67/9 124/20 163/9
John Edmunds [3] 43/11 124/20 163/9 Johns [1] 174/6 Johns Hopkins [1] 174/6
joined [1] 196/16 Journal [2] 127/15 127/15
journals [1] 122/4
judge [1] 119/23
judgement [5] 18/6
20/12 20/17 20/17 20/21
judgements [1] 69/7 judgment [2] 109/7 109/16
judgments [1] 122/25
July [3] 2/1 194/10 200/21
jump [1] 139/16 jumped [1] 11/5
jumping [2] 11/4 197/16
June [6] 63/14 190/3 192/16 193/9 194/10 194/18
June 2020 [3] 63/14 192/16 193/9
junior [2] 133/18 151/21
just [135] 2/4 3/18 4/13 4/17 5/4 5/9 5/18

6/12 7/4 8/14 9/9 10/9 \(176 / 4\)
11/22 11/25 14/11 Keeling [1] 3/24 15/2 15/19 15/21 16/4 keen [3] 55/18 74/6 18/16 21/10 21/11 143/10 22/9 23/7 24/4 24/24 keep [9] 41/9 48/23 26/17 27/9 29/7 29/17 \(48 / 24\) 50/5 84/9 96/15 30/4 30/12 31/23 32/8 121/6 129/3 176/19 32/10 33/23 34/5 keeping [7] 37/16 37/18 38/18 40/19 \(\quad 41 / 4\) 41/7 44/22 66/6 48/23 52/22 53/13 54/12 54/24 55/4 56/18 57/11 61/21 62/2 63/7 64/14 64/17 kept [4] 38/14 67/18 67/25 68/6 68/22 71/2 79/21 176/8
72/13 72/19 73/3
\begin{tabular}{l|l}
\(75 / 15 ~ 78 / 3 ~ 82 / 14\) & \(50 / 2090 / 22157 / 23\)
\end{tabular} 82/24 89/14 90/7 91/3 176/25 192/11 195/17 92/21 93/3 93/13 killer [1] 54/18 94/10 95/5 95/25 kind [7] 24/22 40/8 98/23 107/15 107/16 45/8 45/8 133/2 107/21 108/23 109/5 147/12 156/23 110/21 111/22 113/15 kindly [1] \(1 / 10\) 116/22 121/21 122/23 kinds [1] 129/18 123/5 125/1 125/4 King [2] 85/22 86/4 126/1 130/4 130/4 King's [1] 108/12 131/10 131/12 132/15 Kingdom [18] 124/3 133/7 133/12 135/3 \(126 / 5\) 128/13 129/6
135/16 137/12 138/11 \(140 / 12\) 141/3 143/22 144/10 147/20 152/1 \(144 / 22\) 146/22 147/7 152/2 153/1 156/20 148/7 148/9 149/2 160/25 162/11 163/5 \(157 / 11\) 159/11 162/3 164/17 167/10 169/11 170/12 171/1 172/4 172/8 173/20 174/21 177/2 177/25 184/1 186/10 187/7 190/16 195/6 195/13 195/21 195/22 196/4 197/6 197/9 198/17 202/17 202/25 203/8
justice [13] 72/13 100/10 108/2 108/3 108/6 108/7 108/15 109/7 114/4 120/5 171/1 206/22 206/23 Justice and [1] 109/7 Justice Northern Ireland [1] 108/7 Justice UK [1] 72/13 justification [2] 112/14 112/17
justifications [1] 120/15
justified [2] 106/5 112/16
justify [1] 113/17

\section*{K}

KC [11] 72/9 105/24 108/4 109/19 113/23 170/23 206/7 206/19 206/24 207/2 207/11
KC's [1] 105/19
Keating [2] \(176 / 2\)

76/8 176/24
Keith [4] 96/8 107/13 116/10 122/15
key [8] 32/17 47/24
176/25 192/11 195/17 laboratories [9]
134/3 136/2 136/2 136/4 153/4 153/8 153/14 154/8 155/6 labs [1] 154/14 lack [3] 34/10 81/14 86/12
lacking [1] 185/20 lacuna [1] 87/7
Lady [59] 1/4 50/12 51/5 52/7 72/6 72/10 79/2 79/10 79/16 95/25 96/9 96/14 105/25 106/9 107/20 108/5 108/22 109/2 109/13 109/20 109/25 110/7 110/19 110/25 111/17 112/2 112/13 113/4 114/3 115/12 116/8 116/12 116/22 117/9 118/4 119/3 120/10 122/9 123/8 133/18 140/5 142/22 146/8 146/14 147/22 170/14 170/24 171/12 173/21 175/18 175/21 176/5 177/10 181/9 187/4 189/21 202/19 204/20 205/7
Lady's [2] 12/17 163/11
Ladyship [4] 72/25 99/7 99/10 102/19 Ladyship's [1] 99/10 laid [1] 149/11 Lancet [8] 80/20 94/18 124/17 127/10 127/14 131/7 165/15 189/8 \(\begin{array}{lll}132 / 18 ~ 132 / 19 ~ 134 / 19 ~ & \text { language [1] 27/12 } \\ \text { 141/9 145/23 147/10 } & \text { Lansley [1] 135/20 }\end{array}\) 147/14 149/18 149/20 large [11] 13/1 17/24 151/19 152/22 155/5 155/16 164/23 165/23 168/14 171/10 174/4 186/5
knowing [3] 21/2
130/10 130/25

92/24 130/16 130/21 141/8 151/9 192/4 192/6 192/6 200/5 largely [1] 180/7
larger [1] 200/6
last [19] 1/14 2/4
\begin{tabular}{|c|c|c|c|c|}
\hline L & 117/24 119/3 & 38 & 67/21 68/20 69/10 & loss [1] 166/6 \\
\hline 1 & legitimate [2] 100/20 & 45/19 46/13 52/ & 69/14 69/16 69/17 & lost [5] \\
\hline 5/2 6/12 6/12 14/2 & & 58/10 69/18 70/17 & 69/19 69/22 71/10 & 38/22 58/1 162/25 \\
\hline 25/1 55/20 56/21 & & 8/ & 71/17 & ebruary \\
\hline 72/25 79/7 97/14 & less [15] 23/24 24/ & 145/22 193/24 200/4 & 77/13 77/15 77/ & 34 \\
\hline 166/12 169/24 170/7 & 25/1 39/7 50/6 51/20 & 202/22 & 77/25 88/12 88/16 & lot[19] 12/14 17/1 \\
\hline 184/22 196/25 & 56/12 71/15 74/21 & limit [3] 26/24 151 & 147/12 149/13 149/1 & 24/5 36/13 36 \\
\hline lastly [2] 53/17 179/1 & 76/5 76/13 93/9 100/4 & 153/2 & 158/24 159/20 160/24 & 36/14 37/5 37/14 \\
\hline late [5] 33/14 35/20 & 3/3 & limitations [1] 134/12 & 162/2 166/17 168/18 & 57/17 66/14 66/17 \\
\hline 43/12 161/3 161/22 & lesser [2] 56/2 & limited [16] 2 & 169/17 180/2 188/12 & 69/16 79/8 83 \\
\hline latent [3] 93/5 93/8 & & 30/18 68/ & 198/14 199/22 202/5 & 111/19 132/14 152/2 \\
\hline latent[3] 93/5 93/8 & lessons & 70 & 202/10 204/ & 154/21 \\
\hline later [29] & & & lockdown 1 [1] & ts [2] 49/14 77/23 \\
\hline 18/19 25/2 48/2 & let [7] 4 & 156/13 157/3 & & ] \\
\hline 50/16 53/18 53/25 & 76/11 84/4 139/25 & 166/3 182/21 202/9 & lockdowns [8] 46/17 & 32/1 41/9 64/2 126/6 \\
\hline 63/14 63/21 64/12 & 140/22 143/20 & limits [1] & 46/21 68/14 91/1 & 126/6 203/23 \\
\hline 64/20 83/2 90/5 92/15 & let's [20] 4/20 4/20 & line [7] 19/22 19/22 & 91/23 138/7 138/8 & ower [5] 25/10 \\
\hline 97/9 115/19 136/7 & 11/22 13/19 14/11 & 21/11 27/25 43/25 & 160/2 & 132/9 172/18 202/24 \\
\hline 138/9 142/1 149/20 & 21/10 30/17 43/24 & 46/23 104/22 & London & 1] 44/25 \\
\hline 155/18 156/16 168/20 & 46/1 57/4 64/17 66/2 & lines [4] 20/1 168/2 & 84/18 92/5 177/16 & ly \\
\hline 171/24 189/23 193/5 & 93/11 94/9 94/23 & 184/22 202/8 & 18 & \[
5 / 20
\] \\
\hline 203/5 204/15 & 162/17 170/16 18 & lin & - & \\
\hline lateral [1] 74/25 & & & & M \\
\hline latest [1] 150/1 & level [11] \(4 / 5\) & 137/7 154/16 195/14 & 37/17 41/25 42/1 42/6 & 29/12 41/2 \\
\hline latter [1] 25/10 &  & list [1] 86/18 & 61/25 62/1 75/18 & \(7 / 21\) 48/21 49/1 51/3 \\
\hline Laura [1] 116/25 & 129/2 161/10 163/2 & listed [1] 133/17 & 90/25 91/23 93/5 & 53/12 62/21 73/1 \\
\hline law [6] 98/10 98/18 & 164/14 167/16 202/24 & listen [1] 143/14 & 96/15 104/15 132/20 & 86/4 96/10 97/9 \\
\hline & levelling [1] & literally [1] 74/11 & 162/22 176/9 199/4 & 101/18 103/20 108/12 \\
\hline & levels [8] 61/12 & literature [1] 54/8 & 202/5 205/3 & 115/11 116/2 \\
\hline & 153/15 158/17 191/12 & little [22] 3/23 5/18 & Long Covid [1] 61/25 & 120/22 124/23 143/23 \\
\hline & 201/25 202/22 203/23 & 6/8 16/12 18/7 26/16 & long term [1] 42/6 & 145/7 149/18 154/24 \\
\hline 32/8 & 204/3 & 28/18 33/21 34/23 & long-term [1] 42/1 & 155/19 168/13 172/21 \\
\hline 32/8 & liberty & 41/22 48/13 55/7 & longer [4] 14/13 84/5 & 174/19 180/21 \\
\hline & life [2] 98/8 174/1 & 70/16 82/2 90/5 & 93/5 202/23 & madness [1] 136/11 \\
\hline layperson [1] 177/25 & lifelong [1] 164/9 & 116/24 135/25 137/20 & look [41] & Mail [1] 122/4 \\
\hline 65/6 79 & lifestyle [1] 178/8 & 171/24 184/20 193 & 8/4 10/9 11/2 & ail on Sunda \\
\hline 116/11 117/1 123/12 & lifetime [1] 53/7 & lived [2] & & \\
\hline 206/11 207/4 207/8 & light [3] 73/17 113 & 185/13 & 14/25 18/22 21/10 & main [8] 38/7 86/11 \\
\hline 206/11 207/4 207/8 & 14 & Liverpoo & 28/8 28/9 28/11 29/22 & 81 \\
\hline & lig & lives [2] 184/1 & 34/14 34/17 36/1 & 188/10 190/12 197/2 \\
\hline & 15 & 204/8 & 46/1 47/17 50/24 55/6 & mainly [3] 58/17 \\
\hline & lightly [1] & loc & 2/19 62/20 64/1 & \\
\hline 179/2 195/9 & like [43] 9/13 10/17 & 135/24 149/13 184/13 & 67/9 70/13 92/8 92/17 & maintain [1] 91 \\
\hline & 13/7 18/8 18/21 24/9 & 185/9 & 129/12 136/21 138/21 & maintaining [2] \\
\hline learning [2] 195/17 & 28/5 30/13 30/19 & locally [1] & 149/6 154/20 169/11 & 169/18 170/2 \\
\hline & 31/19 36/9 37/13 & located [1] 112/25 & 177/3 180/6 182/4 & [7] \\
\hline learnt [3] 53/9 97/10 & 50/19 58/21 60/4 & locations [1] 175/13 & 182/24 184/22 & 150/2 178/4 185/7 \\
\hline 201/23 & 72/20 77/7 84/14 & lock [4] 41/12 56/18 & 10 & 188/3 204/16 \\
\hline least [14] & 84 & 71/14 71 & 35/7 57/21 62/16 & ity [2] 84/ \\
\hline 17/10 40/17 45/17 & 106/17 122/23 122/25 & lockdown [78] 41/1 & 62/16 62/21 65/8 & \\
\hline 66/24 72/7 98/25 & 125/4 135/25 141/8 & 41/17 41/19 41/20 & 141/7 149/24 180 & [36] 9/25 18/5 \\
\hline 101/3 101/21 1 & 141/8 141/8 164/11 & 42/19 42/24 44/19 & 194/1 197/24 198/11 & 5/1 \\
\hline 144/14 169/8 & 173/9 178/2 178/20 & 46/3 46/7 47/16 47 & 198/ & \\
\hline 95 & 180/25 182/2 182/22 & 48/12 49/8 49/12 & looking [14] 9/1 & 69/6 75/3 79/5 \\
\hline & 182/24 184/7 184/11 & 49/12 49/22 50/22 & 18/18 29/4 29/7 32/25 & 100/22 102/23 105/18 \\
\hline led [1] 16/9 & 185/16 186/20 195/4 & 51/17 51/25 52/2 & 60/23 69/4 69/5 71/3 & 105/21 108/8 108/9 \\
\hline & 198/20 & 53/20 53/23 54/5 54/7 & 72/23 107/10 178/6 & 108/10 113/4 116/22 \\
\hline \[
22148
\] & likelihood [11] 6/15 & 54/10 54/25 55/4 55/9 & 180/25 181/25 & 130/4 145/2 146/3 \\
\hline legal [12] 54/16 & 6/16 15/11 31/1 31/24 & 55/11 55/14 55/18 & looks [1] 52/23 & 147/15 152/3 156/15 \\
\hline & 125/22 128/25 132/3 & 55/23 56/8 56/10 & lopsided [1] 83/7 & 70/21 179/1 183/23 \\
\hline  & 144/21 145/24 199/20 & 56/12 56/13 56/14 & Lord [1] 109/7 & 185/15 199/16 199/19 \\
\hline 112/6 116/2 117/1 & likely [21] 14/2 28/6 & 56/14 56/16 56/18 & Lord Chief [1] 109/7 & 202/20 204/16 \\
\hline 112/6 116/2 117/1 & 32/20 32/21 35/12 & 67/11 67/13 67/18 & lose [1] 110/20 & maker [1] 120/4 \\
\hline
\end{tabular}
(71) last... - maker
makers [2] 43/19 70/19
makes [8] 17/2 97/17 99/8 110/9 124/4 128/3 136/13 139/20
making [13] 11/15
29/18 48/20 52/12
52/21 66/13 69/12
96/21 133/4 145/4
178/14 197/12 202/25 manage [8] 45/1 45/3 45/7 59/15 59/16 136/8 142/12 152/23
manageable [1] 103/1
managed [3] 89/3 136/7 175/2
management [1] 173/12
managing [1] 88/7 manner [1] 110/11 many [37] 8/1 8/1 8/20 8/23 9/4 16/1 31/13 31/13 34/7 42/15 49/7 50/20 56/1 59/19 81/11 83/19 86/7 86/15 94/4 102/24 104/17 118/22 118/24 124/6 124/7 135/2 143/9 148/19 151/14 151/22 154/22 164/8 166/6 168/22 190/9 192/25 199/1
many weeks [2]
31/13 31/13
March [37] 33/6 42/3 42/23 43/12 44/14 47/22 49/9 63/13 81/5 81/9 142/16 145/14 152/16 156/7 158/1 158/20 159/7 159/15 160/14 161/9 162/4 162/9 162/19 162/23 163/2 165/12 165/14 167/5 168/1 169/12 169/16 171/2 171/18 171/19 173/25 175/14 188/19
March 2020 [4] 42/3 63/13 160/14 175/14
March 23rd [2] 47/22 49/9

\section*{March 24th [1]} 152/16
marginal [1] 54/10 mark [5] 1/5 1/6 1/9 94/25 206/3
masks [2] 141/9 179/18
mass [1] 74/10
massive [2] 58/11 160/6
master [2] 9/24 109/8 \(75 / 1\) material [32] 98/3 99/13 100/12 100/24 101/1 101/18 111/7 111/12 111/14 112/7 112/20 112/23 113/2 113/11 113/14 113/16 114/13 115/13 115/24 117/21 117/22 118/15 118/23 119/8 120/2 120/3 120/6 120/7 120/21 121/13 121/24 154/24
materials [2] 85/2 104/2
maternal [2] 80/13 82/4
mathematical [1] 178/13
mathematics [1] 204/14
matryoshka [1] 106/17
Matt [1] 29/9
Matt Hancock [1] 29/9
matter [15] 8/2 54/1 65/17 96/16 106/21 106/22 106/23 112/19 113/19 142/22 159/22 160/14 160/17 170/14 194/22
matters [9] 60/9 72/5 111/21 116/1 116/5 118/11 121/14 195/9 197/13
maxim [4] 39/7 39/22 40/1 40/11
maximising [1] 185/2 may [72] 13/19 17/14 18/24 22/21 28/5
\(29 / 22\) 30/21 \(32 / 432 / 4\) 29/22 30/21 32/4 32/4
\(32 / 837 / 2046 / 146 / 6\) \(32 / 837 / 2046 / 146 / 6\)
\(51 / 1754 / 656 / 263 / 6\) 64/18 64/24 65/3 69/8 70/22 71/11 72/22 78/3 79/6 80/4 83/1 83/17 86/2 86/14 87/4 87/25 88/11 93/7 95/25 96/20 107/3 107/5 107/13 111/21 112/2 114/25 116/5 117/3 117/3 117/13 117/15 117/17 118/14 118/15 119/4 119/13 120/23 122/16 123/16 130/15 132/18 132/19 134/20 156/2 162/16 176/5 181/12 182/8 188/8 190/3 193/14 194/10 196/12 196/14 203/23
May 2020 [1] 193/14 maybe [3] 3/17 73/25

McLean [1] 64/19 me [39] 4/17 5/24 5/25 6/20 11/1 11/9 19/15 24/21 32/23 35/5 35/18 38/6 39/22 48/14 55/21 58/17 65/11 66/17 67/22 71/20 74/24 77/13 78/10 81/16 84/4 97/12 108/8 108/9 114/4 126/17 141/25 146/5 153/25 160/11 163/8 180/12 180/21 186/10 200/9
mean [29] 9/14 12/10 12/13 26/10 31/23 39/9 40/7 43/20 44/7 45/7 45/23 54/13 74/8 89/25 94/12 107/5 112/10 130/5 138/8 147/8 150/23 150/25 164/14 166/21 168/10 178/1 183/14 190/8 196/10
meaning [3] 93/13 126/7 128/18
meaningful [1] 175/14
meaningfully [1] 119/9
means [13] \(21 / 20\) 25/12 41/11 53/12 98/15 100/5 101/4 101/6 101/19 104/8 151/3 160/18 203/1 meant [5] 22/19 118/6 141/24 193/5 204/4
meantime [1] 123/3
measles [1] 164/7
measure [11] 8/22
41/21 54/25 78/14 123/17 146/3 159/20 178/11 187/17 194/20 201/20
measured [2] 149/6

\section*{182/5}
measures [46] 49/24
56/24 57/15 57/18
57/20 59/3 59/10
59/12 68/19 73/10
73/18 75/23 88/5
99/24 123/15 123/22
124/11 128/22 136/22
138/13 139/21 140/2
141/8 141/13 141/13
141/14 145/1 145/13
146/1 146/16 146/21
155/9 158/24 165/25 166/3 168/3 168/17
168/19 175/1 179/17
180/3 180/17 180/22 181/4 184/13 201/9
measuring [2] 188/2 mid-2020 [2] 63/13

196/12
mechanism [2] 57/16 Mid-January [1] 3/7
173/11
media [11] \(85 / 8\)
96/23 98/18 99/20
100/9 101/16 105/19
108/12 109/3 119/25 200/25
medical [13] 11/3 11/11 11/21 12/18 20/19 21/2 21/15 102/6 142/10 153/10 168/2 200/2 200/19
Medicine [1] 127/15
Medley [6] 2/25 3/24 35/7 36/4 43/17 124/20
meet [2] 14/3 154/9
meeting [16] 22/3
22/3 28/24 29/1 29/13 60/10 60/16 86/24 87/3 87/9 88/21 88/21
129/11 133/2 133/14
134/10
meetings [14] \(3 / 15\)
3/19 31/14 33/5 33/22 million [2] 151/20 34/19 35/25 36/3 37/7 168/25
47/14 60/19 86/15
87/13 183/8
Mellat [2] 100/2 120/17
member [13] 2/8
2/21 3/2 3/4 3/9 3/22 60/17 80/23 83/5 122/5 182/17 183/7 186/23
members [14] 35/4
83/11 84/2 86/18
89/10 118/22 127/18
127/22 127/23 128/3
147/5 153/12 192/4
192/5
membership [5] 81/7
83/1 86/21 179/5
186/25
memory [1] 195/8
mental [2] 68/23 97/6
mention [5] 95/25
138/15 193/13 195/25
199/15
mentioned [6] 25/19
171/23 190/17 191/23
192/8 193/8
MERS [2] 89/17
132/3
message [7] 19/22
19/23 20/23 129/21
143/13 203/19 203/21
met [4] 21/3 107/23
130/1 133/1
method [1] 136/11
mid [5] 3/7 35/20
63/13 165/12 199/21
millions [3] 74/11 74/15 92/7
mind [11] 26/12
26/13 26/15 28/24
36/24 40/20 43/7
90/15 97/9 153/16 154/10
mine [2] 11/6 40/2
minimise [2] 41/14
69/15
minimised [1] 174/25
minimises [1] 40/24
Ministry [1] 125/10
minority [9] 70/7
70/16 70/23 83/5
192/24 193/1 193/7 193/22 194/4
minute [1] 43/24
minutes [27] 10/12
15/8 28/24 29/10 34/19 35/2 35/4 35/8 35/13 35/15 61/7 62/8
62/19 86/15 86/20
87/8 88/20 126/16 133/8 144/16 145/18 149/23 150/7 150/10 160/15 169/12 183/8
misconceived [1]
110/19
misnomer [1] 135/18
missing [1] 204/4
mistake [1] 11/15
Mitchell [5] 105/22
105/24 107/25 110/14 206/19
mitigate [8] 13/3 91/4
mitigate... [6] 137/9 160/19 162/18 163/7 163/21 167/16
mitigating [4] 85/19
142/16 161/12 162/15 mitigation [6] 139/12 156/19 158/16 159/24 160/16 160/17
mixture [1] 124/9
Mm [2] 171/7 186/14
Mm-hm [1] 186/14
mobilisation [2]
129/16 149/12
mobilise [4] 90/19
142/4 149/15 152/12
mobilised [2] 92/14 151/21
mobilising [1] 151/24
mobility [5] 48/11
48/14 50/25 51/16 52/24
model [10] 4/5 20/4 47/25 78/4 78/11
78/20 88/24 141/4 141/5 141/10
modelled [2] 43/18 78/7
modellers [3] 88/25
140/10 141/2
modelling [20] \(3 / 25\)
4/1 4/6 9/11 26/25
42/1 68/11 68/13 77/3
78/3 140/11 140/15
141/21 141/22 144/9
178/13 180/8 180/14
181/8 181/10
models [8] 9/11 12/7 53/3 76/19 77/6 77/6 77/9 78/11
module [14] 1/11
1/12 2/1 2/3 37/11 37/15 79/7 98/1
104/13 104/13 104/14 104/14 117/1 189/23
Module 1 [4] 2/1
37/11 37/15 104/13
Module 2 [5] 1/12 2/3 104/13 104/14 117/1
Module 4 [1] 104/14
molecular [5] 136/3 153/7 153/13 154/8 155/6
moment [17] 5/18
6/17 9/9 14/25 51/6 73/7 75/15 83/15 97/7 109/14 147/21 147/25 171/23 178/17 178/23 195/6 195/21
Monday [3] 1/1 19/17 22/3
month [8] 25/3 36/6
37/3 38/22 38/23

38/25 39/10 166/15 months [6] 27/3 30/21 46/3 50/22 74/25 80/16
months' [1] 150/25 morbidity [1] 61/3 more [70] 4/4 6/9 7/4 8/8 8/8 9/6 11/23 12/11 12/11 12/14 17/9 17/22 20/8 22/10 23/25 24/9 26/23 32/13 32/21 36/24 37/18 40/21 44/15 44/21 44/25 45/11 50/17 55/7 55/12 55/17 55/24 56/2 58/8 58/10 65/3 65/16 65/20 65/25 67/4 69/18 71/18 75/4 75/9 75/12 90/14 102/6 104/3 110/10 121/7 125/5 128/19 132/4 135/15 141/13 147/6 162/15 178/10 178/14 Mr Smith [4] 100/23 179/24 182/5 183/1 184/20 185/16 186/6 193/24 194/2 194/16 196/14 199/5 202/22 morning [6] 1/4 1/5 23/22 74/22 76/16 79/20
Morris [14] 72/7 72/8 72/9 79/3 108/1 108/4 108/24 170/19 170/22 170/23 175/19 206/7 206/24 207/11
mortality [5] 9/6 20/5 61/3 147/13 193/15 most [21] 12/9 41/1 44/1 54/22 66/24 70/16 70/25 80/22 90/20 102/4 104/2 104/20 128/1 134/18 135/18 149/16 152/24 164/25 173/19 192/23 195/2
move [13] 7/8 19/20 28/23 28/25 29/23 38/20 38/20 51/5 54/20 116/24 142/3 187/10 190/15 moved [4] 135/22 173/7 173/7 202/15 movement [4] 49/20
51/15 51/18 53/21
movements [2]
48/19 53/4
moves [1] 173/17 moving [4] 42/24 127/7 163/4 191/21 Mr [33] \(1 / 311 / 111 / 4\) 11/5 11/18 51/12 74/6 74/24 77/13 96/8 96/10 96/13 99/19

100/23 101/5 101/7 102/17 103/13 103/15 105/16 105/19 106/24 107/13 108/12 108/19 108/24 109/9 113/23 116/10 122/15 176/2 176/4 206/16
Mr Bunting [5] 99/19 105/19 108/12 108/24 109/9
Mr Bunting KC [1] 113/23
Mr Hill [2] 96/10 105/16
Mr Keating [2] 176/2 176/4
Mr Keith [4] 96/8 107/13 116/10 122/15
Mr O'Connor [8] 1/3
11/1 11/5 11/18 51/12
74/6 74/24 77/13
Mr O'Connor's [1]
11/4
101/7 103/13 103/15
Mr Smith's [3] 101/5
102/17 106/24
Mr Vallance [1] 108/19
Mrs [1] 116/25
Mrs Laura Taylor [1] 116/25
Ms [23] 33/2 72/7 72/8 72/9 79/3 105/22 105/24 107/25 108/1 108/4 108/7 108/24 109/19 110/14 170/19 170/22 170/23 175/19 206/7 206/19 206/24 207/2 207/11
Ms Calderwood [1] 33/2
Ms Campbell [1]
108/7
Ms Mitchell [3]
105/22 107/25 110/14 MS MITCHELL KC [2] 105/24 206/19
Ms Morris [8] 72/7 72/8 79/3 108/1 108/24 170/19 170/22 175/19
MS MORRIS KC [2] 108/4 206/24
much [59] 2/2 2/20
7/7 8/5 9/6 16/16
17/22 23/20 23/24
23/24 25/5 29/3 43/22
44/21 45/11 52/24
65/16 69/1 69/2 70/15 71/18 72/4 75/4 75/10 75/10 76/7 79/3 79/4 79/9 88/2 90/13 93/8 93/9 95/7 105/17

107/25 109/17 113/12 116/9 118/11 122/15 123/8 134/13 156/2 163/17 164/9 175/5 175/16 175/19 175/22 176/23 182/19 184/9
186/21 188/12 193/24 195/23 203/5 204/22 multiple [2] 195/19 196/22
municipal [1] 5/23
must [28] 27/6 53/1
59/24 59/24 84/9
98/16 99/24 100/3
101/3 107/15 110/4
112/11 112/13 112/17
113/21 114/3 114/6 115/12 116/20 120/13
120/16 120/18 122/10 124/10 132/23 161/9 161/10 165/23
mutual [1] 104/11 my [122] 1/4 6/14 9/23 10/23 11/12
12/17 15/11 20/17 21/6 26/25 27/23 27/25 31/9 33/12 35/17 38/5 40/2 40/11 41/21 42/8 42/11 45/5 narrative [1] 197/16 45/22 50/12 51/5 52/7 narrow [1] 45/10 56/22 57/25 59/6 narrowness [1] 62/18 65/11 65/12 67/8 69/1 72/6 72/10 73/4 74/1 74/12 76/15 77/4 78/15 79/2 79/2 79/10 79/16 81/9 81/14 95/25 96/9 96/14 97/14 105/14 105/25 106/9 107/20 108/5 108/22 108/22 109/1 109/2 109/13 109/20 109/25 110/7 110/14 110/19 110/25 111/17 112/2 112/13 113/4 114/3 115/12
116/8 116/12 116/22 117/9 118/4 119/3 120/10 122/9 122/18 123/2 123/7 123/8 133/18 136/11 140/5 142/22 146/8 146/14 147/22 152/11 152/20 154/12 154/19 163/11 169/24 170/14 170/24 171/12 173/21 173/25 175/7 175/16 175/18 175/21 176/5 176/21 177/10 181/9 182/17 187/4 189/21 194/1 194/19 202/2 202/19 204/11 204/20 205/7 my Lady [55] 1/4 50/12 51/5 52/7 72/6 72/10 79/2 79/10

79/16 95/25 96/9
96/14 105/25 106/9 107/20 108/5 108/22
109/2 109/25 110/7 110/19 110/25 111/17 112/2 112/13 113/4 114/3 115/12 116/8 116/12 116/22 117/9 119/3 120/10 122/9 123/8 133/18 140/5 142/22 146/8 146/14 147/22 170/14 170/24 171/12 175/18 175/21 176/5 177/10 181/9 187/4 189/21 202/19 204/20 205/7
my Lady's [2] 12/17 163/11
myself [5] 36/9 47/6 97/15 109/16 184/7

\section*{N}

Nabarro [1] 165/18 name [5] 1/8 4/4 79/22 176/13 176/16 namely [1] 106/11 names [3] 57/5 86/25 133/18

152/9
national [12] 81/13 91/18 92/14 102/5 129/15 138/22 138/22 142/3 147/12 149/13 193/20 195/4
nationally [1] 145/15 nationwide [1] 166/8 naturally [1] 38/11 nature [7] 12/1 31/24 102/9 110/5 118/10 127/2 132/19
nCoV [1] 125/18 near [1] 28/1 nearly [3] 84/2 160/24 192/6
necessarily [4] 12/23 29/19 138/8 159/4 necessary [13] 48/12 57/14 71/17 74/23 88/5 103/17 103/22 112/19 113/2 113/15 114/22 155/24 170/20
need [55] 1/13 5/4 13/17 13/21 14/5 18/24 20/15 22/18 28/9 28/11 38/14 43/7 52/24 57/9 59/9 59/20 59/21 59/21 59/21 59/23 64/24 76/12 89/11 94/21 95/15 95/16 98/11 106/15 106/20 109/23 109/25
need... [24] 114/4 121/12 122/16 124/12 124/23 131/13 145/23 151/6 152/13 154/19
155/17 157/18 160/20
164/13 165/24 173/11 173/18 196/15 196/19 196/22 200/7 200/14 202/4 202/22
needed [16] 53/20
53/24 53/25 54/19
59/18 74/17 75/9
103/16 128/23 138/4
142/3 147/10 149/15
161/16 180/16 181/7
needing [1] 17/9
negative [4] 66/21
134/7 134/14 134/25
negatives [1] 134/20
Neil [19] 7/14 7/20 8/1 10/5 13/19 14/17 14/23 18/19 19/9 19/24 20/7 21/25 23/3 26/3 26/8 34/25 46/24 47/1 94/1
Neil Ferguson [15] 7/14 7/20 10/5 14/17 18/19 19/9 19/24 20/7 21/25 23/3 26/3 34/25 46/24 47/1 94/1
Neil Ferguson's [1] 13/19
Neil's [1] 46/24
neither [2] 120/12 139/12

\section*{NERVTAG [15]}

178/22 179/5 179/6 179/16 179/23 180/5 180/12 180/23 181/1
182/11 182/25 183/23
189/9 193/17 194/14
never [14] 27/22
31/17 40/5 45/17 53/24 56/17 63/3 63/3 69/22 92/16 97/17 161/1 163/9 183/17 nevertheless [1] 88/13
new [14] 30/12 65/13 65/19 73/19 75/22 81/16 92/1 97/10 101/12 127/15 139/2 147/2 168/20 179/19
New York [1] 168/20 newborn [1] 82/4
news [3] 25/5 110/8 119/25
newspapers [2]
81/14 122/1
next [25] 2/21 6/11
7/16 9/1 10/9 14/3 14/12 19/20 22/16

22/18 37/18 43/8 43/11 43/25 46/23 52/23 79/17 95/2 97/13 101/3 105/10 112/4 156/17 166/15 176/2
next week [1] 14/3 NHS [14] 35/9 35/12 36/2 36/11 44/2 44/17 46/25 61/19 61/24 84/15 88/10 135/22 142/13 154/16 nice [1] 94/1 night [2] 14/2 43/12 nine [3] 103/4 149/8 150/25
nine days [1] 149/8 no [94] 3/6 3/16 4/3 4/16 9/18 10/22 12/13 22/5 22/7 22/19 28/19 30/13 41/18 44/4 47/11 52/22 53/8 55/16 56/14 60/21 63/15 65/5 65/14 66/12 68/12 68/25 73/12 73/15 74/9 74/16 74/24 83/3 83/4 83/19 83/23 84/5 87/10 89/24 93/22 93/23 97/9 98/21 98/22 102/20 103/19 103/19 103/24 105/3 105/16 109/13 114/12 114/14 114/25 126/20 128/13 128/14 130/7 131/24 132/1 134/18 134/18 135/16 136/8 138/8 138/14 138/14 138/16 139/21 139/25 novel [3] 2/14 125/17 140/17 141/24 147/24 144/13
147/24 148/20 155/21 November [5] 67/11
155/21 157/8 158/6 71/11 75/2 203/9 158/20 158/24 158/25 203/20
159/16 159/19 160/10 November 2020 [1] 160/13 160/18 162/2
166/24 168/7 169/3 175/11 176/10 204/20 204/21
no one [5] 68/25
87/10 131/24 139/25 141/24
Nobel [1] 153/19 nobody [1] 87/7 non [8] 44/9 84/22 156/25 159/19 168/6 170/4 198/10 200/15 non-government [1] 84/22
non-pharmaceutical
[6] 44/9 159/19 168/6 170/4 198/10 200/15
none [3] 3/20 76/19 127/7
nonetheless [1]

105/6
nor [2] 83/25 120/3
North [1] 92/5 North London [1] 92/5
Northern [4] 85/22 108/3 108/7 206/23
Northern Ireland [3] 85/22 108/3 206/23 not [263]
not-much-worse-tha
n-a-bad-flu-season
[1] 23/20
note [5] 99/15 100/24
101/5 102/17 106/24
noted [2] 76/18 140/5
notes [39] 96/17
96/20 97/4 97/17
97/21 97/25 98/7
98/16 98/19 98/25 99/3 99/24 99/24
100/15 102/7 102/10 102/13 102/24 104/2 104/21 105/1 105/12 110/3 110/5 110/6 110/12 110/12 110/17 110/20 111/1 111/11 111/18 115/18 115/24 116/16 118/18 118/19 119/5 138/15
nothing [3] \(13 / 2\)
100/20 142/11
noticing [1] 173/2
notion [3] 132/16
168/5 169/10
notwithstanding [1]
67/2

203/20
now [50] 5/14 7/8
12/6 12/23 14/5 15/8 17/6 18/22 20/11 21/14 24/24 25/16 25/22 28/18 31/18 32/24 39/22 41/16 42/20 49/14 51/4 51/7 51/23 53/5 58/17 63/11 71/16 73/14 88/11 89/13 89/24 91/2 92/17 107/15 111/6 113/4 122/18 122/22 124/10 126/1 127/21 165/11 165/12 170/13 171/14 177/22 177/23 181/7 195/8 196/24
nowhere [1] 164/15 NPI [1] 72/23

NPIs [8] 40/25 49/20 51/19 51/20 55/6 68/15 76/6 141/10 nub [3] 132/25 168/8 169/5
number [51] 8/11
8/17 12/3 12/7 12/24
12/25 13/11 14/20
17/18 17/20 17/21
17/22 17/24 25/6 25/9
31/22 34/12 54/4
57/24 76/8 76/8 85/9 89/13 123/25 128/18
130/11 131/14 131/15
131/19 136/1 139/14
141/7 144/13 144/15 144/16 145/9 151/9 152/7 152/7 153/3 153/10 156/14 157/3 174/6 178/23 179/15 179/19 189/12 199/16 204/8 204/17
Number 10 [1] 204/8 number 2 [1] 174/6 number 7 [1] 145/9
numbers [20] 5/2 7/9 8/8 8/14 9/2 12/15 20/4 32/17 32/23
32/24 41/4 41/7 41/9 41/15 75/17 92/7 149/7 154/9 158/18 201/18
Nurse [1] 153/19
nursing [7] 175/1
190/1 190/21 190/24
191/10 191/12 191/13
nutshell [1] 13/14

\section*{0}
o'clock [3] 95/23
96/1 205/6
O'Connor [8] 1/3
11/1 11/5 11/18 51/12 74/6 74/24 77/13
O'Connor's [1] 11/4
oath [1] 123/13
objecting [1] 114/8
objection [1] 112/3
objections [1] 62/5
objective [3] 39/23
43/14 104/16
objectives [1] 69/13
obligation [1] 117/11
obligations [2]
118/21 118/25
obliged [2] 105/25 107/24
observations [4]
178/25 182/15 182/17 183/23
obtained [1] 86/9
obvious [6] 10/1 10/4
41/1 99/11 102/4 105/3
obviously [16] 16/21
24/25 30/11 34/11
53/4 83/25 84/13
106/22 112/4 129/18
146/2 152/14 155/7
173/15 205/4 205/4
occasion [2] 7/19 107/4
occasions [1] 62/14
occupation [2]
192/11 197/25
occupational [2]
192/9 192/10
occur [1] 61/16 occurrence [1] 192/3 occurring [1] 26/9
October [6] 1/1 64/20
181/22 193/7 193/12
205/11
October 2020 [1] 193/12
oddity [1] 107/14
off [7] 24/24 27/4
46/16 46/21 49/11
163/20 167/16
offer [1] 53/22
offered [1] 155/14
offering [2] 71/10 172/16
offers [1] 155/19
Office [1] 169/7
Officer [9] 11/3 11/11
11/21 12/18 20/19
21/3 21/15 153/11
168/2
official [1] 82/6
officially [1] 86/23
officials [3] 27/24
122/6 133/18
often [7] 52/8 55/22
70/23 75/23 132/21
183/14 194/25
oh [4] 51/3 83/23
96/3 109/18
okay [6] 78/12 84/10
90/4 153/22 170/18
172/8
old [3] 58/11 58/18 62/3
older [8] 58/15 58/15
61/11 61/15 64/10 65/2 65/3 67/4
Omicron [1] 74/20
ominous [1] 72/23
omitted [1] 15/5
on [343]
on/off [2] 46/16 46/21
once [8] 46/24 52/6
53/7 61/16 98/19
106/20 123/24 204/14
one [111] 3/18 11/22
12/7 15/4 17/4 19/7
20/1 21/11 22/13
22/22 24/5 24/16

\section*{0}
one... [99] 28/19 36/8 36/9 37/18 37/24 38/1 38/7 38/25 39/15 40/20 40/21 41/1 41/2 43/9 45/13 48/18 49/23 50/5 52/22 52/23 54/24 56/24 58/20 58/23 60/20 60/21 61/21 62/4 62/14 63/8 64/22 66/24 68/25 69/24 71/5 72/6 75/6 75/12 77/14 79/7 86/11 87/10 92/15 93/13 93/16 94/8 95/1 101/11 102/24 104/14 109/9 117/22 127/20
128/20 128/25 129/22
130/9 131/24 132/1 134/12 138/14 139/25 141/24 145/19 151/23 160/23 161/4 161/11 161/12 162/15 163/5 168/12 170/12 171/1 173/2 174/21 178/10 179/21 180/20 181/9 182/17 183/7 183/14 183/19 186/11 187/12 188/22 189/22 190/16 190/17 190/23 191/22 192/11 195/9 195/16 196/11 197/17 197/24 199/25
ones [5] 36/15 75/9 114/5 115/10 198/2 online [3] 87/12
87/13 123/6
only [40] 21/3 24/16 33/24 40/20 41/5 48/4 58/23 70/17 75/24 86/23 91/4 92/10 99/3 99/4 101/23 102/15 104/4 106/7 106/11 109/20 112/3 112/15 113/1 113/11 113/14 113/19 115/17 115/19 117/6 118/8 120/7 121/22 136/8 142/12 145/19 152/19 163/19 164/5 174/19 203/1
ONS [1] 64/23
onset [1] 196/12
onwards [2] 97/3 194/10
open [10] 67/6 67/19 67/21 100/10 108/15 114/4 119/24 120/5 146/16 147/24
opened [1] 64/3 opening [4] 85/18 96/21 107/14 198/19
openness [4] 113/24

114/7 116/13 120/1 operated [1] 105/7 operates [1] 140/23 operation [1] 186/16 operational [1] 144/9 operationalised [1] 3/3

\section*{operationally [1]} 61/2
opinion [6] 6/23 7/7 67/9 67/9 138/18 140/10
opportunities [3] 182/21 184/18 204/5 opportunity [3] 72/15 73/20 96/14 opposed [4] 138/5 141/20 142/18 158/18 opted [1] 3/6 optimism [1] 37/20 option [4] 48/6 74/13 91/4 147/15
options [8] 56/13 56/14 70/19 72/1 74/21 87/24 101/8 147/14
or [167] \(2 / 212 / 243 / 5\) 3/18 4/1 5/12 6/4 7/24 8/15 9/5 9/12 10/19 10/21 11/23 12/11 13/20 14/13 15/18 15/20 16/21 18/12 18/12 20/10 20/25 21/19 22/6 23/18 25/24 27/24 28/1 28/8 organisations [6] 31/21 31/24 32/1 32/4 96/24 98/18 99/20 36/8 38/7 40/20 41/4 42/15 44/3 44/17 44/24 46/15 47/2 47/21 48/4 48/24 49/19 49/21 51/25 52/11 53/24 53/25 54/15 55/23 56/14 56/14 56/17 56/24 57/3 62/6 63/12 64/21 64/21 64/25 67/1 68/13 69/6 70/7 70/17 72/6 72/16 73/21 73/25 80/16 80/25 81/8 82/7 82/9 82/19 83/18 85/4 85/5 86/18 86/24 88/9 88/17 91/1 92/18 92/19 96/21 96/21 99/7 102/7 104/1 107/7 107/8 111/8 111/9 111/9 112/6 112/7 112/24 114/9 115/20 115/21 116/14 117/10 117/12 118/6 119/11 120/6 121/15 122/6 124/3 124/8 130/10 130/12 130/16 130/20 130/21 132/17 134/5 134/19

134/24 135/1 135/2 135/14 135/15 136/6 138/14 139/12 139/12 140/2 140/24 142/6 149/1 150/25 150/25 155/6 155/9 158/13 164/18 164/18 165/9 168/7 169/8 170/12 171/24 173/10 174/2 174/20 178/1 178/8 180/23 182/15 182/22 185/20 186/10 191/19 194/3 195/4 196/13 197/12 198/2 202/4 oral [5] 1/25 96/9 101/17 106/2 108/10 order [15] 26/21
61/21 96/25 98/17 99/7 114/20 121/13 134/15 143/5 161/13 185/11 187/18 187/19 189/18 202/2
ordered [1] 114/25 orders [1] 138/7 ordinary [1] 133/19 organisation [16] 5/15 12/16 12/22 16/10 24/21 80/14 90/17 90/18 90/19 125/7 125/13 125/17 125/20 142/24 148/23 172/11
Organisation's [1] 34/2 105/20 108/13 109/3 organised [1] 104/3
origin [1] 169/9 original [5] 111/25 117/12 181/11 181/13 181/17
originally [2] 178/2 179/7
other [75] 9/4 10/20 15/13 21/18 24/5 27/24 29/14 34/8 40/22 40/25 44/20 45/12 45/16 48/6 49/7 49/14 51/24 54/14 55/1 55/12 56/15 56/20 57/25 58/19 58/23 64/4 64/23 68/4 68/14 68/15 69/17 69/17 70/3 75/18 77/4 77/10 82/11 84/17 89/16 93/7 93/15 94/3 107/22 117/14 120/13 123/25 125/22 128/20 136/19 138/13 141/7 145/12 151/22 153/7 153/12 153/13 156/16 172/16 173/2 174/2 \(44 / 1\)

159/19 165/17 170/10 outcomes [2] 12/8

176/20 180/3 180/13 180/23 183/5 183/10 192/6 198/2 198/9 198/11 198/21 203/24 others [19] 13/16 31/14 35/10 39/17 43/17 54/8 60/5 63/6 90/12 94/1 107/4 112/21 118/24 124/15 126/10 137/21 146/6 157/18 164/24 otherwise [2] 70/17 112/23
ought [1] 155/3 our [36] 1/4 1/11 26/23 49/6 50/20 51/13 62/7 62/10 62/24 79/17 80/22 85/9 86/5 86/24 87/3 89/4 98/5 98/12 100/1 101/14 105/9 112/9 113/5 122/19 124/1 129/17 160/3 168/24 182/22 187/10 189/18 182/23

\section*{195/8 196/23}
ourselves [4] 49/6 50/4 53/5 82/5 out [65] 12/21 13/11 19/23 24/20 30/12 33/15 33/16 33/17 39/24 44/4 44/7 47/6 53/13 53/18 59/16 62/25 65/6 69/15 74/18 81/14 86/20 94/17 97/1 98/5 106/14 106/20 106/24 123/6 133/12 133/25 134/3 135/16 136/10 139/14 144/11 145/6 168/14 173/20 174/22 97/15
175/3 179/7 179/15 185/13 185/18 186/6 189/25 191/22 192/15 195/20 195/21 195/22 199/6 199/21
outbreak [14] 16/8 80/18 89/8 89/10 89/22 128/24 129/3 130/10 130/13 131/1 132/19 140/13 148/12 161/11
outbreaks [9] 16/15 23/9 92/1 139/16 144/17 145/9 174/25 190/11 190/22
outcome [3] 70/17 190/5 190/6

173/14 176/19 180/19 \(150 / 20\) 158/18 162/17 145/21 146/19 148/19 overwhelmed [8] 9/7 149/11 149/15 152/12 27/2 35/9 35/12 35/22 152/16 154/5 156/17 \(\quad 36 / 12\) 44/17 88/10 157/15 162/13 165/1 overwhelming [1]
outer [1] 55/5
outlined [1] 24/11
outlining [1] 24/18
outputs [2] 47/25 197/3
outright [1] 65/10 outset [1] 114/24
outside [7] 49/10
85/4 125/12 125/14 126/23 136/5 143/3 over [31] 5/21 9/5 31/10 31/12 36/6 36/16 36/19 47/15 52/15 53/9 58/9 60/2 60/5 61/6 83/19 86/13 94/16 120/12 122/25 125/10 128/23 133/20 159/6 168/5 176/20 189/1 193/6 193/21 200/5 200/11 201/21 over-recruiting [1] 193/6
overall [5] 88/19 overcrowded [1] 186/4
overestimation [1] 38/7
overleaf [2] 195/23 202/20
overload [1] 166/16 overloading [1] 166/18
overly [1] 70/19 oversight [1] 115/7 overview [2] 178/20 186/22
overwhelm [2] 36/2 61/19
own [12] 6/14 21/6
33/12 52/21 77/19
113/3 115/6 115/7 124/1 154/15 170/6 182/22

\section*{P}

P-H-E-I-C [1] 130/5
pace [2] 173/17
176/21
page [74] 1/14 4/23 4/25 5/1 5/2 5/2 5/3 5/4 6/11 7/9 7/10 7/15 7/15 7/16 13/21 13/23 14/6 15/7 18/24 19/1 19/2 19/20 22/18 22/19 22/20 24/25 29/8 29/9 34/15 36/19 37/19 43/8 43/10
\begin{tabular}{|c|c|c|c|c|}
\hline P & \[
92 / 25 \text { 105/10 123/2 }
\] & paragraph 187 [1] & & 148 \\
\hline [1] \(43 / 11\) & & & & gers [1] \\
\hline 47/18 55/7 60/13 6 & 137/10 137/13 137/15 & paragraph 19 [2] & & 8 \\
\hline 63/9 70/12 72/21 73/1 & 138/5 138/16 13 & & parenthesis & passes [1] 164/2 \\
\hline 73/5 75/13 88/3 101/7 & 140/14 146/4 147/9 & Paragraph 2 [ & 45/ & /2 \\
\hline 111/14 111/22 111/24 & 156/21 156/22 157/20 & 29 & part [27] & 1] 92 \\
\hline 113/1 115/25 116/15 & & p & 571 & paste [1] 113/13 \\
\hline 116/18 117/5 117/6 & 188 & & 78/11 8 & \\
\hline 117/11 121/11 125/10 & 196/10 196/20 199/7 & paragraph 21 & 105/1 107/18 116/19 & pathogens [1] \\
\hline 133/20 140/5 142/25 & 20 & & 17/18 117/19 11 & patience [1] 199/14 \\
\hline 144/12 150/9 150/15 & p & & 119/3 119/4 11 & patients [1] \\
\hline 162/14 162/15 162/16 & 30/19 & 150/1 & 139/11 158/13 164 & Patrick [32] 14/1 \\
\hline 162/17 169/13 177 & pandemics [3] 92/23 & paragraph 273 & 165/6 166/22 173/21 & 21/23 23/2 29/13 \\
\hline 183/21 187/22 195/25 & 137/17 141/14 & & 178/16 178/19 185/7 & 39/17 85/15 86/6 \\
\hline 206/2 & Pandora's [1] 147/25 & pa & 197/1 & 90/12 96/11 96/13 \\
\hline & Pandora's box [1] & & partic & 97/17 97/21 98/21 \\
\hline  & & paragraph 3.10 & 111/10 112/6 11 & 98/24 99/23 104/11 \\
\hline page 2 [3] 22/19 & Pa & 190/15 & 116/1 & 105/3 105/6 106/1 \\
\hline page 2 [3] \(22 / 10\) & paper [8] & p & participants [25] & 106/6 110/3 114 \\
\hline  & 43/1 43/2 43/4 43/6 & 187/22 & 96/20 97/25 98/20 & 114/12 115/17 118/5 \\
\hline [ \(7 / 10\) & 60/22 93/25 & paragraph 3.3 [ & 99/12 101/23 104/ & 119/13 121/4 121/18 \\
\hline & papers [6] 42/3 & 92 & 104/25 106/12 107/1 & 122/14 142/21 206/16 \\
\hline & 89/8 91/6 94/18 & p & 110/18 110/24 114/11 & Patrick Vallance [7] \\
\hline page 34 [1] 63/9 & 124/16 & 191/22 191/25 & 115/2 116/24 118/1 & 1/23 23/2 29/1 \\
\hline page 36 [2] 72/21 & pa & paragraph 3.9 & 11 & 39/3 90/12 142/21 \\
\hline 75/13 & paragraph [63] 4/15 & 189/ & 119/10 119/11 120/8 & 's [11] 96/ \\
\hline \(75 / 13\) & 6/8 6/12 6/13 8/10 9/1 & Paragraph 30 [1] & 120/22 121/15 121/23 & 97/3 98/8 102/10 \\
\hline & 10/9 10/13 11/24 & & 134 & 2/24 106/5 111/18 \\
\hline 162/16 169/13 & 29/12 31/6 34/15 & paragraph 4 [1] 31/6 & participants' [1] & 112/3 116/16 118/1 \\
\hline 162/16 160/13 & 36/20 37/19 47/18 & paragraph 4.12 [1] & & 119 \\
\hline page 5 [2] 29 & 47 & & & pattern [1] 75/2 \\
\hline ] & 6 & paragraph 4.9 & 8/10 15/4 39/10 39/22 & patterns [1] 178/6 \\
\hline [1] & 65/8 70/12 70/13 71/3 & 183/18 183/21 & 44/9 48/10 49/16 53/2 & Paul [1] 153/19 \\
\hline page 7 [1] & 73/2 73/5 75/13 9 & paragraph 5.1 [ & 70/20 71/8 76/ & pause [20] 4/19 4/24 \\
\hline & 100/1 100/23 101/8 & 179/4 & 87/19 88/14 88/1 & 73/6 \\
\hline page as [1] 115/25 & 101/11 101/14 102/ & pa & 100/3 107/10 107/1 & 93/18 94/10 95/19 \\
\hline & 104/7 106/3 133 & 17 & 111/8 111/21 112/2 & 125/1 130/4 131/10 \\
\hline & 136/21 138/11 139/ & paragraph 64 [ & 116/13 116/15 116/20 & 131/12 132/15 133/7 \\
\hline & 139/20 150/12 150/16 & 75/13 & 117/6 117/7 119/6 & 135/3 137/12 152/2 \\
\hline  & 166/12 169/14 179/4 & paragraph 66 [2] & 119/22 120/24 121/14 & 153/1 176/7 195/6 \\
\hline \[
116 / 3
\] & 179/22 183/18 183/21 & 73/2 73/5 & 122/13 127/16 169/6 & pausing [6] 30/4 \\
\hline & 183/25 184/21 187/22 & paragraph 7 [2] & 190/19 200/13 & /13 95/5 166/1 \\
\hline \[
1
\] & 189/25 190/15 190/16 & 9 & particularly [20] & 196/16 202/17 \\
\hline & 191/22 191/25 192/9 & paragraph 7.13 & 44/10 54/11 63/25 & pay [5] 168/25 169/1 \\
\hline pandemic [92] 2/19 & 195/14 199/18 201/5 & 202/18 & 64/9 65/3 65/12 67 & 190/25 190/25 191/9 \\
\hline 3/11 3/15 4/10 5/25 & 202/18 & paragraph 7.9 & 67/20 68/20 82/9 & paying [2] 28/3 32/7 \\
\hline 13/7 14/22 21/5 23 & Paragra & 199/18 201/5 & 85/10 89/6 134/ & PCR [1] 75/8 \\
\hline 26/21 30/19 30/24 & & paragraph 8 [ & 12/13 & peak [5] 9/6 43/ \\
\hline 31/11 31/15 31/17 & & 150/12 & 188/25 194 & /2 44/13 47/3 \\
\hline 32/19 32/20 33/9 & & paragraph 9.20 & & peer [1] 11/13 \\
\hline 33/11 34/1 34/2 34 & paragraph 10 & & & Itimate [1] \\
\hline 36/22 36/23 37/12 & & paragraph of [1] 65/ & 115/20 & 8 \\
\hline 37/12 37/13 37/17 & pa & paragraph we're [1] & 115/20 117/15 & people [103] 8/2 \\
\hline 37/22 38/1 38/4 39/13 & 3 & /3 & 121/21 121/24 176/2 & (23 8/24 9/3 11/1 \\
\hline 39/16 42/2 44/17 45/1 & paragraph 11 [1] & paragraphs [2] 29/22 & 190/4 190/9 199/25 & 13/17 16/13 28/6 38/3 \\
\hline 45/8 48/22 50/16 & 10 & /3 & 2 & 8/18 45/16 49/2 \\
\hline 50/21 52/6 52/24 53/5 & paragraph 15 [3] & para & 4/ & 0/23 51/25 53/6 \\
\hline 54/21 56/5 56/7 57/1 & 101/11 102/17 104/7 & /22 & passage [8] & 53/11 53/14 53/14 \\
\hline & paragra & paragr & 104/4 116/15 & 55/24 57/4 59/7 59/1 \\
\hline 6/7 66/10 66/12 & 101/14 & 97/3 & 116/17 117/4 123/5 & 59/19 59/23 60/1 60 \\
\hline 66/20 67/7 76/20 & paragraph 160 [2] & parallel [1] 183 & 123/7 & 61/15 62/2 66/3 74/1 \\
\hline  & 47 & parameters [1] 25/ & passages [3] 29/11 & 79/11 82/10 83/7 83 \\
\hline 89/22 90/22 90/25 & paragraph 169 [1] & hrasing [1] & 103/9 103/11 & 83/9 85/11 85/21 86/7 \\
\hline 89/22 90/22 90/25 & 55/7 & 35/11 & passenger [1] & 92/14 93/7 93/15 94/9 \\
\hline
\end{tabular}
(76) page... - people
people... [60] 113/12 122/25 124/15 129/1 130/11 130/15 130/17 130/20 130/21 131/8 131/14 131/19 135/6 137/20 138/24 143/9 147/12 149/15 149/17 149/18 151/9 151/14 151/19 151/20 151/24 152/3 152/7 152/18 152/21 152/25 154/15 154/23 161/8 164/25 168/3 168/5 168/15 168/23 170/10 174/8 178/5 184/12 184/13 186/2 186/3 186/4 186/7 186/12 187/2 191/2 192/24 193/1 193/6 193/22 194/4 194/6 198/1 198/8 198/13 204/13
people's [4] 50/2 50/18 52/20 53/4 per [13] 31/1 74/1 92/10 134/2 135/4 135/13 150/11 150/14 151/6 151/16 151/17 152/14 160/25
perceived [1] 86/12 percentage [1] 148/20
perfect [1] 134/18 perform [1] 68/10 perhaps [31] 7/10 9/14 14/11 26/22 29/17 39/9 40/17 41/12 45/19 51/22 52/10 54/22 56/24 60/13 60/15 65/16 66/24 68/16 83/18 88/1 89/14 116/18 124/8 147/25 162/15 178/14 184/1 185/25 197/22 199/5 199/17
perhasps [1] 179/3
period [19] 34/11
36/16 51/24 54/21 54/23 63/12 91/1 93/5 93/8 93/16 93/18 94/24 132/20 189/1 192/14 194/9 199/21 200/6 202/10 periods [2] 75/18 190/3
permission [1] 177/10
persistence [1]
32/12
persisting [1] 164/6 person [16] 83/4
93/13 94/9 95/1 95/2
114/25 117/22 126/18

126/18 128/19 128/20 128/25 149/5 151/7 151/9 152/5
person infects [1] 93/13
personal [12] 33/12 102/6 104/20 105/5 110/3 110/12 110/20 115/18 115/24 177/14 189/13 195/16
personally [1] 33/18 persons [2] 135/8 148/20
perspective [5]
182/14 182/16 185/14
193/10 199/14
perspectives [2] 180/13 180/14
persuade [2] 143/6 143/17
persuaded [1] 122/2 pessimistic [1] 12/9
peter [2] 129/22 139/14 pharmaceutical [6]
44/9 159/19 168/6 170/4 198/10 200/15
phase [3] 56/7 163/4 172/24
phases [2] 134/5 162/17
PHE [9] 84/15 133/22
135/17 136/16 136/19 151/11 151/25 152/2 152/9
PHEIC [7] 129/24
130/5 143/6 143/10 143/18 143/21 144/2
phenomenon [1] 41/24
phone [1] 152/3
phones [1] 48/20
phrase [4] 34/3 39/20 81/25 197/2
phrased [1] 55/22 phrases [2] 38/25 82/6
physical [2] 147/4 153/14
pick [4] 6/12 13/21 45/14 135/1
picked [2] 183/13 183/14
picture [4] 17/7 28/20 180/20 198/23 pieces [3] 106/18 107/9 149/3
pile [1] 102/21
place [24] 29/1 47/14
54/15 76/2 76/10 87/9 90/18 92/21 95/8 95/19 123/5 139/15 145/13 146/1 147/3 149/14 150/3 150/8

156/23 158/22 159/2
161/18 169/16 190/2
places [1] 84/18
plain [3] 116/22
130/4 137/12
plainly [4] 87/6 88/11 119/25 120/5
plan [5] 133/23 163/7
172/22 174/23 175/8
plane [1] 143/19
planned [1] 202/9
planning [5] 6/18
26/22 29/25 36/22 36/23
plans [1] 133/4
plate [1] 102/21
plausible [1] 30/20
play [5] 23/6 65/3
185/13 185/18 186/6
playing [1] 66/13
please [68] 1/8 4/22 6/11 7/13 7/17 11/25 15/7 18/22 19/20 21/10 28/25 29/9 34/14 36/19 37/19 42/20 43/8 47/17 48/16 48/24 55/6 60/4 60/11 61/6 63/9 69/9 70/11 72/13 72/20 72/21 73/5 75/12 76/15 79/21 80/4 85/14 88/3 95/23 125/10 126/17 133/8 133/20 133/25 136/14 136/21 137/6 138/11 147/19 148/1 150/8 150/15 160/11 163/6 165/12 169/11 171/2 176/6 176/14 176/16 177/3 177/5 177/11 183/18 183/21 195/14 195/21 199/18 202/20 pleased [1] 196/24 pleases [1] 96/9 plus [1] 94/5 pm [5] 96/5 96/7 148/2 148/4 205/9 pneumonia [1] 125/8 pocket [1] 10/12 point [55] 9/25 13/12 14/7 17/4 24/22 25/14 26/17 27/23 28/21 29/18 33/8 34/23 35/17 37/21 37/25 38/1 48/13 52/17 56/6 58/14 59/5 68/16 71/22 73/12 73/13 73/14 73/15 81/8 93/10 111/25 115/12 117/8 123/21 126/17 128/12 135/16 136/8 136/10 137/20 139/20 146/15 156/3 163/5 164/12 170/21 172/17
\begin{tabular}{l|l}
\(173 / 5173 / 7173 / 11\) & \(36 / 1240 / 4\) 51/24
\end{tabular} 174/18 195/17 196/25 158/14
202/20 202/25 203/1 possible [19] 12/8
point 7 [1] 126/17 \(\quad 23 / 14\) 34/12 37/2
pointed [1] 35/19
pointing [1] 35/21
points [8] 37/18
72/20 79/8 81/11
89/13 102/23 134/15 202/18
policies [3] 75/19
129/17 138/23
policy [30] 43/14
43/19 43/19 44/12
45/9 55/2 55/10 55/11 potentially [3] 145/19
56/19 56/20 57/1 57/7 200/6 203/3
59/17 60/2 61/8 62/6 62/8 62/11 69/11 PPE [1] 179/18 70/19 70/20 71/8 72/1 practical [9] 35/14 85/17 167/7 169/5
174/15 174/15 182/21 184/17
policy makers [1] 70/19
policymakers [2]
70/24 71/4
politicians [2] 203/16 203/18
poor [4] 109/1
168/22 174/12 174/20
168/22 174/12 174/20
population [28] \(8 / 20\)
41/6 48/20 49/20
51/14 58/5 61/22
62/13 76/18 81/16
93/15 128/20 132/14
151/21 152/15 160/5
163/22 163/25 164/1
164/20 165/6 166/7
166/13 166/20 185/24
186/1 194/8 194/22
populations [4]
61/11 178/5 178/7
182/6
posed [1] 104/17
position [17] 6/14
\begin{tabular}{ll|l}
\(31 / 23 ~ 48 / 263 / 20 ~ 90 / 9\) & prediction [4] 9/14 \\
\(98 / 5104 / 6113 / 21\) & \(15 / 1827 / 7 ~ 27 / 13\)
\end{tabular}
98/5 104/6 113/21
134/9 153/6 155/1
156/7 157/24 158/5
167/4 186/19 193/8
positions [2] 186/3 186/7
positive [3] 134/14 134/21 148/13
positives [1] 134/19
possession [1] 117/14
possibilities [2]
24/18 32/18
possibility [18] 14/18
18/9 23/18 23/22 27/7
27/13 28/9 28/10
28/13 28/16 35/9
35/20 35/21 36/2

PPE [1] 179/18
practical [9] 35/14
37/24 43/22 45/15
52/25 55/1 78/4 85/18
92/19 101/9 103/8
110/10 135/2 143/25 152/15 162/22
possibly [4] 6/3 41/9
69/6 196/13
potential [5] 26/20
61/10 61/19 76/1 135/2
powerful [1] 66/5 66/25 102/18 106/22
140/12 141/19 160/18
186/13 187/2
practice [2] 117/2
134/12
practices [1] 89/2
pre [1] 3/11
pre-pandemic [1] 3/11
precarious [1] 186/2
precautionary [6] 126/12 126/15 132/7 132/17 132/24 155/22
precautions [3] 52/3
61/4 77/23
precedence [1]
120/12
preceding [1] 87/1 precise [2] 12/12 132/18
precisely [2] 31/8 76/6
precision [1] 45/8
predicted [1] 143/15
predicting [3] 27/25
53/8 53/10
predictions [3] 9/12
53/12 178/14
predictive [1] 53/10
preferable [1] 203/5
premise [1] 116/23
preparation [4]
103/17 124/22 171/6 200/8
prepare [4] 113/10
124/12 129/7 200/12
prepared [3] 1/10
55/24 157/17
preparedness [5]
21/6 26/24 34/1 174/5 174/22
preparing [6] 13/17
28/17 199/23 199/23
preparing... [2] 200/2 200/19
presence [1] 170/7 present [2] 35/24
105/21
presented [4] 56/1
114/1 115/15 115/16
presents [1] 70/18
press [20] 18/7 81/5
81/9 110/9 113/22
113/22 113/25 114/15
114/20 115/8 116/21
119/18 121/8 149/9
168/1 171/2 171/5
171/16 173/25 175/8
press's [1] 103/21
pressure [5] 46/7
129/2 138/21 165/24
181/4
presumably [5] 23/3
44/18 49/10 60/19
156/16
pretend [1] 105/2
pretty [4] 40/5 144/23 164/9 188/12
prevent [5] 61/10
73/10 76/1 162/21
204/5
preventative [1] 175/1
preventing [2] 73/18 203/2
previous [2] 14/6 127/6
previously [5] 60/25
65/4 65/16 65/21
190/6
primarily [1] 177/22
primary [1] 87/15
Prince [8] 98/11
99/15 99/16 109/4
110/8 110/11 120/11
122/1
Prince Charles [1] 122/1
Princess [1] 148/8
principal [1] 2/11
principle [8] 114/4
116/13 117/8 120/1
128/5 132/7 132/17
155/22
principles [3] 100/14 120/5 133/19
prior [1] 126/21
priority [1] 174/23
prisons [1] 173/10
privacy [9] 98/22
98/25 99/17 117/23
118/1 118/17 119/2
119/14 120/21
private [10] 98/8
104/21 105/5 112/9

118/10 118/16 121/3 121/5 121/6 121/6 privately [1] 118/5 prize [1] 153/19 proactive [2] 145/25 183/1
probably [13] 15/25
18/1 41/8 49/19 52/20
94/25 144/4 176/18
178/16 182/9 189/4
189/4 193/7
probe [2] 114/13 114/13
probed [4] 111/9 111/10 115/5 116/1 probing [1] 111/12 problem [9] 14/22 28/5 36/22 61/25 79/12 91/3 149/19 165/2 176/10 problems [3] 62/3 80/10 130/9
procedural [1] 96/16 procedure [3] 70/5 70/7 106/24
procedures [1] 142/5 proceed [2] 107/21 158/12
process [8] 21/9
86/13 115/7 119/7 119/9 135/5 150/3 158/9
processes [1] 159/13 processing [1] 153/8 prod [1] 108/8 produce [1] 187/25 produced [8] 9/12 85/15 87/13 102/14 103/23 104/23 140/1 165/11
product [1] 104/18 professional [3] 7/24 80/4 177/13 professor [129] 1/5 1/6 1/10 1/24 2/5 2/19 2/25 3/24 3/24 4/9 5/6 Woolhouse [1] 1/5 8/4 9/9 10/16 11/6 Professor Medley [4] 19/21 23/22 32/8 33/1 2/25 3/24 35/7 43/17 35/7 35/7 38/20 39/4 \(\quad\) Professor Riley [1] 42/17 42/21 42/22
42/25 43/3 43/17 46/1 Professor Rubin [1] 46/14 47/13 47/19 103/6 48/8 48/23 51/13 \(\quad\) Professor Sir [1] 52/22 53/17 54/20 165/13
56/23 57/6 58/25 \(\quad\) Professor Stephen 60/15 63/5 64/19 Reicher [1] 168/13 67/25 70/2 70/22 72/4 Professor Steven 72/11 72/14 72/22 73/3 73/12 75/12 75/16 76/4 79/1 79/4 79/17 79/18 79/20 79/24 80/5 84/7 95/20 96/2 103/4 103/4
103/5 103/6 122/22

42/25
123/11 123/13 125/2 126/17 130/8 133/9 134/9 136/11 137/6 138/9 140/18 144/11 145/6 146/13 147/6 148/6 148/7 150/6 151/4 153/20 153/21 155/16 156/7 157/7 157/24 160/8 161/6 162/12 163/12 163/18 165/13 165/13 166/1 167/25 168/13 169/15 170/20 170/25 171/4 171/14 171/20 172/9 175/16 175/23 176/6 176/9 176/11 176/17 176/18 177/15 190/17 204/18 204/22 206/3 206/9 207/6 207/13
Professor Andrew
Hayward [2] 176/6 176/17
Professor Costello [5] 79/17 122/22 123/13 170/25 175/23
Professor Dame [3] 171/4 171/20 172/9 Professor Edmunds
[5] 42/17 43/3 47/13 64/19 103/4

\section*{Professor}

Edmunds's [2] 46/1 46/14
Professor Ferguson
[1] 103/4
Professor Hale [4]
39/4 72/22 73/12 75/16
Professor Hale's [1] 75/12
Professor Hayward
[1] 204/18
Professor Keeling [1] 3/24
Professor Mark

Professor Medley [4]
\(2 / 253 / 2435 / 743 / 17\)

Reicher [1] 168/13
Professor Steven
Riley [1] 42/22
Professor Venki
Ramakrishnan [1] 153/20
Professor
Woolhouse [5] 1/10
10/16 72/11 76/4

130/8
Professor Yardley [1] 103/5
profile [1] 200/21 programme [1] 187/12
progress [1] 142/12
promise [1] 79/5
promoting [2] 88/9 174/1
proper [8] 85/11
95/11 108/20 149/11
150/3 159/21 161/17 166/24
properly [5] 62/20 115/5 116/1 118/18 160/19
proportion [5] 8/23
130/15 130/16 130/2 130/22
proportional [1]
152/14
proportionality [2] 100/1 120/17 proportionate [3]
98/17 99/25 102/18
proposal [3] 62/13 62/16 62/21
proposals [1] 103/3
propose [1] 100/20
proposed [9] 55/3
56/25 57/7 59/1 59/3 59/10 74/12 101/10 111/6
proposition [1] 98/10
protect [6] 59/7
59/22 59/25 60/1 97/6 142/13
protected [4] 110/10
118/15 118/16 118/21
protecting [3] 57/3
59/23 198/8
protection [2] 110/20 152/10
protections [1] 110/4
protective [1] 189/14
prove [1] 74/4
proved [1] 103/22
provide [7] 22/12
100/13 104/14 176/16
182/23 184/8 192/3
provided [14] 79/25
80/2 87/18 97/2 97/21 104/13 104/20 108/11
110/18 118/20 121/20 purpose [8] 50/17
178/18 183/23 191/10 100/3 100/14 100/20
provides [1] 43/2
providing [1] 184/10
provision [3] 79/24
118/9 119/8
prudent [1] 6/17
psychologists [1]
168/10
public [85] 2/9 52/8

52/21 55/10 55/10 56/15 56/19 56/19 64/22 68/10 69/4 69/11 81/2 81/3 81/15 83/4 83/10 85/8 87/3 87/12 87/15 95/18 100/11 100/11 102/1 106/4 112/22 112/24 113/23 113/25 114/1 115/4 115/8 115/11 115/11 115/16 115/19 118/12 120/9 121/2 121/7 121/17 125/11 126/5 127/23 129/25 135/5 135/17 135/18 135/19 135/21 135/23 135/24 136/5 141/23 143/23 147/5 151/4 152/10 153/3 169/20 169/25 172/13 172/15 173/17 174/10 177/15 181/21 183/24 184/3 184/6 184/13 184/15 184/24 185/5 185/8 185/12 187/2 192/4 194/15 198/3 198/16 198/21 203/13 203/18 publication [4] 85/1 97/18 111/3 122/3 publicly [6] 120/6 120/22 203/7 203/8 203/12 203/19 publish [4] 114/25 119/11 121/8 121/13 published [35] 12/5 12/15 16/17 42/3 62/17 66/10 86/14 86/18 87/8 87/23 87/25 89/9 94/18 99/6 105/6 108/21 115/19 116/20 117/7 117/12 118/6 119/13 120/2
121/12 121/21 124/17 125/17 127/11 127/13 146/5 149/9 162/9 177/11 189/7 194/18 publishing [3] 86/19 99/13 112/4
pubs [1] 198/20 pulled [1] 181/6 pulling [1] 150/2 punch [1] 54/18 purely [2] 52/10 180/14 100/3 100/14 100/20 101/4 106/13 110/13
purpose-built [1] 50/17
purposes [9] 26/22 60/11 80/22 99/5 103/2 103/10 103/12 110/21 123/18
pursue [2] 89/11
159/24
pursued [1] 160/16 pursuing [1] 158/16 put [43] 9/16 31/22
32/18 32/23 32/24
44/20 55/7 56/6 58/6
59/13 70/15 78/10
81/11 90/12 90/18
92/21 103/9 111/19 112/18 113/1 113/19 114/17 115/4 115/19 116/17 117/15 121/9 121/10 121/16 121/22 123/6 139/15 141/19 145/12 145/25 146/14 147/2 149/14 152/16 156/17 164/24 174/21 175/3
putting [5] 20/3
37/23 85/12 104/1 150/3

\section*{Q}

QE [1] 160/6
qualifications [1] 80/5
qualifying [1] 28/12
quality [2] 26/2 26/14 quarantine [5] 16/14 57/18 57/19 129/17 166/8
quarantined [2]
138/24 148/11
quarantining [1] 95/12
query [1] 153/17
question [37] 6/5 7/4
10/22 12/17 14/24 16/21 55/21 63/8 65/19 67/1 68/7 69/22 73/4 77/12 83/19 92/22 104/10 107/7 107/16 111/8 112/7 112/7 112/13 114/6 114/9 115/14 115/15 130/25 136/18 138/11 169/24 169/25 171/21 173/25 175/7 184/1 197/11
questioning [1] 100/25
questions [32] 1/7 4/10 60/4 68/1 72/6 72/9 72/12 79/2 79/19 81/2 96/21 104/17 111/11 123/12 147/19 147/23 153/23 170/15 170/16 170/19 170/23 170/25 175/17 176/12 204/20 204/21 206/5 206/7 206/11 207/8

207/11 207/15 quickly [14] 9/2 16/13 50/15 89/21 91/21 92/2 92/2 131/6 rather [19] 4/5 12/20 137/22 139/16 151/24 154/18 165/1 196/9 quite [35] 4/18 10/1 15/6 15/16 17/24 17/25 20/14 26/13 30/6 36/8 37/7 43/11 45/2 49/2 49/5 49/24 52/8 53/3 54/12 63/11 64/8 64/13 67/10 83/23 91/5 94/20 117/2 118/18 122/17 131/6 151/2 165/24 183/17 204/3 205/4 quotation [1] 173/21 quote [3] 94/1 97/11 106/3
quoted [1] 204/7 quoting [1] 127/4

\section*{R}

R number [3] 8/11 76/8 76/8
R value [1] 139/14
R0 [7] 8/17 12/3
12/25 20/2 27/19 145/15 146/7
R0 number [1] 12/25 raft [3] 49/23 56/15 57/20
raise [5] 17/15 72/5 198/6 200/3 203/8 raised [7] 16/25 78/21 126/6 131/12 180/5 187/4 189/9
raising [1] 194/14
Ramakrishnan [1] 153/20
ran [2] 87/12 157/15 range [7] 32/18 72/1 83/10 87/14 183/5 183/15 183/16
ranges [1] 180/20 rapid [4] 47/25 90/18 90/18 136/23 rapidly [2] 77/16 181/5
rate [37] 8/12 8/18 8/22 9/6 12/4 12/25 13/5 13/5 14/17 17/17 20/2 20/3 20/5 20/10 27/19 27/20 38/9 38/15 57/14 57/21 74/6 90/25 94/7 124/5 131/8 131/13 131/17 131/22 131/25 132/2 132/8 132/9 132/22 139/22 147/13 188/25 194/6
rates [12] 77/20
78/13 89/4 89/4 174/7

188/2 190/25 194/3 194/20 198/4 204/1 204/3

32/13 33/14 39/5
40/23 97/13 107/14 133/5 137/9 144/1 147/11 159/24 160/17 164/11 180/12 181/24 183/1 184/10 ratio [1] 17/18 rationale [3] 181/6 181/7 203/15 re [3] 64/3 85/18 161/14
re-emerged [1] 161/14
re-opened [1] 64/3 re-opening [1] 85/18 reach [3] 126/24 144/22 204/3 reached [7] 24/2 26/17 30/8 61/13 123/7 144/21 201/25 reaches [1] 135/15 reaction [1] 31/4 reactive [1] 183/1 read [14] 24/15 29/20 43/24 72/15 73/7 86/8 103/16 109/16 123/6 144/10 144/19 145/6 170/6 173/20
reader [2] 32/8 32/9 readership [1] 189/9 readily [2] 112/22 119/13
reading [2] 104/16 109/5
ready [4] 96/2 123/2 134/1 150/13
real [12] 28/10 28/13 28/16 51/24 52/25 53/4 91/4 111/2 115/12 158/24 185/13 197/25
realisation [1] 74/16 realise [1] 46/25 realised [1] 41/20 realistic [1] 74/13 reality [5] 90/15 150/6 157/7 157/14 158/3
really [43] 10/1 28/19 28/22 29/17 38/15 39/14 41/5 48/4 53/20 54/19 58/20 59/8 61/7 71/2 81/4 85/7 90/21 90/22 94/2 134/17 149/21 166/14 173/7 178/4 178/6 178/9 180/14 181/24 182/4 185/22 190/12 192/22 194/20 195/10 198/11 199/8 199/14 200/3

201/24 202/5 202/20 203/4 203/21
reason [23] 6/23
12/24 17/13 17/14 30/13 44/18 53/2 63/17 65/14 76/6 76/9 77/2 92/12 92/13
113/1 113/17 114/18 114/24 160/1 169/3 169/19 169/21 170/3 reasonable [24] 12/8 26/21 27/21 27/22 30/1 30/22 30/23 31/9 31/14 31/18 32/5 32/15 32/20 33/12 37/6 37/9 37/16 98/21 98/24 99/17 117/25 119/1 119/14 120/20 reasonably [5] 48/24 104/12 121/19 124/24 162/22
reasons [8] 32/16 40/17 40/20 50/5 61/7 120/20 171/13 201/11 reassurance [1] 11/16
recall [11] 1/17 14/15
15/8 16/7 18/18 37/5
51/4 86/22 120/10
156/7 162/12
recalls [1] 73/24
receive [1] 163/11
received [6] 4/12
5/22 23/2 108/11
114/25 163/11
receiving [1] 113/5
recently [2] 65/1
171/9
recognised [3] 59/11
115/6 170/2
recognising [1]
14/19
recognition [2]
163/23 192/22
recollection [1] 62/18
recommend [1]
56/17
recommendation [2] 47/24 88/4
recommendations
[2] \(87 / 19\) 202/8
recommended [2] 167/13 203/11 recommending [2] 56/11 141/12
record [4] 41/18 126/16 136/14 145/18 recorded [2] 17/19 31/5
records [2] 29/12 64/21
recourse [1] 104/23
recruit [1] 192/25
recruiting [1] 193/6 redacted [2] 98/20 133/19
redaction [1] 116/4 redactions [3] 98/4 104/22 110/17
redrafts [1] 71/3
reduce [9] 57/14
57/20 59/20 89/3 91/4
161/10 191/11 200/17
202/2
reduced [1] 41/6
reducing [3] 61/3
74/6 158/17
reduction [1] 49/19
refer [16] 10/10 17/8
25/5 37/19 63/11
63/13 63/14 65/7 70/5
107/17 115/22 146/12
150/24 166/10 167/8
183/22
reference [12] 4/17 39/10 60/24 63/15 101/18 103/1 136/16 137/12 137/13 166/20 167/10 175/7
references [2] 11/23 153/12
referred [14] 20/2
27/15 38/21 54/24
55/5 66/25 100/21
116/15 117/4 123/1
127/10 137/14 150/11
154/12
referring [8] \(12 / 2\)
19/13 26/2 34/4 47/6
47/8 151/1 151/25
refers [2] 77/12
135/16
reflect [3] 53/19
121/1 122/24
reflected [3] 35/3
35/13 141/15
reflection [1] 33/8
reflections [3] 68/3
105/5 194/19
reflective [5] 110/3
110/12 115/18 130/12 158/4
reforms [1] 135/20
regard [2] 106/25 173/23
regarding [8] 36/21
125/8 183/19 183/24
194/11 199/16 199/20
201/14
regardless [1]
169/25
regards [1] 151/18
regimes [1] 191/14
regional [2] 150/17 153/3
regular [6] 60/17
78/22 188/5 189/16
(79) pursue - regular
regular... [2] 191/14 191/19
regulations [3] 52/11 52/19 144/4
Reicher [1] 168/13 reinforced [1] 119/19 related [7] 16/18 55/1 163/16 182/9 182/20 183/2 192/8
relates [1] 57/11
relating [2] 102/5 175/7
relation [28] 72/14 93/8 106/22 127/16 148/24 179/21 182/10 184/22 187/21 187/23 188/16 191/6 192/1 192/19 193/11 194/9 196/25 197/11 197/13 197/15 197/16 199/19 199/22 202/17 202/19 203/9 203/10 203/12
relationship [2]
146/7 180/18
relative [1] 58/24
relatively [4] 58/4
165/4 166/3 194/18
Relativity [1] 171/13
release [1] 97/12
released [4] 86/23
86/24 87/2 112/24
releases [1] 138/20
releasing [2] 14/12 191/8
relevance [2] 117/14 117/17
relevancy [1] 92/23
relevant [16] 100/25
101/12 104/24 106/12
107/8 107/12 111/14 113/14 114/9 115/10 116/1 116/5 118/12 119/6 123/7 173/21 reliable [2] 26/6 91/13
relief [2] 122/3 196/21
relying [2] 41/5 75/4
remain [1] 123/13
remained [4] 64/1 65/18 67/5 97/19 remaining [1] 54/21 remarks [1] 167/8 remember [12] 31/12 39/17 78/21 78/23 128/6 143/11 149/12 159/3 162/16 171/8 174/12 181/22
remembering [1] 111/17
remit [2] 4/6 181/24 remotely [1] 100/19
remotest [1] 40/4 remove [1] 158/14 repeat [4] 32/3 98/6 176/15 197/14 repeated [2] 39/18 125/25
repeatedly [1] 37/8 repeating [1] 114/4 replay [1] 23/13 report [42] 5/23 14/7 14/8 14/13 26/3 33/25 34/3 64/18 64/25 65/5 65/9 72/16 72/17 73/2 75/12 76/18 85/16 85/16 86/1 86/9 87/23 88/11 101/17 114/16 114/17 125/18 125/20 126/1 128/17 145/14 146/10 148/22 149/4 149/9 189/19 194/17 195/19 200/1 200/18 200/19 200/21 201/2 report 29 [1] 85/16 reported [4] 125/11 125/14 142/24 200/25 reporting [3] 100/17 100/21 154/17
reports [10] 64/21
65/1 86/5 87/13 87/18 127/10 131/8 193/14 193/19 193/21
represent [5] 45/20
76/21 83/3 97/7
171/17
representation [3]
184/2 192/23 193/21 representatives [1] 84/15
represented [1] 77/2 representing [1] 106/1
reproduction [4] 25/6 25/8 94/7 128/18 request [4] 97/20 97/21 114/19 115/23 requested [1] 92/8 requests [1] 125/25 require [3] 99/2
102/2 103/8
required [8] 36/24
82/20 110/23 115/2 117/8 123/23 134/11 154/6
requirement [1] 54/17
requires [4] 101/25 104/2 104/9 195/1 research [9] 2/12 2/13 49/6 80/10 137/9 154/22 162/18 163/7 194/1
researching [1] 162/15
residential [2] 49/3

49/10
residents [1] 191/13 resilience [1] 105/10 resisting [1] 71/24 resolved [1] 117/9 resort [1] 56/22 respect [6] 98/16 99/24 101/18 104/11 114/15 196/23
respected [1] 10/19 respectfully [4]
106/15 106/19 107/2 107/20
respects [1] 105/8
respiratory [4] 89/18
132/13 179/12 197/6
respond [5] 37/12 37/13 53/11 89/21 90/10
responded [3] 13/20 15/13 171/21
responders [1] 173/15
responding [1] 52/10 response [36] 7/8 7/10 11/25 13/19 13/22 15/23 17/5 21/1 21/11 21/11 22/8 22/9 22/12 24/9 33/8 34/1 34/2 34/6 36/22 36/25 39/16 41/8 46/1 46/11 46/16 53/16 88/8 88/15 88/19 97/20 104/17 143/12 149/22 172/2 174/23 182/23 responsible [1] 184/12
rest [7] 116/18
116/18 117/11 117/12 121/12 148/18 149/14 restaurants [1] 198/21
restrain [1] 136/15
restraining [1] 122/3 restricted [1] 75/8 restriction [4] 96/25 114/20 114/23 147/4 restrictions [9] 40/8 44/24 49/24 54/15 169/16 199/1 201/15 201/16 202/21
restrictive [2] 74/21 75/23
result [3] 106/13
134/7 147/13
resulted [2] 162/1 162/2
results [2] 134/14 194/14
retains [2] 98/24 99/23
retired [1] 152/22
retrospective [2]
54/4 160/11
retrospectively [1] 103/23
return [3] 51/8 70/11 197/9
returning [3] 78/3 99/22 122/22
Reuters [2] 34/16 124/21
reveal [2] 112/9 113/2
revealed [1] 113/11 reverse [2] 61/21 134/15
reverted [1] 3/10 review [3] 56/5 75/15 197/2
reviewed [2] 11/13 34/1
revolves [1] 23/22
Richard [1] 165/15
Richard Horton [1] 165/15
right [77] 1/21 4/18
5/7 5/10 6/5 7/21 9/20 11/25 15/10 18/16 22/1 28/4 32/22 43/2 44/20 47/18 51/4 63/5 64/8 64/13 67/24 78/18 82/18 84/17 84/25 86/13 87/16 89/7 98/8 99/23
112/16 114/3 119/20 120/14 120/16 121/4 121/5 122/11 122/22 128/15 130/7 131/5 132/6 132/10 140/4 140/25 141/17 142/22
143/22 144/7 148/1 155/1 155/21 156/2 156/5 158/11 160/22 160/24 162/7 165/10
166/24 167/2 167/21
168/20 169/3 171/6 172/22 179/14 186/10 189/7 192/2 192/5 192/10 192/15 195/11 196/25 205/1 rightly [3] 36/8 127/13 181/22 rights [19] 98/9
98/22 99/18 99/23
100/9 103/21 106/6 110/1 111/5 112/12 112/21 113/18 113/22 114/15 117/23 118/3 119/20 122/8 122/14 rigorous [1] 20/16
Riley [3] 42/22 42/25 46/5
rise [2] 76/10 76/11
Rishi [1] 171/3
Rishi Sunak [1]
171/3
rising [1] 76/1
risk [29] 31/21 32/13 32/15 58/5 58/8 60/23 61/1 61/5 61/24 63/17 63/23 63/24 64/1 64/5 64/7 75/25 76/24
126/6 168/15 173/9 188/8 188/11 190/10
190/22 192/3 192/12
193/15 198/3 198/17
risk-structured [1] 60/23
risks [3] 175/2 192/9 192/10
roadmap [1] 199/6 robust [2] 196/11 196/23
role [6] 7/1 65/4 69/3 179/11 185/8 197/24
roles [2] 133/15 178/21
roll [1] 74/18
rolled [1] 134/3
rolling [1] 86/20
Rolls [1] 109/8
room [4] 73/23
100/17 100/22 114/16
root [1] 38/6
roughly [4] 5/22
44/22 50/13 193/3
round [1] 152/3
route [3] 40/18 70/21
71/8
routine [1] 194/22
routinely [1] 195/18
Roy [1] 93/25
Roy Anderson [1]
93/25
rubella [1] 164/7
Rubin [1] 103/6
rudimentary [1]
94/20
Rule [2] 118/9 170/15
Rule 10 [1] 170/15
Rule 9 [1] 118/9
ruled [2] 145/21 146/19
rules [2] 52/11 52/19
ruling [3] 115/17
117/13 117/17
run [4] 134/2 135/4
150/14 180/2
run-up [1] 180/2
running [2] 44/14
129/10
runs [1] 113/6

\section*{S}

SAFER [3] 187/12 187/16 187/21
safety [1] 57/17
SAGE [112] \(3 / 13\)
3/15 3/18 4/4 31/3
34/19 34/25 35/2 35/3
35/8 35/10 35/24 60/9
(80) regular... - SAGE

\section*{S}

SAGE... [99] 60/17 60/19 60/22 60/25 62/5 62/15 62/23 68/2 68/4 68/5 70/3 70/8 70/8 70/15 71/13 71/20 74/2 80/23 80/25 81/1 81/8 81/19 81/20 81/22 81/22 81/23 81/25 82/2 82/4 82/5 82/6 82/12 82/13 82/15 82/18 82/19 82/21 82/22 82/23 83/7 83/11 83/15 83/17 83/21 84/2 84/12 85/2 85/5 85/10 85/16 85/24 86/1 86/1
86/6 86/9 86/11 86/13 86/14 86/18 86/19 86/21 87/8 87/12 88/13 88/17 89/10 126/12 133/13 133/15 139/20 141/18 144/5 144/9 145/18 149/24 150/7 151/4 151/5 153/12 160/15 163/10 168/11 169/12 170/1 178/22 179/9 181/10 181/17 181/24 182/12 182/15 183/7 183/16 186/21 186/25 187/1 202/7 203/11 204/9
SAGE 8 [1] 151/4 SAGE EMG [1] 178/22
SAGE's [1] 87/9
said [59] 14/7 23/3 24/4 24/6 24/19 26/3 26/5 27/10 27/24 28/10 28/10 30/22 30/25 31/5 31/18 32/4 33/2 35/9 36/8 37/8 38/5 41/22 45/9 46/19 51/15 53/18 54/3 54/9 54/18 56/7 57/11 66/11 69/13 71/7 71/14 71/20 76/16 81/10 87/18 100/21 114/16 124/10 124/21 126/1 129/12 142/21 143/1 154/5 154/13 158/20 163/9 168/2 169/1 170/7 170/9 172/3 173/14 173/23 174/23
sake [1] 151/10 same [41] \(8 / 58 / 8\) 10/20 10/24 14/1 16/20 16/24 17/2 18/21 21/12 26/21 29/3 29/17 29/18 30/6 38/12 44/23 56/16 77/24 92/3 92/13

103/5 107/5 111/14 111/24 115/25 120/19 123/3 128/16 131/19 132/12 148/22 151/13 155/11 159/10 159/21 174/13 174/13 174/14 188/12 194/13
SARS [29] 16/3 16/8 16/10 16/17 16/18 16/22 16/24 17/2 23/14 24/8 24/12 30/13 37/13 39/25 58/24 89/8 89/16 89/23 91/6 94/7 94/10 94/11 94/12 94/13 94/15 94/16 132/2 132/3 146/6 SARS outbreak [1] 16/8
SARS-1 [8] 89/8 89/16 89/23 91/6 94/11 94/15 132/3 146/6
SARS-2 [3] 94/12 94/13 94/16
SARS-CoV-2 [1] 16/17
sat [2] 126/12 126/12 satisfied [3] 106/14 107/22 107/23
Saturday [2] 19/7 32/11
save [2] 115/3 161/4 saved [1] 204/8
saw [3] 65/9 142/10 198/19
say [125] 6/13 9/1
9/21 12/1 13/12 18/16 19/10 19/14 22/15 22/24 22/25 23/10 25/11 25/15 26/13 26/15 27/5 27/12 28/8 31/25 32/21 33/10 33/14 34/15 36/11 36/20 39/6 40/4 40/5 40/22 43/13 43/17 43/18 43/25 43/25 45/16 46/11 46/12 46/19 47/23 49/14 55/8 56/10 60/5 62/14 63/15 63/17 66/8 66/9 66/17 66/24 68/8 68/24 70/13 70/13 71/6 71/7 76/25 87/13 93/5 93/11 94/9 94/10 95/14 95/22 98/6 98/15 98/18 98/19 98/23 101/4 101/10 101/15 101/15 101/24 102/10 102/11 103/11 103/22 104/6 107/15 109/23 109/25 110/7 110/10 110/19 113/13 113/15 115/12 115/23 schoolchildren [1]

116/3 119/7 122/23 \(\quad 67 / 22\) 139/1 142/8 143/14 144/2 153/16 155/22 157/10 157/11 163/17 166/11 166/13 170/12 171/10 171/18 172/2 174/21 178/9 183/2 184/23 185/4 189/8 190/12 196/8
saying [42] \(12 / 914 / 1\) 15/10 15/16 18/10 25/22 26/18 27/16 28/13 36/5 36/13 38/2 44/13 50/5 56/12 62/24 67/2 71/14 74/5 78/10 78/12 82/11 90/17 113/8 124/18 127/6 129/13 132/18 139/3 142/1 145/9 145/11 151/11 156/18 156/22 157/20 161/9 161/24 164/16 168/7 190/16 204/7
says [19] \(8 / 22\) 13/24 14/5 14/11 21/12 22/2 29/14 29/24 30/17 46/2 61/9 73/13 73/14 85/19 113/23 169/14 172/9 188/18 201/5 scale [10] 38/13 73/10 74/10 74/15 75/10 90/20 127/5 130/12 153/15 158/6 scaled [9] 91/8 92/20 154/4 154/9 155/7 158/21 159/5 159/13 162/23
scaled-up [1] 92/20
scaling [1] 138/22
scenario [30] 12/8
12/10 12/14 16/25
23/19 23/20 24/10
24/11 24/12 26/23
27/10 27/16 27/22
30/1 30/6 30/9 30/19 30/20 30/23 30/24 31/9 31/15 31/18 37/6 37/9 37/17 46/13 46/14 46/20 154/14
scenarios [7] 9/12
12/6 23/6 28/22 30/2 30/5 30/17
scheduled [1] 96/1
scheme [1] 169/2
schemes [1] 160/4
school [6] 2/9 63/16
65/12 84/18 141/8
202/10
school-aged [1] 63/16

125/20 126/13 127/13 schools [17] 64/3 130/4 132/8 134/21 66/1 66/5 66/9 66/12 135/8 138/6 138/14 66/19 67/1 67/5 67/12

67/14 67/19 67/21
67/23 77/7 77/8 175/2
202/11
Schools' [1] 85/17 science [14] 53/9 53/10 56/4 89/6 124/4 146/4 146/15 154/12
169/15 172/23 175/9
180/18 182/20 184/17
Sciences [2] 200/2 200/19
scientific [17] 2/13
29/14 54/8 81/21 82/2 82/15 84/1 84/14
85/23 140/14 142/10 150/19 153/11 178/24 184/8 187/11 203/15
scientist [4] 5/14 84/6 84/22 179/11
scientists [15] 38/18 42/6 82/18 83/20
83/22 84/3 84/11
84/13 84/17 84/17 91/7 133/23 140/11 141/2 165/20
Scotland [17] 2/15 3/25 4/4 11/3 11/11 11/22 12/18 21/3 21/5 21/7 22/13 23/9 26/20 27/21 43/20 74/2 92/6 Scotland/UK [1] 23/9 Scottish [6] 3/22 4/1 4/3 32/11 105/23 206/18

\section*{Scottish}

Government's [1] 4/3
scrap [1] 9/13
screen [14] 1/13 4/16 96/18 100/15 104/5 111/13 112/24 113/14 115/19 116/17 117/5 121/10 121/16 162/11
screening [1] 135/1 screenshots [1] 117/19
scroll [1] 133/25
season [2] 23/20 150/22
seasonal [4] 13/6 13/6 42/5 132/4
second [31] \(8 / 10\)
15/18 19/10 23/18
23/18 25/14 30/17
30/18 30/20 41/2
76/15 88/21 97/4
103/8 119/15 133/2
133/9 133/13 140/7
161/12 161/13 161/20
162/5 166/12 175/7

186/15 187/10 189/18 197/4 198/14 199/7
secondary [1] 188/4 secondly [5] 61/17 91/12 123/19 178/23 187/13
secretariat [1]
133/19
section [6] 60/14
75/12 96/24 114/19
114/22 119/19
section 19 [1] 114/22
section headed [1] 60/14
sections [2] 76/17 104/24
sector [1] 191/7 sectors [3] 185/24 199/2 199/3
security [5] 102/5 109/19 109/21 177/22 207/1
see [59] 4/15 6/4 7/18 8/10 14/6 15/18 17/9 18/20 19/20 20/1 21/10 21/11 21/14 22/23 24/15 29/2 29/8 33/4 43/25 44/2 44/8 44/11 47/14 50/1 50/4 50/7 50/23 55/20
60/13 60/22 63/1
64/24 69/6 71/13
72/17 74/10 92/12
92/13 101/23 115/8
121/23 125/6 133/12
133/23 149/23 154/20
166/14 170/16 177/5
183/4 183/6 186/24
190/15 194/5 198/14
198/20 201/17 201/22
201/25
seeing [2] 52/17 114/8
seeking [1] 10/18 seeks [1] 115/17 seem [6] 9/16 35/4 35/13 45/17 109/4 112/22
seemed [3] 5/24 45/2 141/22
seems [7] 4/16 18/10 24/21 27/2 57/2 107/14 110/14
seen [19] 6/9 24/12
35/2 47/5 53/21 54/17
59/14 65/22 99/3
103/2 107/8 118/23
122/5 150/6 171/5 171/9 171/9 193/17 200/7
segmentation [12]
55/2 57/1 57/3 57/11
57/23 60/14 60/23
60/25 61/8 61/12

segmentation... [2] 61/16 62/11
segmented [1] 61/23
Select [1] 163/3
self [8] 54/16 59/14
74/14 74/18 75/1 128/21 168/21 168/23
self-imposed [1]
54/16
self-isolation [3]
59/14 168/21 168/23
self-sustaining [1] 128/21
self-testing [2] 74/14 74/18
self-tests [1] 75/1
send [3] 18/20 22/15 133/22
sending [4] 14/8
15/13 20/23 86/9
sense [3] 55/13
77/14 184/16
sensible [2] 20/18
103/19
sensitive [3] 70/25
100/12 121/24
sensitivity [3] 98/3
105/13 134/4
sent [18] 4/11 5/6
7/14 7/18 7/19 14/6
15/1 15/9 15/14 22/9
22/23 25/1 29/7 46/11 117/22 129/21 143/13 167/5
sentence [2] 166/12 178/1
sentences [1] 8/14
sentiment [1] 34/12
separate [5] 65/17
82/24 117/5 136/20
149/3
separating [1]
186/16
separation [1]
184/16
September [5] 80/1 177/4 177/6 203/11 204/10
September 2020 [1] 203/11
sequelae [2] 62/1 77/17
sequence [2] 16/17 35/18
sequitur [1] 156/25
serial [2] \(94 / 25\) 160/
series [2] 4/11 60/5
serious [7] 24/2
74/12 81/16 124/14 124/19 124/22 132/4
seriously [3] 99/10 130/11 147/3
seriousness [2] 34/20 35/15 serological [1] 64/22 served [1] 102/19 service [3] 184/24 198/2 200/12
services [2] 79/6 135/19
session [1] 36/4
set [29] 42/21 47/16 50/20 68/11 70/19 71/9 73/24 81/1 82/3 82/25 85/11 92/15 97/1 98/5 129/15 138/21 142/4 146/24 153/18 179/7 179/15 181/11 181/11 182/19 182/22 189/25 191/21 194/23 195/20
sets [2] 39/15 162/13
setting [3] 73/8
129/14 188/4
settings [12] 76/21
77/10 77/25 78/1 78/4 78/7 136/23 182/7 189/6 189/15 198/12 198/24
several [2] 39/18 155/13
severe [10] 26/23 40/7 44/3 44/19 44/23 49/24 54/10 76/13 202/4 203/3
severely [1] 143/11
severity [1] 23/23
sexual [1] 155/13
shall [5] 2/17 11/7
14/9 51/8 122/24
share [1] 34/16
shared [6] 14/23
21/13 77/5 97/18
115/1 132/12
shares [1] 105/8
sharing [1] 21/18 sharp [1] 196/20 she [9] 20/25 21/11 21/12 21/12 22/2 22/2 172/3 172/15 174/19 she's [1] 108/8 shielding [5] 57/12 57/23 59/11 59/13 62/11
ship [4] 148/8 148/10 148/13 148/16
shocked [1] 81/5
Shoe [1] 95/17
shops [1] 198/17
short [13] 51/10
72/13 72/20 87/13
91/1 96/6 97/4 108/22
148/3 158/24 159/20
169/17 204/15
shorter [1] 93/8
shorthand [1] 132/18
 19/8 22/10 137/6
should [65] 28/3
28/17 32/6 38/22
38/24 42/12 47/21
54/25 56/22 59/3
60/15 65/22 67/1
68/17 71/13 72/2
78/10 88/5 96/17 98/10 104/9 104/24
107/21 110/17 111/16 97/23 170/8 177/21
113/25 114/5 115/11 Singer [1] 129/22
115/14 115/16 115/24 single [4] 70/18
116/6 122/23 124/9
124/9 127/20 129/6
129/14 129/17 133/2
133/4 134/1 136/10
137/1 140/19 140/20
149/1 149/21 150/1
150/13 154/19 155/10
157/11 157/12 169/18
169/21 170/2 173/24
176/19 179/24 180/1
180/5 183/13 194/20
200/12
show [9] 49/8 69/25
82/24 89/6 137/21
146/5 146/8 189/5 197/25
showed [10] 91/7
127/16 140/1 145/14 Sir Jeremy Farrar [2] 145/19 147/16 148/20 5/9 163/8
148/23 160/15 168/18 Sir Patrick [15] 97/17
showing [5] 42/3
89/10 100/15 101/6 126/21
shown [4] 99/7 102/4
104/4 115/25
shows [4] 94/2 146/6 146/16 155/3
sick [6] 157/10
168/25 169/1 190/25
191/2 191/9
side [1] 178/12
sides [1] \(98 / 1\)
sight [2] 49/25 58/1
sign [1] 115/2
signal [2] 194/5 196/13
signals [1] 201/22
signed [4] 1/20 80/1
99/4 177/6
significance [7] 8/15 16/4 39/12 108/18 108/18 125/19 156/11
significant [15] 6/14
8/15 15/11 17/23
19/16 63/16 65/3
73/11 75/19 125/5
163/21 171/17 178/24 191/5 191/16
significantly [3]
80/22 132/4 191/24

121/11 128/19 178/19
Sir [41] 5/9 85/15
85/22 86/4 86/6 96/11
96/13 96/17 97/3
97/17 97/21 98/8
98/21 98/24 99/23
102/10 102/24 104/11
105/3 105/6 106/1
106/5 106/6 110/3
111/18 112/3 114/7 114/12 115/17 116/16 118/1 118/5 119/1 119/13 121/4 121/18 122/14 153/19 163/8 165/13 206/16
Sir David King [2] 85/22 86/4

97/21 98/21 98/24
99/23 104/11 105/3
105/6 106/6 110/3
114/7 114/12 115/17
118/5 119/13
Sir Patrick Vallance
[9] 85/15 86/6 96/11
96/13 106/1 121/4 121/18 122/14 206/16
Sir Patrick's [11]
96/17 97/3 98/8
102/10 102/24 106/5
111/18 112/3 116/16
118/1 119/1
sister [2] 187/14
192/19
sit [1] 108/23
sits [1] 176/21
sitting [1] 68/5
situation [9] 18/8
24/17 34/21 35/16
39/23 97/16 127/7
149/6 194/24
six [5] 91/17 125/15
157/16 157/19 174/23
six weeks [3] 91/17
157/16 157/19
sizable [1] 201/10
size [2] 44/23 152/15
sizeable [1] 199/20
skeleton [1] 119/24
slightly [3] 17/6
25/10 27/12
slipped [1] 186/18
slow [5] 6/6 48/24
74/18 139/9 140/13
slowing [2] 139/11
141/4
slowness [1] 143/12
small [9] 20/1 54/12
58/4 73/10 110/17
130/15 130/22 163/5
165/6
small-scale [1] 73/10
smaller [2] 106/18
106/18
Smith [5] 21/14
100/23 101/7 103/13 103/15
Smith's [3] 101/5
102/17 106/24
snapshot [1] 97/7
so [323]
so -- may I[1] 71/11
so-called [1] 141/10
social [14] 44/5
44/10 59/21 68/19 133/22 147/3 165/25
166/3 169/16 179/22
180/16 181/4 199/17 201/9
social care [1] 59/21
societal [1] 68/22
society [6] 40/25
53/15 68/14 138/6
198/19 199/2
solicitor [1] 117/1
solicitors [1] 102/20
solutions [1] 80/9
sombrero [2] 142/18 161/10
sombrero as [1] 142/18
some [77] 3/17 4/10 12/19 15/14 20/16
25/4 25/4 25/16 25/22
26/8 28/5 29/18 32/17
33/22 35/3 35/7 36/21
40/8 42/15 49/6 50/14
51/16 52/5 54/5 60/4
63/24 66/3 68/1 74/21
82/10 83/3 83/9 83/18
84/9 85/1 85/3 88/8
89/16 94/20 97/14
102/1 103/1 103/14
104/15 105/1 108/10
125/4 135/6 144/5
146/3 146/5 150/6
152/22 156/8 165/24
168/14 169/11 170/14
170/16 171/5 171/17
172/4 172/8 172/20
173/4 173/8 178/25
180/15 181/6 182/9
183/23 192/6 193/2
some... [4] 193/18
194/2 194/14 205/4
somebody [5] 8/2
69/5 95/15 132/21 182/14
somehow [1] 45/3
someone [6] 5/12 7/22 36/9 58/9 132/20 201/15
something [29] 4/2
10/1 10/3 10/10 12/11 13/7 13/16 18/11 20/18 28/7 28/17 35/20 36/2 39/2 41/13 41/16 45/25 52/25 60/2 63/2 63/6 71/23 101/13 131/12 132/11 165/9 168/2 174/20 185/20
sometime [1] 73/24
sometimes [1] 164/7 somewhat [1] 81/5 somewhere [3] 69/5 94/15 95/3
soon [5] 16/16 85/18 123/2 194/18 198/19
sooner [1] 143/6
sophisticated [1] 20/14
sorry [31] 6/3 7/12
10/13 11/18 18/25
22/19 22/22 47/10 48/23 48/25 57/19 59/2 65/2 66/21 66/23 79/20 84/7 95/24 96/4 109/11 115/15 136/11 148/5 154/1 159/6 160/8 176/8 176/15 187/7 197/14 205/3 sort [21] 6/25 9/22
16/2 19/11 31/21 33/7 35/14 55/3 60/6 62/3 63/12 64/23 68/10 135/25 138/4 178/9 178/10 181/25 182/21 187/19 189/8
sort of [16] 6/25 9/22 16/2 31/21 35/14 55/3 60/6 62/3 64/23 68/10 138/4 178/10 181/25 182/21 187/19 189/8 sorts [2] 153/15 154/9
sought [1] 118/8 sound [4] 13/15 53/8 62/5 190/3
sounding [1] 7/4
sounds [1] 67/16
source [1] 50/17
sources [2] 102/25 186/9
South [7] 136/10

151/14 159/4 159/9 spread [28] 30/3 166/10 174/11 174/12 \(30 / 14\) 30/18 49/15 South Korea [6]
136/10 151/14 159/4 159/9 166/10 174/12 South Korean [1] 174/11
space [2] 97/15 121/5
spaces [1] 198/21 SPC [1] 140/20
SPC-M [1] 140/20 speak [2] 26/5 203/12
speaking [8] 19/6 20/6 62/7 85/5 165/4 176/20 176/21 195/15 specialist [2] 153/7 153/13
species [1] 16/20
specific [6] 65/25
134/1 150/13 182/20 185/16 186/16
specifically [3] 81/1
82/12 159/6
speculate [1] 144/6
speed [1] 144/25
speedily [1] 122/17
spend [1] 177/23
spending [2] 49/10 169/2
spent [4] 80/16 160/4 168/25 184/13
SPI[34] 2/22 3/2 3/14 31/13 33/5 35/24 36/3 37/6 42/23 43/5 62/19 66/3 67/11 68/4 68/7 68/9 68/13 68/24 69/1 76/19 78/22 78/23 83/12 139/8 140/8 140/11 141/1 144/9 144/20 145/6 168/12 180/8 180/9 180/9 SPI-B [2] 83/12 168/12
SPI-M [10] 3/2 66/3
67/11 139/8 140/8 140/11 141/1 180/8 180/9 180/9
SPI-M-O [22] 2/22 3/14 31/13 33/5 35/24 36/3 37/6 42/23 43/5 62/19 68/4 68/7 68/9 68/13 68/24 69/1 76/19 78/22 78/23 144/9 144/20 145/6 spillover [1] 61/11
spinning [1] 102/21
spirit [1] 113/24 spoke [3] 85/8 200/11 203/19
spoken [2] 203/7 203/8
spot [1] 92/1
73/10 74/4 74/7 81/16 88/7 91/4 91/10 93/24 123/19 126/23 131/3 137/8 139/9 139/11 140/13 141/5 142/6 146/7 148/15 158/18 160/5 178/5 182/1 188/9
spreading [6] 131/6 143/15 144/24 147/9 155/8 162/4
spreads [4] 123/23
131/1 132/13 135/14
spring [1] 60/6
Sridhar [1] 165/18 staff [11] 122/5 191/17
stage [23] 11/2 18/4 41/17 79/12 94/17 130/19 131/24 133/9 135/5 145/23 146/5 146/22 147/8 150/1 151/13 158/6 193/3 194/9 194/12 197/5 198/16 203/23 204/15 stages [4] 14/21
76/20 95/15 159/3
stagger [1] 165/24
stand [2] 26/19 44/5
standard [1] 9/18
standing [3] 3/4
14/22 151/13
start [14] 4/9 4/10 5/5
6/18 10/16 13/17 21/5 43/9 80/4 134/17 147/3 151/14 185/15 193/2
started [10] 86/19 88/16 92/4 92/9 129/20 172/24 181/20 188/12 198/20 201/25
starting [7] 11/24 24/22 33/8 42/8 44/11 60/14 201/18
starts [1] 19/1
stated [2] 128/22 174/4
statement [63] 1/11 1/15 1/17 1/18 1/19 2/20 4/14 4/20 34/10 34/15 35/10 39/3 39/5 47/18 48/8 49/18 65/8 68/3 68/9 70/6 70/11 76/3 76/19 79/25 79/25 86/12 97/3 97/4 104/15 107/10 125/8 142/8 144/10 144/20 146/12

173/14 173/15 190/13 statutorily [1] 119/19 190/18 190/20 190/21 stay [8] 41/14 54/11 190/25 191/11 191/13 54/17 69/15 77/21 54/23 55/6 63/9 63/11 straightforward [2]

167/22 169/6 170/5 170/7 175/10 177/3 177/7 178/18 179/4 179/15 183/22 184/21 187/22 191/23 193/13 195/13 195/23 199/19 statements [8] 96/22 104/13 107/12 107/14 107/19 123/1 153/10 168/14
states [10] 89/3
89/15 89/17 90/7
91/16 129/14 141/11 142/2 147/16 174/8
statistic [1] 58/8
statistical [1] 9/14 138/6 149/7 199/11
stayed [1] 152/25 stenographer [4] 122/17 122/19 136/14 176/21
step [5] 101/3 155/3
155/5 162/19 182/22
step 1 [1] 162/19
Stephen [1] 168/13
steps [5] 129/7
141/19 145/25 147/3 155/24
Steve [1] 46/4
Steven [2] 42/22 46/5
Steven Riley [1] 46/5
still [15] 27/18 61/23
76/1 88/14 94/20
107/16 116/6 117/8
118/20 118/25 119/2
119/14 160/16 173/8 192/18
stimulate [1] 184/11 stop [8] 142/12
142/18 147/5 157/7
157/14 157/25 158/4
158/25
stopped [5] 156/6
156/24 157/2 157/12 174/16
stopping [2] 156/11 158/19
story [2] 38/21 60/9
straight [2] 4/21
79/16
straightaway [2]
143/10 149/9 117/2 194/25
strands [2] 64/22
65/1
strategic [6] 39/23
69/12 88/8 88/15
88/18 174/22

146/25 154/13 156/18 strategically [1] 157/10 158/12 163/17 159/22
strategies [1] 146/9 strategy [29] 23/10 88/23 89/11 91/3 92/24 93/1 93/9 137/8 137/11 137/14 137/15 137/17 140/21 141/15 142/15 142/15 157/20 159/25 160/16 162/8 162/13 162/20 163/24 164/17 167/6 186/17 196/2 196/18 196/19
stream [1] 49/16 streets [1] 124/16 strength [1] 23/3 stress [1] 27/6 stressed [1] 198/7 stressful [1] 97/6 strict [5] 99/1 99/12 110/22 115/3 173/4 strictly [1] 71/17 strike [1] 22/8 strikes [1] 101/16 striking [1] 67/20 stringent [1] 168/3 strong [2] 78/1 185/22
strongly [4] 44/21
55/8 73/22 143/17
struck [3] 81/16 100/6 161/22
structure [3] 68/4 159/1 186/19
structured [1] 60/23 structures [2] 50/20 78/16
studies [15] 54/5
66/11 131/7 178/24
182/5 182/10 187/11
187/13 191/21 192/7
192/23 193/20 197/9
197/16 197/24
study [28] 178/3
187/14 187/15 187/15 187/16 187/21 187/23
188/11 188/17 189/1
189/4 189/11 189/18
189/19 190/2 190/4
190/5 190/7 191/5
192/14 192/19 192/20
192/22 193/4 193/8
197/11 197/17 201/20
style [1] 168/16
subcommittee [1] 144/9
subcommittees [3] 34/20 83/21 186/22 subgroup [15] 179/8 181/11 181/13 181/16 181/17 181/18 181/19 181/23 181/23 182/11 182/15 182/18 183/4 183/7 186/23
subgroups [12]
70/15 181/9 182/18 183/16 183/20 185/20 186/11 186/12 186/12 186/16 186/16 194/21 subject [4] 11/14 41/18 118/22 132/16 submissions [31] 96/9 96/13 96/23 97/2 98/6 98/12 99/20 100/2 100/22 101/14 105/15 105/18 105/19 105/23 106/2 108/2 108/8 108/10 108/11 108/22 109/3 109/6 109/19 114/21 116/11 122/24 206/15 206/18 206/21 207/1 207/4
submit [3] 86/5 107/2 107/21
submitted [3] 85/21 106/15 106/19
subsequent [3]
14/15 20/9 161/4
subsequently [4]
31/13 88/25 152/19 192/7
subset [2] 58/4 59/8
substance [1] 117/24
substantial [1] 126/3
substantially [1]
150/21
substantive [2] 6/13 29/10
substitute [1] 109/1
success [1] 73/8
successful [5] 16/11 45/10 59/17 61/3 173/4
successfully [1] 122/2
such [15] 78/1 79/12 82/20 102/6 117/21 119/4 120/6 123/22
124/2 163/24 164/10 184/7 189/5 196/19 201/25
suffer [2] 61/23 91/19
suffered [1] 91/20
suffice [1] 135/13
sufficiency [1]
194/11
sufficient [6] 113/17 157/21 176/25 180/9 180/23 184/2
sufficiently [2] 81/24 82/19
suggest [10] \(34 / 12\) 39/5 45/23 65/2 110/14 139/7 146/24 169/8 193/15 196/18
suggested [2] 65/20 101/13
suggesting [3] 24/16 46/6 84/11
suggestion [2] 19/17 114/14
suggests [1] 131/14 suited [1] 68/9 summarise [12] 26/17 33/20 33/21 33/23 57/6 68/8 123/16 171/15 188/1 188/1 189/20 190/6
summary [4] 33/7
48/2 58/25 188/5 summer [4] 60/6 73/25 165/8 200/22 sums [1] 58/9
Sunak [1] 171/3 Sunday [3] 22/16 22/24 122/4
Sunetra [1] 164/24
Sunetra Gupta [1] 164/24
supplied [1] 106/11
supplies [1] 155/9
support [20] 47/19
56/10 56/17 73/10
73/17 114/6 115/23
124/24 149/16 150/5 158/22 159/1 159/17 160/21 161/17 167/2 168/20 168/21 170/8 186/7
supported [1] 138/25 supporting [1] 56/8
suppose [1] 107/7 supposed [1] 22/4
supposition [1] 128/1
suppress [19] \(85 / 12\) 90/25 92/1 137/10 138/20 139/1 139/10 142/7 145/5 147/17 161/10 163/21 163/24 167/19 167/19 167/19 202/3 202/13 203/22
suppressed [3]
57/24 91/17 91/21
suppressing [3]
142/18 158/18 161/11 suppression [11]
74/23 88/6 88/25 90/2
128/11 139/12 139/13 157/23 158/15 159/25 160/18
Supreme [1] 120/18
Supreme Court [1] 120/18
sure [22] 1/14 7/9
15/16 30/14 50/12
60/15 62/7 65/9 66/3
73/23 77/4 79/4 83/14
\begin{tabular}{l|l} 
84/8 108/7 132/20 & Taiwan [2] 91/19
\end{tabular} 161/14
surfaces [1] 182/3
surge [1] 27/3
surprised [1] 154/23
surprising [1] 103/6
surveillance [14]
91/25 166/8 166/14
166/20 166/22 166/25
194/19 195/2 195/10 195/18 196/2 197/3
197/8 201/19
survey [3] 50/18
54/20 190/8
surveying [1] 50/24
suspect [2] 10/25 38/18
suspected [1] 18/12
sustainability [1] 41/22
sustainable [7] 40/11 41/21 42/9 42/11 55/12 80/6 126/19
sustained [1] 127/17 sustaining [1] 128/21 swab [1] 64/23
swine [4] 37/22
37/25 38/8 77/9
swine flu [4] 37/22 37/25 38/8 77/9
switching [1] 156/19
symptom [1] 138/2
symptomatic [3]
95/16 145/22 180/21
symptoms [11] 16/12
16/13 25/17 93/21
95/2 95/3 126/21
128/7 134/5 137/21 148/21
Syndrome [1] 89/18
system [40] 9/7 12/7 35/22 68/17 75/24
85/11 88/2 89/21 91/9
91/14 91/25 92/15
92/20 95/12 103/11
123/3 123/5 138/22
138/23 139/15 142/3
147/2 150/7 151/8
154/2 154/4 158/22
159/17 159/22 160/21 203/25
systems [5] 27/1
174/14 194/23 195/18 196/23

\section*{T}
table [1] 48/7

147/15 149/18 150/24 \(\quad 166 / 11\)
151/2 152/4 156/15 take [43] 3/8 4/14 surely [2] 114/22 \(\quad 4 / 17\) 9/2 11/20 12/2

161/17 162/1 162/24 teaching [1] 80/10 163/18 166/16 166/18 team [24] 80/17 166/22 172/15 202/16 97/23 97/24 99/10

161/17 162/1 102/24 teachers [1] 63/18
15/5 19/21 21/21
24/17 30/21 32/9 33/1
33/21 48/5 52/22 60/8
61/21 63/6 67/18
69/11 70/22 88/5 94/21 95/8 107/4 124/10 125/4 126/17 139/8 140/13 141/3 145/25 146/16 146/24 155/5 155/24 156/2 170/9 171/14 194/24 195/5 199/4
take weeks [1] 30/21
taken [22] 42/18 61/8 71/18 98/2 98/16 99/9 99/24 100/2 101/1 103/7 105/12 106/9 114/12 120/16 127/20 tells [2] 13/1 64/25 141/19 146/21 148/14 temporarily [1] 46/8 155/4 169/21 170/3 ten [7] 20/1 38/19 202/13
takes [1] 132/20
taking [9] 27/4 46/9
\begin{tabular}{c|l} 
taking [9] \(27 / 446 / 9\) & ten days [1] \(95 / 4\) \\
\(52 / 361 / 4129 / 7133 / 5\) & ten lines [1] 20/1
\end{tabular}
156/23 162/21 202/11 ten months' [1]
talk [9] 20/3 20/4 150/25
23/6 26/1 47/5 57/4
63/18 95/18 159/6
talked [3] 17/17
41/16 118/17
talking [16] \(2 / 20\)
12/18 20/7 21/18 51/1
62/9 64/7 64/14 73/7
75/6 75/7 75/16
123/14 133/3 136/6 145/8
talks [2] 39/3 172/16
target [5] 45/25
73/24 75/5 75/7
116/24
targeting [2] 59/8
92/11
task [1] 72/23
tasked [1] 72/22
tasks [2] 68/11
152/20
Taxonomy [1] 16/19
Taylor [1] 116/25

101/20 101/22 102/20
111/7 111/19 112/6
112/22 113/1 113/5
113/5 113/6 113/8
113/20 114/10 116/3
117/2 149/5 152/10 155/14 169/8
teams [2] 113/9
135/23

130/8 134/21 134/24
technical [2] 17/4 171/13
technically [1] 8/18
technology [1] 74/25
Tedros [5] 143/1
143/14 143/19 156/17
167/13
Tedros Ghebreyesus
[1] 143/1
Tedros' [1] 167/8
Tedros's [2] 129/22
143/13
teenaged [1] 64/10 tell [10] 5/9 8/14
21/20 39/9 55/24 63/3
66/3 68/16 68/25
159/23
telling [7] 27/11
45/20 52/23 71/13

74/15 93/15 95/4
144/14 150/25
ten days [1] 95/4

150/25
ten years [1] 38/19
tend [1] 192/23
tended [1] 193/23
tens [1] 113/7
term [7] 9/10 34/10
42/1 42/6 62/1 126/9 132/17
terminology [1]

\section*{140/23}
terms [21] 8/7 33/23
34/6 58/6 73/8 89/20 99/1 99/2 99/9 99/12
118/23 177/13 177/25
178/17 182/19 185/1
186/21 191/16 192/14
195/8 196/6
terrible [2] 33/11 158/4
test [52] 56/8 75/3
75/4 75/5 90/18 91/11 92/19 93/23 95/15 99/25 106/11 106/13
106/16 106/20 107/22
124/23 129/15 134/1
134/4 134/6 134/7
134/16 134/18 135/1
137/20 137/24 139/18
141/6 142/3 146/2
147/2 150/3 150/13
156/15 158/21 159/1
159/4 159/10 159/16
159/21 160/20 161/1
161/17 162/1 162/23
171/22 171/22 171/22
171/25 171/25 172/20
(84) subgroups - test
\(T\)
test... [1] 174/24
tested [4] 26/24
135/9 148/12 148/18
testing [54] 19/23
57/18 64/23 73/3 73/9
73/16 74/3 74/10
74/14 74/18 91/9
92/20 93/3 93/9 95/8
123/17 124/2 134/11
134/13 135/6 135/8 136/4 136/16 136/19 138/6 138/22 150/7 150/19 151/14 153/6 153/15 156/6 156/12 156/24 157/2 157/8 157/12 157/15 157/25 158/4 158/9 165/2
166/21 166/24 173/9
173/16 185/17 188/6
188/6 189/16 190/2
191/14 191/19 191/19
tests [27] 74/1 75/1
75/1 75/6 75/9 91/11 92/7 92/8 92/10 128/7 134/2 134/18 135/4 135/7 135/13 149/15 150/11 150/14 151/16 153/8 154/17 156/14 157/3 157/8 157/9 157/15 157/21
texts [2] 117/18 117/19
Thailand [1] 125/11 than [68] 4/5 4/6
12/11 12/12 12/20
20/8 23/20 23/24 25/1 25/9 25/10 25/13
26/23 31/11 32/13
32/21 39/19 39/20
39/20 39/21 40/23
42/10 42/10 42/11
44/25 45/12 58/10
58/15 58/16 65/4
65/16 65/21 65/25
67/4 69/17 71/21
71/22 71/22 75/10
89/4 90/15 97/13
110/10 122/20 128/19
132/4 132/9 133/5
137/9 143/6 144/1 144/15 147/6 147/11
156/9 159/24 160/17
161/5 180/12 180/14
181/5 181/24 183/1
184/10 189/3 194/8
200/6 202/23
thank [79] 1/23 2/2
3/21 4/8 4/21 5/5 8/25 11/17 18/16 18/23 22/21 24/14 24/23 26/17 29/21 33/1 42/14 56/23 63/5 72/8 72/10 73/5 75/11 75/14 76/14 78/25 78/25 79/2 79/3 79/4 79/9 79/10 79/13 79/14 79/24 88/2 95/20 105/17 107/25 108/5 109/17 116/9 122/15 123/8 123/10 125/1 163/12 163/13 170/24 171/11 172/8 175/6 175/16 175/18 175/19 175/21 175/22 175/24 176/3 176/5 176/13 176/18 176/23 177/9 186/8 187/7 191/25 195/23 195/24 199/12 202/20 204/22 204/23 205/7 205/8
thank you [57] 1/23
3/21 4/8 4/21 5/5 8/25 18/16 18/23 22/21 24/14 24/23 26/17 29/21 33/1 42/14 56/23 63/5 63/10 67/24 70/2 72/8 72/10 73/5 75/11 75/14 76/14 78/25 78/25 79/2 79/10 79/13 79/14 79/24 95/20 108/5 123/10 125/1 163/12 163/13 170/24 171/11 172/8 175/6 175/18 175/21 176/5 176/13 176/18 177/9 187/7 191/25 195/24 199/12 202/20 204/23 205/7 205/8
thanks [2] 15/19 21/12

\section*{that [1323]}
that the [1] 164/15
that's [118] 1/11 2/16 2/23 3/12 4/18 5/3 5/5 5/10 5/17 7/21 8/13 8/17 12/2 12/4 13/15 13/25 16/7 17/18 18/7 19/11 22/9 24/4 24/12 25/8 28/4 28/10 29/17 29/20 30/4 30/14 30/16 32/25 37/24 \(38 / 539 / 239 / 2541 / 14\) themselves [7] 4/13 42/11 44/7 44/20 45/14 46/5 46/9 46/17 46/22 47/11 49/14 50/9 55/21 56/18 56/23 58/20 58/22 59/8 59/25 63/5 67/13 69/24 70/25 70/25 75/2 76/23 77/9 78/25 80/8 80/12 83/8 83/23 86/17 87/2 90/16 91/2 91/5 91/16 93/11 93/25 95/1 95/19

98/23 103/2 103/18 116/3 123/8 128/4 130/1 130/7 131/19 133/2 136/6 136/20 138/9 138/19 142/22 147/18 157/22 161/24 169/13 173/6 177/17 177/18 179/10 179/14 181/16 182/13 183/2 183/21 185/17 187/22 188/24 191/22 191/25 192/5 193/17 195/7 197/6 201/13 202/24 203/1
that: [1] 55/22
that: you [1] 55/22
their [47] 23/12 52/1 52/3 52/4 52/21 59/20 59/23 62/12 62/21 77/17 77/19 83/1 83/20 88/20 88/21 89/3 90/8 91/21 92/2 92/9 98/1 103/10 105/4 107/18 110/13 113/3 113/22 114/21 123/1 135/10 135/21 137/7 137/8 142/11 144/25 145/15 148/24 149/7 149/17 149/17 154/15 156/13 157/20 174/15 184/14 184/15 185/9
them [51] 4/15 16/14 16/14 20/13 23/7 23/7 27/20 33/4 40/20 42/15 44/1 49/23 50/4 50/7 54/5 56/17 59/22 63/4 66/6 71/10 77/10 77/11 89/14 91/25 92/1 95/3 97/8 97/8 97/9 97/10 97/18 103/1 104/3 104/23 111/20 113/13 119/11 121/6 122/24 138/21 139/16 143/6 143/20 152/20 164/9 173/16 173/17 188/14 195/3 195/3 196/15
theme [2] 8/5 70/11 themes [2] 42/15 54/22 52/13 66/4 67/3 67/6 121/23 188/8
then [99] 3/8 3/22
5/19 6/8 6/11 8/16 9/1 10/9 11/7 13/4 14/16 15/1 15/23 16/23 17/23 18/20 23/18 24/1 24/10 26/16 27/5 29/22 30/7 30/21 32/25 33/9 36/19 41/9 42/8 43/18 46/10 46/10 46/23 47/15

53/23 58/15 61/7 61/22 63/6 63/13 63/18 70/3 70/10 74/18 81/6 81/12 87/12 90/24 91/14 91/22 91/24 94/24 97/23 98/21 111/1 112/3 112/13 113/14 116/20 123/6 128/8 128/17 129/11 133/17 133/20 134/9 136/16 137/11 137/21 138/20 139/15 142/24 146/8 148/18 149/8 149/14 150/8 157/24 158/12 160/17 160/25 161/6 161/12 166/10 166/11 167/8 171/3 172/15 173/13 173/17 177/21 178/12 181/13 181/23 184/17 186/6 186/25 202/4 204/15
theoretical [1] 181/25
there [237]
there's [19] \(8 / 19\)
15/11 17/14 20/12 20/16 40/13 40/16 57/16 57/20 58/19 61/24 71/16 89/13 137/20 138/14 178/12 187/11 192/17 196/18
thereafter [1] 107/10 therefore [21] 10/18 42/8 89/20 90/17 91/3 91/8 93/22 108/16 117/5 117/22 123/24 124/22 125/21 128/3 129/1 129/10 131/6 142/6 143/13 143/16 147/10
these [44] 10/3 13/14 18/5 28/18 29/4 33/7 37/18 40/20 57/21 58/6 59/19 60/9 60/11 61/6 62/8 68/1 73/17 74/21 76/24 77/10 86/8 103/2 103/12 107/15 110/6 110/12 110/20 111/1 111/11 111/17 113/11 114/1 115/16 136/12 154/23 155/24 178/11 185/15 187/20 190/20 195/5 196/2 199/4 201/22

\section*{they [216]}
they'd [5] 50/1 50/2 50/7 78/7 127/6
they'Il [2] 66/3 203/1
they're [15] 32/14
54/15 66/12 66/13 66/15 69/18 102/3 102/3 107/12 118/21 135/9 138/19 145/7

151/25 172/18
they've [1] 111/22 thing [15] 8/8 10/21 33/10 38/12 45/6 54/19 55/20 90/22 102/22 128/2 133/2 163/19 170/12 174/21 204/12
things [26] 15/13 29/14 36/14 38/22 49/15 49/23 54/14 56/21 62/4 69/17 77/7 77/15 81/6 85/10 107/15 124/14 129/18 129/20 142/6 178/11 182/2 183/13 186/17 189/12 192/11 198/20 think [177] 2/1 3/7 3/9 4/25 5/1 5/10 7/9 7/12 7/15 9/21 11/4 11/10 14/2 14/5 15/19 18/1 18/24 20/8 21/5 21/15 22/9 23/21 26/2 28/6 29/10 30/16 31/25 33/10 33/22 34/7 35/17 37/8 38/17 38/24 39/4 39/12 39/14 39/14 39/19 40/2 40/12 41/3 41/7 42/2 42/22 43/2 43/7 44/20 45/1 45/11 45/19 46/12 46/19 48/6 50/14 51/19 51/21 52/5 53/17 54/3 54/24 55/9 56/18 58/1 58/2 58/14 58/23 60/18 61/6 62/9 62/10 62/15 64/7 64/17 66/4 67/2 67/20 68/17 69/1 69/3 69/18 69/23
71/19 71/25 72/6 73/13 73/24 78/9 79/16 80/15 82/8 82/9 85/7 86/7 87/5 87/12 87/24 90/14 90/21 94/16 94/19 111/23 111/25 122/15 127/13 127/24 129/9 132/8 133/1 136/2 142/20 142/20 142/22 144/4 145/6 148/12 151/15 151/25 154/9 156/10 156/13 156/18 156/24 162/16 163/1 165/18 171/4 171/10 174/19 175/15 179/23 180/6 180/15 180/21 181/1 181/3 181/3 181/5 181/22 182/8 182/17 182/23 183/2 183/12 184/2 184/5 184/16 185/7 185/15 185/16 186/20 187/1 187/3 187/18 188/10 188/14
think... [21] 189/12 189/15 190/15 191/8 191/14 194/19 196/11 196/20 197/2 197/22 198/6 198/25 199/5 199/7 199/25 200/23 202/15 204/7 204/12 205/1 205/6
thinking [11] 10/20 42/6 42/8 75/10 77/11 92/22 148/24 180/17 185/1 185/23 196/21
thinktank [1] 136/1
third [8] 18/24 19/1
24/10 103/15 124/15 128/17 150/15 191/21
thirdly [3] 175/12 178/25 187/14
thirds [1] 84/2
this [331]
this virus [1] 57/14 Thomas [1] 72/15
those [111] 8/14 8/23 8/23 9/2 11/20 12/15 14/23 19/8 20/4 20/16 23/4 30/5 31/12 36/3 40/13 42/15 48/21 48/21 49/1 49/4 50/3 50/21 56/20 56/24 59/7 61/4 61/21 62/5 63/15 63/25 65/1 65/7 68/6 68/18 69/20 70/8 72/4 77/18 77/25 78/1 78/4 79/2 83/9 83/19 85/25 91/6 92/6 96/20 98/16 99/2 99/3 99/3 99/9 99/24 100/14 100/18 103/7 103/11 105/14 106/1 106/12 106/16 107/9 108/22 110/5 115/4 118/24 121/9 122/9 122/23 129/18 134/15 138/13 141/13 147/23 148/20 149/3 152/21 153/13 154/8 155/6 155/19 161/8 175/16 182/18 183/8 184/18 184/19 185/5 185/11 186/7 190/3 190/11 190/14 190/15 191/10 193/11 193/21 193/23 195/20 196/14 197/4 197/15 198/4 198/5 198/6 199/9 199/10 201/24 202/7 204/5
though [8] 48/8 60/8 62/8 88/16 118/10 122/12 148/16 204/1
thought [19] 6/15
19/18 26/8 26/14 30/15 32/19 32/19

38/3 44/15 54/7 65/4 94/8 118/14 119/4 132/9 132/10 179/25 201/7 203/16
thoughtful [1] 104/16 thoughts [3] 6/19 121/6 180/24
thousand [1] 151/21 thousands [4]
102/25 113/7 135/15 204/8
threat [4] 38/8 38/13 38/16 126/3
three [11] 23/6 24/18 30/5 89/9 94/9 124/16 127/10 127/12 129/1 184/22 197/22
three weeks [1] 127/12
threw [1] 109/11 through [21] 8/19 11/16 19/21 33/5 52/6 80/10 88/6 89/17 125/4 132/25 155/18 163/22 163/25 164/1 164/19 172/22 172/25 178/5 180/15 186/18 198/9
throughout [3] 21/18 39/13 64/2
throw [1] 134/14 throwback [1] 137/14
thrown [1] 62/25
tier [2] 202/16 203/25 time [94] 2/4 5/9 6/19 7/1 10/2 11/10 17/8 17/20 18/12 18/14 21/3 21/7 21/16 23/25 25/7 25/24 26/11 29/3 29/18 30/16 32/23 41/25 43/6 45/21 45/23 46/15 47/1 47/20 48/3 48/10 49/9 totally [1] 166/15 49/25 50/4 50/14 \(\quad\) touch [8] 19/3 19/4 50/22 51/17 52/25 54/4 56/11 62/10 65/6 65/15 78/7 80/16 83/20 86/19 87/9 89/2 90/17 91/23 92/3 93/19 93/22 93/23 94/16 117/6 124/22 126/11 127/3 127/5 128/16 129/21 142/1 144/23 148/22 150/25 155/7 156/8 157/22 161/20 164/17 165/11 165/12 166/1 168/5 176/25 177/18 177/23 traced [2] 124/1 180/4 180/6 188/12 173/1
188/13 188/23 189/18 tracers [5] 152/1
 195/5 199/4 199/21
201/19 201/21 202/7

202/12
timeline [1] 178/20 times [9] 39/18 48/1 56/1 56/4 58/9 58/11 89/4 144/15 174/7
timescales [1] 97/23 title [1] 172/10
titled [1] 87/23 today [7] 36/16 171/6 176/23 177/1 178/18 204/19 205/2
together [3] 8/4 126/15 181/6
told [11] 17/6 23/4
23/21 31/20 44/1
60/18 74/11 84/5
153/2 167/10 187/1
toll [3] 46/25 55/19
75/20
Tom [1] 56/4
Tom Whipple [1]
56/4
tomorrow [3] 7/23
42/25 205/6
tone [1] 39/15
too [14] 19/18 32/1
32/1 38/6 38/10 38/10
53/25 54/1 67/22
70/15 70/16 113/12
168/3 168/15
took [6] 29/1 47/14
48/3 87/9 174/14 190/2
tools [1] 147/11
top [7] 15/23 29/2
37/19 155/25 163/20 167/16 195/25
topic [11] 49/6 51/5
51/19 76/15 78/22
108/10 171/1 179/3
187/10 189/21 195/7
topics [2] 72/13 112/10 178/16 179/20 179/22 \(184 / 21\) 187/12 189/24
touched [3] 183/25
touched [3] 183/25
195/13 200/18
towards [7] 4/12 47/15 47/16 70/10 174/16 191/17 195/13 trace [16] 123/17 124/23 139/18 141/6 147/2 150/4 158/21 159/1 159/16 159/21 160/20 161/1 161/17 162/1 166/22 174/24 155/13
tracing [21] 73/9

73/16 90/20 91/13 92/14 95/12 129/16 138/23 142/4 144/18 145/11 151/7 151/8 151/18 152/24 155/11 166/8 166/25 173/9 175/13 185/17 track [2] 48/19 158/25
tracks [2] 142/19 158/19
tragedy [1] 58/2
trail [1] 13/11
training [2] 172/16 184/6
transcribed [2] 111/18 111/22
transcribing [1] 111/20
transcripts [1] 102/14
transient [1] 41/24
transit [1] 49/4
transmission [60]
16/12 16/23 17/1
17/23 24/6 25/16
25/18 25/24 26/7
26/11 29/16 57/14
57/21 63/8 65/4 65/23
65/25 66/14 76/25
77/20 78/12 90/25
91/15 123/20 124/8
124/18 125/21 126/2
126/18 126/19 127/9
127/18 127/20 128/21
128/23 131/2 139/22
143/3 145/20 145/21
145/24 146/17 146/19
147/5 161/4 174/24
179/1 179/18 181/16 181/18 181/21 182/8 182/11 189/5 190/13 191/6 198/22 199/16 202/2 203/22
transmit [1] 16/2
transmits [1] 180/19
transmitted [1] 182/6
transmitting [2]
77/22 93/12
transparency [5]
86/13 108/16 113/25
114/7 120/1
transport [1] 198/16
transposed [1]
181/23
travellers [2] 124/2
135/7
traverse [1] 118/11
treated [2] 102/11
169/19
tremendously [6]
57/25 58/5 58/6 59/6 74/19 77/16
trial [1] 120/4
trialled [1] 75/2
tribunal [1] 100/3
tried [1] 52/18
trifecta [1] 75/16 triple [1] 20/6 true [10] 1/19 34/7 66/18 66/19 71/1 80/3 80/11 83/23 91/22 183/2
Trust [2] 5/11 15/15
truth [3] 1/18 52/5 177/7
try [15] 39/24 47/6
48/23 66/21 67/25
109/13 135/10 136/14
143/17 162/17 184/15
190/10 194/2 196/9 203/14
trying [21] 9/25 20/17
24/3 28/14 40/10
44/12 44/21 46/12
46/19 55/15 60/1
79/11 142/18 178/11
180/14 185/10 185/11
197/4 198/12 198/24
199/2
Tuesday [2] 5/7
205/11
turn [13] 30/12 33/15
33/17 178/22 178/24
179/4 183/18 187/21
187/25 195/14 195/23
199/18 202/19
turned [2] 33/16
59/16
Turning [1] 117/24
tweet [2] 81/12 167/4
two [44] 3/18 10/23
11/23 25/6 29/11 30/1
30/17 40/17 49/21
49/23 54/22 63/7
64/21 67/20 68/6 72/6
72/7 72/13 72/20 82/6
83/11 84/2 89/6 91/6
91/8 92/3 92/4 93/17
103/3 129/1 134/11
134/13 134/15 144/11
147/19 147/23 149/3
165/11 167/5 178/1
178/9 186/9 197/9
197/16
two days [2] 93/17 167/5
two weeks [1] 67/20
two-thirds [1] 84/2
type [8] 17/5 47/3
52/25 88/14 106/17
117/3 172/20 179/16
types [1] 9/11
typographical [1]
73/13
U
UCL [4] 80/6 80/21
\(U\)
UCL... [2] 177/16 188/4
UK [41] 9/4 21/19
23/9 24/2 29/25 30/20 33/24 34/5 34/7 39/16 40/14 49/9 54/12
59/13 72/13 72/24
73/8 73/15 75/17
75/22 85/21 85/23
87/24 92/23 109/19
109/21 126/6 130/19
134/4 139/8 141/23
142/9 142/10 142/11
149/22 150/17 156/18
166/2 172/21 177/22 207/1
UK advisory [1]
142/9
UK Government [1] 156/18
UK's [1] 36/21
UKHSA [5] 110/2
114/6 115/23 195/25
196/16
ultimately [2] 100/5 142/13
unable [2] 21/19
190/25
unanimous [1]
144/25
uncertainty [1] 32/17
unclear [4] 134/4
144/17 145/9 164/18
uncomfortable [1]
105/4
unconstrained [1] 61/18
uncontrollably [1] 162/4
under [21] 6/1 16/8
16/15 90/23 94/8 98/8 99/12 110/22 112/18
118/9 118/23 120/8
123/13 129/3 133/19
135/24 137/19 140/23
165/23 169/14 192/23
under way [1] 6/1
undergone [1] 89/16
undergrad [1] 9/23
undergraduates [1] 10/11
underneath [1] 10/13
understand [17]
11/25 31/4 52/18 99/9 103/12 112/2 137/3 139/25 141/18 165/24 166/6 185/10 198/12 198/24 199/2 203/13 203/17
understandably [2] 168/4 168/15
understanding [14]

78/16 100/16 123/19 124/4 126/25 155/8 178/4 180/19 182/2 189/7 191/6 192/2 192/15 197/1
understands [2] 140/7 155/2 understood [11] 23/24 32/25 36/5 65/17 65/21 67/5 75/11 76/14 134/10 146/18 175/6
undertaken [2] 36/23 187/20
undertaking [7] 9/17 99/2 99/4 99/13
118/22 194/13 197/24 undertakings [4]
110/22 115/3 118/24 120/8
undertook [1] 187/13 undesirable [1] 101/9
undoubtedly [2]
81/18 120/19
unfolded [1] 33/11
unfolding [1] 35/2
unfortunately [1] 199/4
unimmunised [2] 93/15 128/20
United [18] 124/3 126/5 128/13 129/6 140/12 141/3 143/22 144/22 146/22 147/7 148/7 148/9 149/2 157/11 159/11 162/3 171/19 174/1
United Kingdom [15] 124/3 126/5 128/13 140/12 141/3 143/22 144/22 147/7 148/7 148/9 157/11 159/11 162/3 171/19 174/1
universities [1]
154/22
University [4] 2/6 2/9
2/12 177/16
unknown [4] 59/12 61/14 126/19 135/14 unless [2] 99/6
105/14
unlike [1] 77/7
unlikely [5] 24/7
30/16 30/16 61/2 61/10
unnecessary [1] 107/3
unpick [1] 66/21 unpopular [1] 59/15 unredacted [2] 97/22 102/13
unseen [1] 97/19
until [11] 19/17 74/20

75/1 80/13 94/6 99/6 123/7 134/16 192/16 201/24 205/10 unusual [2] 58/22 102/1
up [97] 1/13 3/14 4/16 6/12 13/21 36/6 36/16 44/3 44/14 44/16 45/14 46/13 46/20 46/21 46/21 49/8 49/25 50/21
50/22 51/25 57/4 58/9 62/12 63/6 71/11
71/25 72/19 73/1 73/8 76/10 76/11 81/1 81/6 82/3 85/11 88/1 88/22 91/8 92/10 92/16 92/20 107/9 107/15 116/17 117/3 117/15 117/20 119/16 120/23 Usher Institute [1] 121/16 122/10 123/6 2/8 129/14 129/15 134/14 using [8] 7/4 31/17 135/1 137/8 138/21 33/7 36/9 48/18 138/22 142/4 142/20 146/24 147/14 148/24 151/16 153/15 153/18 154/4 154/9 155/7 usually [1] 141/13 155/18 158/7 158/21 utilised [2] 179/24 159/13 160/1 160/2 160/3 160/5 160/25 162/20 162/23 169/1 174/7 176/19 180/2 181/11 181/11 182/3 183/13 183/14 192/16 vaccination [2] 164/8 192/18 193/25 194/23 164/13
198/19 202/14 204/1
updates [1] 22/12
updating [1] 25/3
upheld [1] 122/8
upon [20] 74/22 79/5 92/25 96/2 122/24
138/16 164/5 168/10
178/16 179/20 179/22
179/24 183/25 184/21 185/21 186/25 187/12
189/24 199/14 200/18
upwards [1] 174/16
urge [1] 143/17
urgency [2] 34/10 34/21
us [51] \(1 / 8\) 1/13 5/9
8/14 16/4 17/6 20/11 21/17 21/20 23/21 25/23 31/20 34/23 35/23 37/2 39/9 41/25 45/20 48/13 52/23 54/16 57/6 60/8 60/18 64/25 68/16 69/19 69/23 69/25 77/21 89/6 110/23 114/19 115/2 136/8 136/13 140/22 153/2 156/2 160/15 166/6 167/10 168/11 174/14 176/13 versus [1] 67/9

176/16 177/4 196/22 199/22 201/5 201/20
USA [1] 174/5
use [16] 12/20 27/11 34/10 45/15 81/25 82/5 82/13 82/14 96/20 98/7 108/24 166/21 189/13 189/13 190/20 191/11
used [20] 9/10 12/24 20/9 20/17 26/22 28/12 34/3 45/4 49/5 76/19 82/6 99/4 105/1 107/11 137/1 152/19 152/20 154/15 154/18 155/10
useful [3] 121/25 134/6 185/14
Usher [1] 2/8 114/13 180/12 198/15 usual [3] 80/2 101/6 122/20 181/2
utilising [1] 123/4
utmost [1] 108/15
V
validity [1] 170/1
Vallance [17] 14/1
21/23 23/2 29/13 39/3
85/15 86/6 90/12
96/11 96/13 106/1
108/19 121/4 121/18
122/14 142/21 206/16
valuable [5] 50/19
69/3 85/2 154/5
173/19
value [10] 7/7 8/3 9/2
93/12 139/14 180/23
184/25 198/7 198/8
203/14
valued [1] 6/23
variants [1] 179/19
variety [1] 63/25
various [7] 57/2 68/3
81/13 101/8 106/25
141/9 195/20
vary [1] 138/17
varying [2] 165/21
184/14
vast [1] 169/2
Venki [1] 153/20
verse [1] 26/4
version [2] 14/13
62/22
very [182] 2/2 4/10 5/21 6/14 6/24 7/7 8/5 9/18 9/18 9/21 9/21 10/22 13/2 13/4 13/4 13/8 13/8 13/12 13/12 13/22 14/20 16/1 16/9 16/11 16/18 16/18 16/18 17/2 17/10 18/25 19/6 19/13 19/22 21/4 21/4 21/8 22/10 25/2 26/5 26/24 27/23 28/21 28/21 29/3 29/19 33/14 33/14 34/11 35/4 37/5 40/3 40/9 40/13 41/13 41/13 43/10 44/18 45/9 45/10 50/15 51/24 52/5 52/16 53/2 53/11 53/12 53/12 54/6 54/10 54/16 55/16 55/16 56/6 56/9 56/9 56/23 57/12 57/12 58/2 58/3 58/22 59/15 59/15 59/15 59/16 62/15 62/15 69/12 72/4 73/22 73/22 76/7 78/10 78/22 79/3 79/4 79/8 79/9 81/15 81/25 82/14 83/6 83/9 85/13 86/4 86/23 86/24 87/14 88/2 88/20 89/11 90/16 91/7 91/21 92/1 92/2 95/19 105/16 105/17 106/24 107/25 109/17 109/20 114/5 114/24 116/9 117/20 118/11 122/15 122/24 123/8 124/12 124/19 124/21 126/6 127/3 130/15 130/16 133/5 138/23 143/11 145/4 146/8 149/10 150/1 151/24 155/1 156/17 159/9 160/8 165/1 165/6 168/4 172/21 172/21 173/3 173/4 173/4 173/18 175/16 175/19 175/22 175/25 176/23 180/1 182/18 184/9 185/9
185/12 186/2 188/11 188/20 191/12 194/5 194/16 195/23 199/13 201/9 204/16 204/18 204/22 204/24
viable [1] 45/11
video [3] 102/7
171/14 173/22
view [56] 11/13 35/11 42/12 44/13 45/16 45/18 46/9 48/3 48/9 52/6 52/15 53/22 54/2
55/17 56/22 57/13
view... [40] 58/1 59/6
66/2 66/18 67/5 67/12 67/18 69/11 70/18 70/23 71/5 71/19 71/23 74/1 82/19 85/13 90/13 110/16 112/9 132/12 140/24 142/11 142/14 144/20 149/1 149/2 154/19 160/11 164/24 167/3 170/8 173/24 182/25 185/19 195/22 197/4 201/6 201/12 201/14 202/2
viewers [1] 173/3 viewpoint [1] 143/22 views [12] \(8 / 210 / 18\) 45/21 65/7 65/11 65/12 65/24 70/7 70/16 77/4 109/21 118/16
vigorous [1] 36/25
viral [4] 81/12 89/22 90/10 182/2
virology [6] 87/15 136/4 153/7 153/13 154/8 155/6
virtually [1] 201/8
virtue [2] 56/8 120/21 virus [70] 23/12 23/15 30/7 30/9 30/12 39/24 40/3 40/22 41/24 42/4 49/16 57/14 58/8 59/8 59/24 73/11 77/22 77/24 81/16 85/12 88/6 89/1 91/10 91/15 91/17 93/4 93/11 94/6 95/11 123/19 124/23 124/25 126/23 127/2 129/8 131/1 132/13 132/23 134/22 135/14 137/8 137/11 138/20 139/2 140/21 142/19 144/21 145/5 148/14 148/25 154/18 155/8 155/25 158/16 158/17 158/25 162/3 163/20 163/24 164/5 164/15 164/19 187/14 191/22 192/14 192/17 193/9 197/10 199/17 202/13

\section*{Virus Watch [6]}

187/14 191/22 192/14 192/17 193/9 197/10
virus-free [1] 59/24
Viruses [1] 16/20
vital [6] 74/4 74/7
91/8 119/17 130/24 155/3
Vivaldi [3] 187/13 189/18 190/1
voice [2] 10/17 48/24 voices [1] 176/19 voluntarily [2] 97/21 104/23

\section*{volunteered [1]} 152/22
volunteers [3]
151/22 152/17 197/20 vulnerability [1] 76/17 vulnerable [2] 59/7 175/13

\section*{w}
wait [5] 19/18 50/8 134/16 201/24 204/15 waited [2] 19/17 50/7 waiting [6] 22/11 52/2 79/21 176/8 176/24 204/2 Wales [8] 4/1 98/11 99/15 99/16 109/4 110/8 110/11 120/11 walk [1] 44/21 want [49] 4/9 6/12 7/8 11/12 11/13 12/19 23/7 27/9 28/23 29/11 32/2 34/13 38/20 38/24 39/20 39/21 39/21 40/19 42/10 42/10 42/11 42/16 43/1 43/9 48/14 54/20 55/16 55/20 55/22 57/12 59/5 60/8 63/7 68/6 69/14 71/21 71/22 71/22 88/12 113/12 135/1 147/15 147/23 153/17 155/18 167/3 178/17 183/18 190/5
wanted [16] 12/13 18/7 18/16 40/15 45/14 47/5 70/4 72/5 73/20 74/10 108/9 152/11 152/18 156/14 157/5 187/7
wanting [1] \(15 / 21\) wants [2] 112/11 114/9
warning [1] 36/12 was [626] was 2.8 [1] 94/19 washing [1] 179/18 wasn't [31] 6/25 11/15 21/2 22/11 27/20 27/21 36/24 37/15 41/20 41/23 48/9 50/14 50/21 54/9 59/11 66/19 67/6 69/2 70/23 72/17 74/8 75/1 78/14 78/19 81/20 81/23 133/9 148/17 157/25 160/9 185/22 watch [7] 36/4

187/14 191/22 192/14 \(47 / 13\) 47/15 49/8 192/17 193/9 197/10 water [1] 45/6 wave [23] 8/19 8/21 13/2 13/4 61/15 74/20 75/23 76/1 161/11 161/20 weekend [3] 19/15 161/20 162/5 196/10 29/5 47/16 199/7 199/20 200/5 weekly [1] 87/12 200/7 201/7 201/10 201/23 204/13 waves [2] 73/11 73/19
way [56] 6/1 9/16 12/9 16/24 17/2 21/21 24/7 37/11 37/13 37/22 38/3 38/10 38/10 40/21 41/4 41/7 41/14 44/4 52/6 57/3 58/24 68/4 68/8 68/22 70/3 92/15 96/19 97/14 102/2 102/3 102/4 102/18 103/20 103/25 110/12 111/22 113/11 116/24 117/16 119/22 119/23 121/10 124/1 132/23 132/24 134/13 136/12 138/14 139/18 157/17 158/17 172/22 175/14 184/7 189/23 203/17
ways [4] 55/12 68/2 83/3 106/25
we [430]
we'd [10] 50/3 50/6
62/21 76/9 110/19 157/16 174/11 193/18 200/7 201/23
we'll [19] \(2 / 205 / 17\) 9/20 13/21 22/18 29/22 41/7 43/7 43/10 44/2 44/3 46/19 62/8 83/13 136/18 162/11 170/20 178/16 178/22 we're [20] \(14 / 19\) 22/20 33/3 38/15 41/18 45/24 53/5 71/3 71/9 79/16 89/24 96/14 122/22 136/6 169/17 178/11 178/13 well known [2] 187/11 187/25 194/22 119/15 164/10 we've [23] \(3 / 133 / 17\) wellbeing [1] 68/22 9/10 12/6 24/12 28/18 Wellcome [4] 5/10 29/7 31/10 32/16 34/25 36/15 43/16 57/24 92/7 156/20 172/21 174/8 176/24 179/6 180/9 187/1 200/18 201/5 website [3] 96/18 100/15 115/20
Wednesday [1] 43/12 were [271] week [23] \(2 / 25\) 14/3 25/1 25/13 27/10

89/2 129/11
5/11 7/3 15/15
Wellcome Trust [1] 5/11
went [13] 18/20 22/22 40/14 40/15 41/19 42/23 47/5 59/10 81/12 84/4 89/1
weren't [29] 15/16
21/24 29/2 35/24

49/14 50/23 52/1 55/18 60/17 60/19 61/23 70/7 70/8 77/2 77/11 77/21 78/16 78/18 81/22 87/8 119/9 142/5 145/11 149/18 152/19 154/25 181/12 182/11 183/10
West [2] 92/5 154/13 what [200] 5/19 6/9 6/9 8/23 11/3 13/4 15/16 17/9 18/7 18/10 19/20 20/25 21/4 21/20 23/4 23/19 23/21 24/3 24/4 25/23 27/11 28/1 28/10 30/11 31/5 32/3 35/1 36/5 36/9 38/2 38/14 38/17 38/24 39/9 39/25 40/22 41/10 43/25 45/19 46/12 46/14 46/19 46/20 46/22 47/6 47/8 48/14 49/7 49/18 51/17 52/9 52/11 52/16 52/22 53/5 53/7 53/17 54/9 55/11 55/14 56/12 56/20 57/6 57/7 57/11 57/15 58/25 59/3 62/23 63/14 64/7 64/13 64/25 65/23 67/2 68/1 69/3 69/7 71/6 71/7 71/14 74/2 74/5 74/10 74/17 76/16 77/9 77/19 78/13 80/25 81/22 82/18 87/24 88/13 89/7 90/16 91/5 91/10 91/11 91/16 92/18 93/10 93/18 93/25 97/15 100/3 100/21 100/21 100/23 101/3 101/24 106/15 111/6 113/8 113/15 113/23 114/7 118/17 123/21 124/6 125/19 126/25 128/7 128/16 129/13 129/16 131/24 132/18 132/21 133/4 134/12 136/7 137/3 138/19 140/1 140/10 140/23 141/10 141/11 141/18 141/21 142/1 142/20 143/23 144/20 145/23 147/18 148/19 149/1 149/1 150/23 151/2 151/24 153/16 156/11 157/8 158/20 159/15 160/23 161/24 163/7 164/3 164/3 164/18 166/18 167/10 167/13 170/17 171/10 173/11 173/23 173/24 178/1 178/5 178/10 179/6
what... [24] 181/1 181/20 182/23 183/4 183/6 183/9 183/10 186/6 186/22 189/11 190/6 190/10 190/11 190/16 192/21 193/3 197/20 199/6 201/14 201/17 201/23 202/15 203/19 204/2
what's [10] 8/18
11/24 16/4 26/16 31/4 33/8 53/15 67/19 69/14 129/13
whatever [6] 42/8
53/12 59/7 63/20 134/13 141/9
WhatsApps [2]
117/17 117/18
when [75] 3/10 5/22 20/6 24/2 26/4 29/6 47/20 49/5 49/12 50/11 51/4 53/20 55/11 56/20 62/18 64/3 66/10 74/11 75/3 75/24 75/25 78/21 78/23 82/25 86/21 86/24 87/2 87/10 92/3 92/9 93/6 93/6 94/10 96/20 96/21 97/10 107/8 107/10 110/16 112/20 114/23 115/4 115/17 121/19 123/23 123/25 124/3 124/8 124/9 124/13 124/15 124/16 129/21 130/4 130/9 133/1 134/5 134/22 134/24 135/20 136/6 152/16 154/14 154/24 155/16 155/20 161/14 163/2 165/2 170/17 172/21 181/18 192/14 202/21 203/23
where [45] 6/8 12/7
23/14 29/5 29/10 30/9 31/7 31/8 32/3 35/19 39/23 49/2 49/11 59/25 60/9 62/14 70/25 73/3 103/8 106/18 116/14 119/25 120/5 139/1 139/13 157/16 160/15 164/12 168/20 169/22 173/6 173/7 173/18 174/5 177/18 178/11 178/13 179/23 186/19 190/2 197/3 197/18 198/2 198/12 199/21
whereas [3] 20/6 159/13 168/22
whereby [2] 123/5 139/15
wherever [1] 23/15
whether [53] 7/5 9/12 15/17 16/21 18/4 21/17 31/25 35/6 40/19 47/21 48/12 53/19 53/22 54/15 64/14 65/19 65/25 67/1 73/21 85/4 92/18 92/19 92/21 100/4 100/5 107/7 107/8 110/1 111/3 111/16 115/13 116/13 117/10 117/25 126/19 126/20 130/10 130/20 136/18 138/1 144/17 144/25 145/9 145/25 146/15 146/18 154/4 154/20 155/2 155/6 164/5 164/18 180/5
which [203] 2/8 2/13 2/24 3/13 4/14 5/24 6/17 7/15 10/5 16/8 17/19 24/10 24/21 24/25 25/1 26/23 27/18 29/10 32/4 34/1 34/3 34/11 34/13 37/21 38/13 38/22 40/6 40/24 42/23 42/23 47/16 48/18 50/2 50/5 50/17 50/18 51/15 51/16 51/20 51/21 53/18 54/21 54/24 54/25 55/1 55/2 56/25 57/16 61/14 62/1 62/11 62/22 64/8 64/19 65/18 65/18 65/19 66/2 66/8 66/25 69/4 70/3 71/5 73/17 75/4 76/24 77/13 80/15 81/12 81/13 82/12 82/13 86/19 93/7 93/8 93/12 95/6 95/10 98/11 101/11 101/18 106/12 108/13 108/17 109/4 110/11 111/3 111/14 115/1 116/19 116/25 117/3 117/14 117/15 118/4 118/19 119/23 120/3 120/7 120/11 120/20 121/9 121/14 122/1 122/4 122/10 123/4 124/5 124/21 124/23 125/14 126/1 126/3 126/9 126/24 127/4 127/10 127/11 128/17 128/20 129/11 130/11 133/8 134/25 136/4 136/13 136/19 137/24 140/1 140/23 141/15 146/6 146/12 146/15 148/10 148/23 148/25 149/8 149/19 150/8 150/10 150/25 154/5 155/20 156/22 158/5

158/5 158/14 159/10 whom [3] 10/19 70/8 159/15 160/18 161/22 168/12 162/9 162/13 163/16 whose [1] 8/2 164/1 165/11 165/12 why [42] 5/19 6/20 166/9 166/15 167/10 \(\quad 8 / 14\) 10/10 10/16 167/14 170/7 172/23 177/3 178/3 178/10 178/13 178/22 178/24 179/19 179/21 179/22 181/10 181/14 181/14 181/21 181/25 182/9 183/18 183/24 185/20 187/4 187/10 187/12 187/25 188/17 188/17 189/3 189/16 189/22 190/22 191/1 191/13 191/21 191/22 193/8 194/11 197/10 198/6 198/24 199/3 203/25
while [2] 6/16 41/22
whilst [1] 195/7 Whipple [1] 56/4 white [1] 194/8 Whitty [11] \(14 / 2\) 21/19 21/23 23/1 29/23 31/5 132/10 142/21 163/1 165/13 165/14
who [76] 2/25 5/12 7/22 12/5 16/2 20/19 21/14 72/7 77/21 79/17 82/1 82/11 82/14 83/8 83/11 83/20 84/5 84/12 87/7 89/1 100/18 105/18 112/6 113/9 116/25 125/23 125/24 129/13 129/22 129/22 130/1 130/15 130/17 130/20 130/21 131/14 131/19 131/20 133/3 135/6 135/8 141/11 142/1 143/5 143/9 143/11 145/4 145/4 149/4 152/3 153/6 154/15 156/22 161/9 164/24 165/20 166/9 167/7 168/10 168/12 171/21 172/1 172/3 172/10 174/19 174/21 176/21 182/14 184/12 186/3 190/21 198/4 198/5 198/9 199/9 199/10 who's [1] 151/7 who've [1] 184/13 whole [17] 33/19
39/15 45/22 48/20 49/23 55/2 56/14 57/20 75/25 81/3 101/7 102/22 121/20 130/12 138/6 141/7 152/17

\section*{whole-society [1]} 138/6

13/15 16/25 18/8 19/11 37/2 38/13 40/17 45/14 50/5 56/18 61/7 77/2 81/18 82/23 83/8 92/10 92/12 92/13 93/3 93/10 110/6 113/20 138/18 154/13 156/24 157/10 159/22 160/14 160/16 166/6 169/3 180/9 180/16 180/18 181/6 201/11 203/11 wide [7] 40/7 41/10 87/14 183/4 183/15 183/16 189/8
widely [5] 49/5 65/20
131/1 149/10 200/23
widening [1] 189/13
wider [8] 39/19 39/21
42/11 71/22 77/20
95/7 193/10 195/22
widespread [1] 201/8
Wild [1] 154/13
wilderness [1] 10/18 will [75] 1/17 4/15 8/20 8/24 14/3 14/12 15/19 15/20 15/24 16/4 18/20 25/12 26/4 witness's [1] 100/25 26/24 28/2 33/4 39/1 witnesses [7] 3/17 40/5 41/12 46/7 47/13 \(\quad 96 / 21\) 100/11 103/7 \begin{tabular}{ll|lll} 
& \\
\(51 / 7\) & \(60 / 13\) & \(70 / 20\) & \(71 / 4\) & \(103 / 9\) \\
\(121 / 9\) & \(121 / 22\)
\end{tabular} 71/7 72/6 77/4 91/14 92/17 96/9 98/2 100/13 100/20 101/19 103/1 103/25 104/14 105/1 108/7 108/14 109/25 111/1 111/4 111/12 112/15 112/19 wondering [1] 114/16 117/20 118/23 147/20
120/10 121/8 123/2 Woolhouse [9] 1/5 123/3 123/6 124/7 \(\quad\) 1/6 1/9 1/10 10/16 126/9 130/12 134/18 \(\quad 72 / 11\) 76/4 130/8 135/1 136/12 139/14 206/3
145/17 147/24 163/11 word [10] 28/12 163/25 164/2 168/3 45/15 45/15 82/5 82/8 168/15 173/3 173/17 \(111 / 21\) 113/13 116/4 176/2 176/19 178/24 \(150 / 19\) 166/21 204/15
Wilson [1] 154/11
window [3] 95/5 95/7 137/24
winner [1] 153/20 winter [9] 150/21
150/24 151/1 199/20 199/24 200/3 200/6 200/20 201/10
wisdom [2] 164/17 167/11
wish [4] 104/4

105/21 106/23 170/21 wishes [2] 105/18 115/21
withdraw [1] 170/5 withdrew [3] 79/15 176/1 204/25
within [22] 13/20
21/7 23/9 23/12 27/3
30/3 30/8 30/15 77/22
84/9 91/17 97/22
110/2 150/18 152/9
183/4 185/14 188/13 189/5 191/12 193/17 195/3
within weeks [1] 150/18
without [17] 11/12 11/13 23/16 44/23
56/11 61/1 102/22
104/21 104/23 123/16
126/15 130/24 145/3
160/23 166/13 166/24 201/8
witness [27] 1/4 1/10 4/14 39/3 79/15 79/17 79/24 86/12 101/1 103/17 103/19 104/13 111/8 114/10 114/14 114/18 115/21 116/17 117/3 121/15 123/1 142/23 154/12 170/6 176/1 176/2 204/25
wolf [1] 38/19
won't [7] 9/15 46/24
79/5 96/15 98/6 109/14 144/11
wonder [2] 48/12 65/11
\(1 / 6\) 1/9 1/10 10/16
\(72 / 11\) 76/4 130/8
words [8] 20/8 68/4
75/20 90/1 97/5 101/8
104/15 145/7
work [50] 12/14
41/25 44/15 45/17
46/8 47/6 53/13 62/22
62/23 62/24 67/13
68/24 77/14 92/16 98/1 99/5 102/9 103/14 103/17 104/19
105/8 111/19 113/9
113/12 118/13 148/19

worked [12] \(5 / 9\)
45/18 50/5 50/8 56/21 62/18 63/3 68/5 70/4 97/24 152/12 185/21
workers [12] 90/19
152/21 187/17 187/24 188/3 188/7 188/11 188/14 188/22 189/6 189/16 189/17
workforces [1] 198/1 working [15] 6/25 22/20 68/2 101/23 113/10 122/19 146/24 177/18 184/14 185/9 190/21 191/10 194/15 195/17 196/24
workings [1] 85/25
workplace [1] 198/10
workplaces [1] 175/1
works [1] 134/16
world [29] 5/14 12/15
12/21 16/9 23/15
24/20 33/25 34/2 34/8 41/19 54/12 64/4
66/11 80/14 85/4
90/16 99/13 105/6
125/7 125/13 125/16
125/19 142/24 148/19
148/23 172/10 172/12 174/2 175/4
worried [5] 15/10
15/11 33/13 37/15 149/19
worry [4] 4/20 72/19 109/16 153/21
worryingly [1] 131/9 worse [4] 23/20 31/11 44/24 134/25
worst [25] 12/4 12/6 12/8 12/10 12/13 16/2 26/21 27/16 27/22 28/22 30/1 30/22
30/23 31/9 31/14
31/18 31/19 32/5
32/16 32/20 33/12
33/17 37/6 37/9 37/17
worst-case [9] 12/6
12/8 27/22 31/9 31/14 31/18 37/6 37/9 37/17
worthy [2] 81/18 85/3 would [177] 6/17 8/2 9/23 10/4 10/11 12/14 12/20 13/7 16/22 17/5

17/25 20/6 20/15
114/21 171/18 20/25 21/5 23/13 24/1 wrong [14] 4/16 24/7 24/8 24/15 29/20 24/15 52/20 81/17 30/12 30/13 30/19 31/11 31/21 31/22 32/21 33/22 35/12 35/14 37/13 38/2 83/6 89/5 98/18 98/23 140/10 140/20 140/21 156/20 158/3 186/10
wrote [4] 56/4 56/5 38/12 39/19 40/1 42/4 81/9 165/13 42/4 43/22 44/16 44/17 44/25 52/9 54/9 55/18 55/20 56/15 56/17 57/8 57/20 61/10 61/14 61/16 61/19 61/23 63/2 69/2 69/11 69/20 69/25 69/25 73/18 74/4 74/7 75/25 76/3 76/5 78/9 78/15 86/5 86/7 91/22 94/9 94/21 95/10 97/19 101/10 102/13 102/14 103/6 103/22 103/23 105/4 107/2 107/20 109/9 113/9 116/19 119/12 121/18 121/21 121/22 121/23 124/14 124/22 125/4 126/3 126/23 126/24 127/24 128/19 128/25 129/3 129/12 132/7 132/10 134/6 134/14 135/13 136/7 138/24 140/2 140/16 143/23 144/4 144/20 144/21 144/23 144/25 145/1 145/2 146/8 146/21 147/1 147/10 147/18 150/25 151/6 151/10 152/13 152/15 152/21 153/17 154/23 158/25 159/20 161/16 164/8 164/8 164/22 166/19 168/5 168/16 169/4 170/5 170/9 170/11 173/1 174/16 175/5 178/10 180/22 180/25 181/7 182/1 183/2 183/9 183/14 184/12 185/4 185/14 185/15 185/23 185/25 186/6 186/21 190/20 190/23 191/3 196/8 200/5 200/23 201/9 202/4 202/12 203/24 204/1 wouldn't [13] 9/19 31/23 32/2 44/16 62/22 62/23 62/24 64/3 67/13 86/3 112/23 115/3 130/25 write [1] 81/13 writing [2] 97/8 121/6 written [13] 91/6 93/25 97/1 97/5 98/5 99/18 100/1 101/14 105/5 106/2 111/18

Wuhan [10] 5/21 5/23 6/7 125/9 125/25 127/6 149/13 151/20 152/13 168/16
Wuhan-style [1] 168/16

X
Xi [1] 143/20
Xi Jinping [1] 143/20

\section*{\(Y\)}

Yardley [1] 103/5 yeah [80] 20/12
80/19 82/14 82/17 83/14 84/16 84/19 84/21 87/5 87/17 89/25 90/6 93/2 93/22 95/9 125/3 126/8 126/14 127/1 127/19 130/18 131/11 131/18 133/1 133/10 134/23 136/17 137/7 137/18 137/23 138/10 139/6 139/19 139/24 140/9 141/16 141/22 142/17 146/20 147/1 147/1 147/8 147/18 150/5 152/6 153/5 153/5 153/9 154/3 154/7 156/10 157/6 157/16 158/2 159/8 159/12 159/14 159/18 161/7 161/15 161/21 161/23 161/25 163/15 164/21 165/5 165/9 165/16 166/4 167/9 167/9 167/15 167/17 167/24 188/21 190/8 190/19 196/23 197/19 200/10 year [7] 1/20 9/5 53/10 58/11 64/21 74/17 177/4
years [6] 8/1 38/19 42/7 46/4 64/12 160/3 Yep [2] 22/17 191/20 yes [127] 1/22 2/7 2/10 3/1 3/8 4/7 5/8 5/11 5/13 6/2 6/22 7/7 7/16 7/21 8/1 8/8 9/25 10/3 10/7 13/9 14/4 14/10 14/19 14/25 15/22 17/13 17/16 18/3 18/24 19/5 19/10 19/12 20/20 20/24 21/16 22/15 23/13

23/18 24/4 24/13 24/19 25/21 26/2 26/13 27/17 28/15 28/16 28/21 29/10 29/20 31/20 34/9 34/24 36/1 36/18 37/24 41/10 43/4 43/6 43/8 43/21 44/7 44/11 45/23 46/18 47/22 47/23 48/6 48/14 48/16 50/10 51/3 51/3 51/7 51/24 52/14 53/17 56/3 57/10 60/4 60/7 60/14 64/11 64/12 64/16 65/9 65/14 67/8 67/15 69/9 71/1 72/3 77/1 78/5 88/20 109/18 132/8 137/16 142/20 147/22 151/18 162/17 163/11 166/23 168/10 170/5 170/11 172/7 174/3 176/16 177/20 180/9 183/2 187/5 187/6 187/9 189/2 189/10 190/4 190/5 191/14 191/18 192/17 195/12 196/8 201/4 205/7
yesterday [1] 24/11 yet [3] 26/25 126/20 128/12
York [1] 168/20 you [777]
you know [17] 12/20 36/8 38/19 41/20 90/12 94/15 94/20 128/1 129/19 134/19 141/9 147/14 149/18 151/19 164/23 168/14 186/5
you on [1] 19/15 you'd [2] 20/10 171/18
you'll [4] 15/8 16/7 18/18 162/12
you're [47] \(1 / 142 / 8\) 9/17 12/9 13/2 13/3 13/16 15/21 19/13 22/24 22/25 24/3 24/17 25/3 25/22 32/11 38/2 39/24 44/11 44/13 45/19 55/14 55/23 60/1 60/16 64/7 64/8 64/13 64/19 67/2 80/22 91/12 93/4 124/6 127/4 130/2 134/24 137/10 155/21 161/24 171/10 177/14 185/17 186/17 195/15 195/16 196/17
you've [55] 6/4 6/9 9/9 17/6 18/8 20/2 23/21 28/12 31/20

38/21 41/2 43/18 45/22 52/22 53/17 54/24 55/4 60/18 65/14 76/16 76/18 79/20 80/1 80/2 89/15 93/11 93/22 93/23 94/6 94/23 94/23 110/16 110/23 131/12 132/12 132/16 134/16 134/21 134/24 153/2 158/20 159/9 167/10 173/23 177/6 178/18 179/15 187/18 191/23 195/9 196/5 196/16 202/25 203/7 203/8 younger [4] 61/11 61/13 61/18 193/24 your [171] 1/8 2/4 2/19 4/14 5/19 6/9 6/19 7/5 8/7 10/11 10/20 11/6 12/1 12/3 13/14 15/17 17/9 22/24 24/16 28/20 30/6 31/4 31/23 32/9 32/14 33/8 34/10 34/14 35/23 36/4 36/13 39/5 39/23 40/8 41/8 44/13 45/15 45/20 46/13 46/20 47/17 48/8 48/23 48/25 49/18 51/21 54/22 55/6 62/6 63/9 63/11 65/7 65/8 65/24 66/23 68/3 68/8 69/14 70/5 70/11 70/23 76/18 76/18 79/6 79/9 79/21 79/22 80/4 81/18 82/19 83/17 86/11 87/18 93/23 94/13 96/19 97/23 99/7 99/10 99/10 101/22 102/19 104/1 111/6 111/9 111/19 112/19 112/22 113/1 113/5 113/6 113/8 113/20 114/10 115/6 115/7 122/16 123/15 127/25 130/7 132/23 136/15 138/18 140/10 140/24 142/8 142/14 146/12 146/13 146/24 148/5 149/1 149/2 149/25 154/1 154/5 155/8 157/1 157/10 158/12 163/17 163/19 167/3 167/4 167/22 169/6 171/6 171/23 173/24 175/25 176/13 176/16 176/25 177/3 177/21 177/23 178/20 179/4 179/4 179/11 179/15 182/10 182/10 182/14 182/16 182/25 182/25 183/21 184/21
\(\mathbf{Y}\)
your... [22] 185/19
185/19 187/22 188/16
191/23 193/13 195/8
195/13 195/15 195/17
196/17 197/1 197/2
197/5 197/15 199/13
199/14 199/18 201/6
201/14 204/18 204/22
your Ladyship [3]
99/7 99/10 102/19
your Ladyship's [1]
99/10
yourself [5] 82/20
112/5 143/5 171/19
188/2
yourselves [1] 82/23
YouTube [1] 171/5
Z
zero [1] 59/20
Zika [1] 80/17```

