IN THE MATTER OF THE INQUIRIES ACT 2005

AND IN THE MATTER OF THE INQUIRY RULES 2006

UK COVID-19 INQUIRY

DEPARTMENT OF HEALTH AND SOCIAL CARE

Ninth Statement of Sir Christopher Wormald

Module 2 Personal Witness Statement

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1. I, Sir Christopher Stephen Wormald, Permanent Secretary of the Department of Health and Social Care, 39 Victoria Street, London SW1H 0EU, will say as follows:

A. Role during COVID-19

2. I make this statement in response to a request from the UK COVID-19 Public Inquiry (the Inquiry) dated 14 July 2023 made under Rule 9 of the Inquiry Rules 2006 asking for a personal witness statement for my recollection of some of the core political and administrative decisions made in respect of COVID-19 between 1 January 2020 and 24 February 2022 and my recollections and views in the role I played as Permanent Secretary in such decision-making.

3. This statement covers the period set out above. Where it is necessary to refer to events outside that date range, I will make that clear and explain why I have referred to that event. As the Inquiry is aware, I have made the following other witness statements for this module on the following subjects:

    a. Third Witness Statement of Sir Christopher Wormald, which addresses 1 January 2020 – 31 July 2020 (CW9/1 - INQ000144792).

    b. Fifth Witness Statement of Sir Christopher Wormald, which addresses 1 August 2020 – 31 July 2021 (CW9/2 - **INQ000253807)**

    c. Eighth Witness Statement of Sir Christopher Wormald, which addresses 1 August 2021 – 24 February 2022 (CW9/3 **INQ000273635)**

4. This statement is to the best of my knowledge and belief accurate and complete at the time of signing. Notwithstanding this, it is the case that the Department of Health and Social Care (the Department) continues to prepare for its involvement in the Inquiry. As part of these preparations, it is possible that additional material will be discovered. Additionally, this statement has been prepared under significant time pressure and while best endeavours have been made to identify all the relevant documents and events, it is possible that some have been missed. In this eventuality the additional material will of course be provided to the Inquiry and a supplementary statement will be made if need be. I shall refer to parts of the corporate witness statements filed on

behalf of the Department where appropriate and necessary. I note that the Inquiry has asked me not to replicate information set out in these corporate witness statements.

5. This statement has been read by the following individuals in final draft format to check only for factual accuracy:

    a. Professor Sir Chris Whitty, Chief Medical Officer for England

    b. Clara Swinson, Director General, Global Health and Health Protection

    c. Jonathan Marron, Director General, Office for Health Improvement and Disparities

    d. Michelle Dyson, Director General, Adult Social Care

Role of DHSC

6. Policy-making in health and social care on an overall and strategic level is led by the Secretary of State for Health and Social Care, supported by the Department. The Department fulfils its functions within a detailed legal framework which places operational decision-making for health and care within a range of statutory bodies, principally (at the time of the start of the pandemic) NHS England and NHS Improvement (NHSEI), individual hospitals and Clinical Commissioning Groups (now Integrated Care Boards). The Department does not directly fund or deliver adult social care which is the responsibility (for publicly-funded recipients of care) of the 153 top tier Local Authorities. Responsibilities for health protection and health promotion were mainly discharged by

Public Health England (PHE), with PHE and the Department sharing responsibilities for planning and managing the response to health protection incidents and emergencies. Full details of these arrangements are set out in my third witness statement, in particular paragraphs 6 and 7.

7. The role of the Department is therefore not to manage the day-to-day operations of the health and care system. The Department supports ministers in setting the strategic direction for the health and care system. Our objectives are delivered in conjunction with our arms' length bodies, and are to help people lead healthier lives, creating a safe, high-quality health and care system that is financially sustainable. As a Department of State, our role may be summarised (as we communicated to departmental staff and set out in the Department of Health Annual Report and Accounts 2016-2017 (CW9/4 - **INQ000279945)**: as

    a. Providing direct support and advice to ministers to help shape and deliver policy to meet the Government's objectives;

    b. Setting the strategic direction for the system, by leading the key strategic debates and linking into the wider government agenda;

    c. Driving accountability, by holding others to account and being held to account by ministers and Parliament;

    d. Acting as the guardians of the frameworks for health and care, including but not limited to legislative, financial, administrative and policy frameworks, designed to ensure the systems work to enable services to be delivered; and

e. Acting as the trouble shooters, who step in and help put things right if the system fails to work as it should.

8. During COVID-19, the role of the Department expanded to make a number of decisions about policy and operations which went far beyond that which would be usual outside of pandemics or other national emergencies. The Department also set up and ran a number of bodies centrally. This was highly unusual and exceptional, and done in order to respond to the need for speed essential during the pandemic.

Background and Career History

9. As set out in my third witness statement to the Inquiry, I have been the Permanent Secretary of the Department of Health and Social Care since May 2016. I first joined the Civil Service in 1991 as a fast streamer at the (then) Department of Education and Science. I worked there until 2006, including in a role as principal private secretary to the Secretary of State for education and skills between 2001 – 2004. In 2006, I became Director General at the Department of Communities and Local Government (now Department for Levelling up, Housing and Communities) where I was Director General of Local Government and Regeneration. In 2009, I became Head of the Economic and Domestic Affairs Secretariat at the Cabinet Office. With the formation of the coalition government in 2010, I took on an additional role as Head of the Deputy Prime Minister's Office until March 2012. I was also head of the Policy Profession between 2012 and 2016, which designs, develops and proposes appropriate courses of action to help meet key government priorities and ministerial objectives.

10. In March 2012, I was appointed as Permanent Secretary to the Department for Education. I held that role until May 2016, when I assumed my current role.

Role of Permanent Secretary

11. In my role as Permanent Secretary, I have overall responsibility for:

    a. Ensuring ministers receive appropriate advice on strategy and objectives for the health and social care system. This will sometimes involve giving advice personally, but more often ensuring that people and systems are in place to ensure the quality of advice given by the wider Department.

    b. Acting as the Chief Executive of the Department, leading and managing the staff of DHSC (totalling 1,815 at the start of the pandemic) and ensuring that Ministerial decisions are implemented (CW9/5 **INQ000279946)**.

    c. Acting as the Principal Accounting Officer of the Department, with responsibilities as set out in 'Managing Public Money' (CW9/6 - **INQ000279942)**

12. In fulfilling these roles, I am supported by the other senior staff of the Department. In particular, Professor Sir Chris Whitty, the Chief Medical Officer (CMO) for England, is an integral part of the management structure of DHSC and a member of the Departmental Board and the Executive Committee (ExCo). His role is set out at paragraph 70 of my first witness statement (CW9/7 - INQ000184643). In brief, the CMO acts as the

UK Government's principal medical adviser, and the professional head of all directors of public health in local government and the medical profession in government. The CMO provides expert, independent advice on behalf of DHSC across government.

13. I should also note, as is set out at paragraphs 73 to 74 of my first witness statement (CW9/7 - INQ000184643), the role of Second Permanent Secretary in DHSC was created in light of the immensity of the task facing the Department. The role was first held by David Williams from 6 March 2020 to April 2021, and is now held by Shona Dunn. David Williams started as the Second Permanent Secretary on 6 March 2020, initially to cover the non-COVID aspects of DHSC. By that time, COVID-19 had become the overwhelming focus of my activity. The Second Permanent Secretary initially led on Finance, Group Operations, and "business as usual". Increasingly, as COVID-19 became the majority of the Department's work, David acted as my deputy across the board.

14. As the Permanent Secretary, my role does not involve making decisions about policy and very rarely will I personally create written advice or intervene on the substance of any advice provided. Such responsibilities are for ministers advised by policy makers and experts within the Department or from arms' lengths bodies. While I am expected to have a good working knowledge of most areas of the Department, I am rarely the expert on any specific area. My role is more often to ensure that advice has been constructed properly, assist other officials in the development of their advice, and help

ministers come to decisions based on the advice provided to them. In practice, the majority of advice on policy areas given to ministers is developed by senior civil servants in the Department. After a particular approach is adopted, it becomes my role to ensure that ministerial decisions are implemented by the Department.

15. On major issues, I would expect to be consulted upon submissions to ministers and contribute to the development and options put. This will normally be via discussion with the relevant director general or other senior staff. However, a distinction should be drawn between matters where I provide a view on the basis that it will be considered alongside other views; and those matters where I have a direct decision to take and expect my decision to be followed in advice to ministers. The latter circumstance usually arises for Accounting Officer matters or matters involving the Civil Service Code or the conduct of government business.

16. I will usually be copied in on all advice to ministers, regardless of whether I had been involved in its development. When this happens, my office will usually read the advice, summarise it, and all of the summaries are put in my daily update. Having read the daily update, I can therefore choose whether or not to intervene in any specific issue. This practice continued throughout the pandemic (for example, see the summary of submissions given on 19 February 2020 or 12 May 2020, (CW9/8 and CW9/9 - **INQ000279885** **INQ000279925** respectively). Where policy developments involve clinical issues, a clinician within the Department would usually be consulted, or an

advisor with clinical expertise. Such clinicians would usually be the CMO or a Deputy Chief Medical Officer (DCMO), but DHSC would also consult experts from arms' length bodies, such as NHS England (NHSE), PHE, or Departmental Expert Committees.

17. I will frequently attend ministerial meetings on key issues, for example where strategy is being discussed, particularly controversial issues, or issues that are under debate with the Cabinet Office or No. 10. My role at these meetings will usually be to help ministers explore the options and identify the consequences and risks of particular actions. Frequently, I try to act as a 'devil's advocate' to ensure all avenues are explored. I am rarely there to give direct advice, unless it touches on Accounting Officer matters or issues to do with the Civil Service Code, but I frequently give opinions as a part of discussion. This process continued during COVID-19.

18. I set out my role during the pandemic in greater detail below, particularly during the period January to March 2020. In summary however, over the course of the pandemic I saw my role as follows:

    a. Managing and leading the Department so it was organised to deliver its pandemic functions, particularly so that it could deliver the Department's battle plan (CW9/10 - INQ0000144792);

    b. Ensuring DHSC Ministers received the right advice at the right time;

    c. Troubleshooting where the system failed to work as it should;

d. Representing the Department across government, including with officials at Cabinet Office and No 10, largely through attendance of departmental and cross-government meetings.

19. Further to my role as Accounting Officer, between 1 January 2020 and 24 February 2022, I was involved in two requests for ministerial directions to be given. As a civil servant, I am obliged to implement the decision of ministers. However, as the Accounting Office for the Department, I am directly accountable to Parliament for public spending. Therefore, I am obliged to seek a written "direction" from the Secretary of State when I am asked to spend money where it does not meet the test of regularity, propriety, value for money or feasibility. These directions are then sent to Parliament. In this case, my directions were because I was going to be authorising spending beyond that set out in the budget of the Department and beyond usual spending controls. The first arose on 28 March 2020, when I requested the Secretary of State to authorise the Department and its arms' length bodies to spend money on urgent coronavirus issues, even if spending would be in excess of formal Departmental Expenditure Limits authorised by Parliament through the estimates process (CW9/11 - **INQ000279919)**. This was granted by the Secretary of State on 29 March 2020 (CW9/12 - **INQ000279920)** Amanda Pritchard, NHS Chief Executive, made a second request for a Ministerial Direction on 7 January 2022 for the Secretary of State to authorise the creation of contracts with independent sector providers in order to maximise the use of independent sector bed capacity across England, in the event that NHS bed capacity became at

significant risk of being overwhelmed (CW9/13 - **INQ000279939)** That Ministerial Direction was granted by the Secretary of State on 8 January 2022 (CW9/14 - **INQ000279941)**

20. As a civil servant, I am obliged to abide by the Civil Service Code which was first issued in statutory form by the Constitutional Reform and Governance Act 2010, and the Civil Service Management Code, published in 2016, which sets out the performance and conduct expected of officials in more detail. This set out the core values of the Service and gives illustrations of the standards of behaviour expected. As I have been a civil servant since 1991, prior to the publication of this code I abided by the same standards. The 2010 Code did not impose any new duties upon me as a civil servant, but articulated and codified the values which I have always recognised to be in place.

B. Structures and Decision-making

21. In my first witness statement (CW9/7 - INQ000184643) paragraphs 61 to 62, 106 to 120, I set out the organisations most material to the Inquiry's consideration which are led by, or formally accountable to, the Department. In my third witness statement, which dealt with the Department's response to the pandemic between January 2020 and July 2020 (CW9/1 - INQ000144792), I set out at paragraphs 6 to 8 the strategic purpose of the Department, at paragraphs 20 to 21 the arms' length bodies relevant to the Inquiry, and at paragraph 22 to 27 information on expert groups relevant to this inquiry who provide advice to the Government and the Department. The Inquiry also

has a document which sets out the senior decision makers in post during the pandemic in relation to Module 2.

Cabinet Office Decision-Making Structures

22. I have been asked to provide a list of any decision-making committees, groups or fo-rums in the Cabinet Office and DHSC dealing with the UK Government's response to COVID-19 which I either (i) attended or (ii) provided advice or briefings in respect of. Additionally, I am also asked a number of questions by the Inquiry about my "role" in various decisions made in respect of non-pharmaceutical interventions (NPIs), and about "advice I gave" or "data I gave". Preliminarily, it must be noted that I was much more involved in the decisions taken around the time of the first lockdown than I was later on, as my role evolved. Prior to the first lockdown, I was a voice in the room at many of key meetings at Cabinet Office and No 10. By the time of the second and third lockdowns, much more extensive decision-making structures had been established (as set out in my fifth and eighth witness statements) and my role reverted back to the more traditional permanent secretary role within the Department.

23. I have been asked a series of questions about the efficacy of Cabinet Office structures and processes in dealing with the response to COVID-19, and my personal views of them. There were three forms of specific "Cabinet Office" responses to COVID-19:

a. *COBR Meetings*: Cabinet Office Briefing Rooms ("COBR") meetings, bringing Ministers and Officials, as appropriate from relevant government departments and agencies, along with representatives from other organisations as necessary. I attended COBR meetings chaired by the Secretary of State on 24 and 29 January 2020; 5, 18 and 26 of February, and 2, 9, 11 and 12 of March.

b. *Ministerial Implementation Groups Meetings* ("MIGs"): The Cabinet Office decided to create Ministerial Implementation Groups (or MIGs as they became known) to make decisions about various aspects of the pandemic response. Four were established to support COBR from 17 March 2020. The MIG system continued until 29 May 2020. These were ministerial meetings. I attended one Healthcare MIG (HMIG) meeting on 22 March 2020. Often, however I was involved in pre-briefs for MIGs, generally with the Secretary of State.

c. *Cabinet Committee Meetings:* The MIG system was replaced with two Cabinet Committees, COVID-Operations ("COVID-O") and COVID-Strategy ("COVID-S") (CW3/77 and CW3/78 - INQ000106454; INQ000106455). The COVID-O and COVID-S model of collective decision-making remained in place until March 2022 and February 2021 respectively. I did not attend many COVID-O or COVID-S meetings (CW9/15 and CW916 – INQ000090171; INQ000090180), but again attended pre-briefs, generally with the Secretary of State.

24. Additionally, from 2 March 2020, COBR meetings were supplemented by regular, often daily, COVID-19 meetings chaired by the Prime Minister, with the Deputy Prime Minister deputising when the Prime Minister was unavailable.

25. In my opinion, one of the key learning points of the pandemic, is that the Government needs standing structures that go beyond COBR for managing ongoing as opposed to incident related crises. COBR is an efficient system for an initial response to an emergency, or for an emergency which is short lived-in nature – for example, the Salisbury poisonings in 2017. However, it is not in my view well-suited for longer term crises, such as a pandemic. It is not designed for, nor is it appropriate for long-term decision making.

26. On the other hand, while the MIGs brought a clear structure and I supported their creation at the time, that structure had drawbacks. Decisions were often divided into silos which were not truly cross-governmental and it was not always clear whether the decisions bound the whole government or not. Often, they were not chaired independently and could be seen as partisan. For example, the healthcare committee, HMIG, was chaired by the Secretary of State (CW3/75 and CW3/76 - INQ000106236; INQ000106237). This gave rise to concerns that the Secretary of State was effectively 'marking his own homework' when he chaired the meetings and reviewed the preparedness of the NHS. Ultimately, the MIGs did not work in practice.

27. As a consequence of difficulties in the MIG system, the Cabinet Office set up Cabinet Committee meetings, COVID-Strategy (COVID-S) and COVID-Operations (COVID-O). These committees took the main decisions on COVID-19 and considered whether legislation should be introduced and why. While the committees handled "set-piece' decisions, day-to-day management of COVID-19 continued to be handled by the Prime Minister and his team through meetings at No 10. In my view, these decision-making structures operated well, and were able to reach rational decisions quickly and efficiently. It was more effective to have a cross-governmental structure and function which operated centrally, allowing decisions to be made swiftly and integrated across government as needed. COVID-O and COVID-S may be an attractive blueprint to follow for future crisis-response decision-making structures for issues that go beyond what the COBR structure was designed for.

28. I am also asked whether the Prime Minister's style had any influence on structures of decision-making. As noted above, major decisions on strategy – such as when to impose and lift national lockdowns had to in the end be taken by the Prime Minister. My observation of his decision-making is of course partial. From what I observed, the Prime Minister disliked formal meetings and preferred to develop his thinking iteratively via a series of meetings with his advisers, Cabinet Ministers, senior scientists and others. From my perspective, he seemed to take the views of the CMO and the Government Chief Scientific Adviser (GCSA) very seriously. Formal decisions were then taken in Cabinet or a Cabinet committee at the end of this process.

DHSC Decision-Making Structures

29. Under the Civil Contingencies Act 2004 (CCA), the Secretary of State was identified as the designated responder and DHSC was identified by the Civil Contingencies Secretariat (CCS) as the Lead Government Department (LGD) for pandemic preparedness, response, and recovery. As I stated in my evidence to the inquiry in Module 1, the Department is legally the emanation of the Secretary of State, so in almost all cases the legal powers of the Department are vested in the Secretary of State personally, but are discharged by the Department. The emergency response and decision-making structures were identified in my third witness statement, at paragraphs 38 to 52.

30. I have been asked to consider whether the DHSC structures and processes for dealing with emergencies worked effectively in dealing with the coronavirus emergency. In my personal capacity, I sat as a member of the DHSC Departmental Board, which acts as an advisory board to the Secretary of State and I chaired the Department's ExCo, which oversaw the management of the Department.

31. As I emphasised in my evidence to the inquiry for Module 1, the basis of departmental decision-making is the submission system to the Secretary of State (decision-making by submission occurs where civil servants provide formal advice and request sign-off for decision in a 'submission' or written document). From my perspective, this practice continued throughout the pandemic without issue. In my view, decision-making within

the Department worked well in general and was guided by the battle plan (discussed further below). The rigour of decision-making by submission was maintained.

32. During the initial stages of the pandemic, the Operational Response Centre (ORC) had sole responsibility for providing system-wide leadership for emergency preparedness and response to COVID-19. As explained in third witness statement at paragraphs 39 to 46, the role of the ORC transitioned between three phases of operation as the Department's understanding of COVID-19 developed. Initially, ORC was the sole manager of the response (Phase 1), before providing coordination across a number of workstreams across the Department (Phase 2), and eventually transforming into a whole departmental response (Phase 3). The second phase was moved to in mid-February 2020 and the third phase on 4 March 2020.

33. As described at paragraph 77 of my third witness statement, a Gold structure was implemented in the Department on 11 June 2020 to review data from the JBC to provide oversight of operational decisions around local lockdowns, and to further escalate issues which had been escalated which required national decisions (CW3/80; CW9/17; CW9/18 - INQ000106468; **INQ000279927** **INQ000279926)**. Weekly Gold meetings (also known as Local Action Committee meetings) were chaired by the Secretary of State and covered the latest epidemiological briefing and assessment; assurance for containment action underway; discussed the implications of any trends identified; and proposed issues to raise with the Cabinet Office and Prime Minister on a weekly basis

(CW3/80 to CW3/82 - INQ000106468; INQ000106471; INQ000106469). Final decisions were taken by ministers following recommendations to COVID-O and COVID-S. These meetings remained in place throughout the period with which the Inquiry is concerned.

34. Alongside the Gold structure there was also a Silver structure chaired by the CMO which agreed the key messages to be put to the Gold meeting. These meetings took place regularly and were backed by extensive data packs which gave a very clear picture of what was happening in local areas. I exhibit examples from two meetings on 20 August 2020, one of which focused on the North of England, and a meeting on 1 January 2021 [CW9/19 to CW9/25 - **INQ000279930** **INQ000279928** **INQ000279929** **INQ000279931** **INQ000279937** **INQ000279936** **INQ000279938**]. I considered the meetings themselves to be clear, informed and data driven. In retrospect we could have set up such meetings earlier, disconnected from local lockdown or tiering decisions.

35. The ORC process was effective at providing relevant, timely information to decision-makers in the Department. However, from 2 March 2020, when the Prime Minister first chaired COBR, it became clear that decision-making concerning the response to COVID-19 went beyond what DHSC alone could do. Both the size of the crisis and the decisions needed to be taken went well beyond the remit of DHSC, including economic and domestic policies, and the dominant issue of foreign affairs. From this point most

key decisions were taken on a national, cross-governmental level. This was both inevitable and necessary as the response required the whole of government and the whole of society to make decisions. Whilst DHSC continued to lead on the health and social care aspects of the response, decisions about the national strategy were made by the Prime Minister and via collective Cabinet decision making. As a consequence, the LGD structure fell away.

36. Perhaps reflecting this outcome, I am asked whether the LGD structure worked effectively as part of the COVID-19 response. In my view, there are a variety of perspectives available on this. In theory, the alternative to an LGD structure would be a centralised crisis preparation and management function. A possible advantage of such an approach would be that a centralised function could assist in maintaining focus, and therefore resources, on crisis preparation during peace-time. Additionally, it could facilitate skill transfers between different sectors and the development of a cadre of specialist crisis managers. On the other hand, it would risk crisis preparation being siloed as 'someone else's problem' and arguably disincentivise crisis preparation within departments. Equally, it could create dual reporting lines for front-line services, such as hospitals and potentially devalue or diminish the sector-specific knowledge needed in dealing with some aspects of crises. In the case of the COVID-19 pandemic, it was evidently crucial, for example, that that the people who planned and implemented the regulatory approval and roll out of vaccines had prior experience of vaccination programmes.

37. While the case is arguable, in my view, unless the gains were shown to be significant, retaining and improving the LGD system should be preferred given the cost and disruption the creation of a centralised crisis preparation system would cause.

38. A more important lesson to be learned from the pandemic, however, is the demonstrated need for an escalation system when a crisis moves from being a discrete emergency event, to an ongoing national crisis. Over the course of the pandemic, this clearly emerged as the most important missing piece from our emergency response architecture. All our crisis systems – LGDs, Local Resilience Forums (LRFs), COBR, the CCS, Scientific Advisory Group for Emergencies (SAGE), the CCA – were predicated on short term, event response. For those circumstances, these systems have proved themselves effective in the early stages of COVID-19 and other emergencies. They are in my view much less well suited to crises that play out over months and affect every aspect of society. For those types of situations, it is only the Prime Minister that can provide the visible national leadership required and make the trade-offs between competing public interests. In the case of COVID-19, these trade-offs required complex balancing exercises between health issues and wider societal and economic effects. The structures to assist the Prime Minister in doing this – for example COVID-S, COVID-O, the COVID-19 Taskforce (see my third witness statement, paragraph 76 and paragraphs 233 to 235) had to be invented during the crisis. The COVID-S and COVID-O structure was modelled on the EU Exit Strategy (XS) and EU Exit Operations (XO)

Cabinet committees in place for EU exit. The LGD approach is not conducive to the replication of these systems or the escalation to a cross-governmental response. It would be beneficial to have a standing escalation function, to be used when a national emergency – such as a pandemic – is so large that it goes beyond the capacity of an LGD either because of its scale or because it goes beyond the remit of a single department.

39. Finally, in terms of government structure, I would make one final point regarding the LRF system. LRFs were effective as a medium for coordination between local players, information exchange, and for responding to immediate crises. However, they were not designed for or adequately resourced for conducting long-term local management and lacked executive oversight powers. In my view, too much weight was put on the LRF system which was not resourced to carry out executive functions over a long period of time.

Remit of DHSC

40. In April 2020 there was discussion with the Cabinet Secretary about seeking to spread work on pandemic response across government so that the whole burden did not fall solely on DHSC. This included having the Vaccine Task Force (as discussed at paragraph 58 of my fifth witness statement) led by Department for Business, Energy and Industrial Strategy (BEIS), and involving the Department for International

Trade and the Foreign Commonwealth & Development Office in personal protective equipment (PPE) procurement.

41. We also received considerable help from the military on some matters falling within the DHSC remit, particularly command-and-control systems, logistics and the Nightingale Hospitals. I discuss military assistance during the pandemic at paragraph 303 of my third witness statement. The Nightingale Hospitals are likewise discussed at paragraphs 162 to 163 of that statement.

42. There were also a number of debates about which areas should report direct to the Prime Minister rather than via the Secretary of State – particularly around Test and Trace and PPE procurement. These questions were in my view more to do with Ministerial direction and accountability than the Department, as DHSC continued to provide the staff, accounting officer functions and accommodation for both programmes.

43. I was not involved in any other discussions about any general division of the remit of DHSC.

Cabinet Office and DHSC Relationship

44. I have been asked if the relationship between the Cabinet Office and DHSC worked effectively during the pandemic. The honest answer is that it was varied. The

relationship between officials at the Cabinet Office and the Department was always good, and we were always able to have constructive discussions and debates. I had two emerging concerns, the first being that it was not always clear where decisions were made, particularly in the period preceding the introduction of COVID-S and COVID-O. Secondly, the duplication of queries from the Cabinet Office created some difficulty. I was concerned at points that the valuable time of key DHSC staff, for example in procurement, was being taken up by having to explain to Cabinet Office staff what was going on. This was obviously inefficient and unproductive.

45. I raised my latter concern in WhatsApp exchanges with both the Cabinet Secretary and Tom Shinner on 25 March 2020 (CW9/26 and CW9/27 - **INQ000279918** **INQ000279917)** My concerns were at their highest in April 2020 and declined after more rigorous systems were established.

46. At the political level, I would describe the relationship as more “up and down”. There were well-documented tensions between the Secretary of State and No. 10 political advisors, and between these political advisors and civil servants (including the Cabinet Secretary). In my view, the conflicts and tensions were time-consuming and consequently affected the efficiency of the Government’s response. However, I think it is easy to exaggerate their actual effect on decision-making or strategy. I am doubtful that any personality conflicts affected either the timing or the substance of decisions taken on NPIs in March 2020. I am doubtful that personal tensions had any effect on

the decisions reached for subsequent national lockdowns, although I had less insight on the decision-making process as opposed to genuine differences of opinion on strategy.

Formal and Informal Decision-Making

47. I have been asked to consider to what extent key decisions during the pandemic were made outside of formal government processes, for example during informal and non-minuted meetings and WhatsApp. Working in government has always involved informal discussions between ministers, special advisers and officials when making decisions – whether in parliament, in one-to-one discussions, by phone or in the margins of formal meetings. This long predates digital communication. During the pandemic, WhatsApp and similar systems were likewise used extensively to share information and have informal discussion. This was partly for speed and partly because face-to-face contact – and thus the more traditional routes for informal discussion – were obviously limited by social distancing and lockdown requirements.

48. However, there is an important distinction to be drawn – whether communication is digital or not – between formal decision-making and informal discussion. The former should be by written advice and response or in minuted meetings, with the results retained on file and in an auditable form. As for the latter, it is the substance of the discussion that is important not the medium it is communicated by. I do not therefore view WhatsApp or similar platforms as an inappropriate way to share information or

discuss things informally any more than I do a conversation in the margin of a meeting. In some ways, it is evidently more transparent as it leaves a record, which an everyday conversation or phone call would not. Equally, if informal communication – whether digital or traditional – were to replace written advice and formal decision-making meetings I would also consider that a problem.

49. I think that the record of formal submissions to ministers set out in the DHSC corporate statements for Module 2 demonstrates that this was the case throughout the pandemic. I believe I have retained all texts, WhatsApps and emails on all devices with Ministers, decision makers and other the individuals about whom I have been asked.

Special Advisers

50. I understand that Special Advisers are expected to follow the Code of Conduct for Special Advisers (CW9/28 - **INQ000279948)** Special Advisers can be exceptionally helpful to an official, enabling ministers to give strategic advice on policy and on operating with and assisting, for example, with parliamentary colleagues or the media on policy issues. However, whilst it is their role to provide advice to ministers, it is not their role to direct government policy or to direct civil servants.

51. Within DHSC, Special Advisers performed their traditional role of advising ministers and worked well with the Civil Service. I can recall no instances where I was concerned

about the role of advisers becoming blurred in DHSC. My observations of advisers in No.10 is of course much more partial. It appeared to me that there was some blurring of the lines in No. 10. In particular, I expressed frustration in WhatsApp messages to the Cabinet Secretary that there were Special Advisers attending SAGE meetings (CW9/29 - **INQ000279915)**. In my view, this was inappropriate because those meetings were not intended to be a forum for politicians or officials, save for those who take minutes. While I did not attend these meetings and cannot state to what extent Special Advisers were involved in discussion, their presence gave rise to a risk that there would be at least the perception of inappropriate political interference in the provision of scientific advice.

Information Sharing

52. I have been asked a number of questions about key areas which worked well and whether there were issues, obstacles and missed opportunities to deal with the adequacy of information, information-sharing, co-ordination, strategy and planning.

53. In respect of information sharing, the biggest issue for the Department, and across government, was knowledge about the disease itself and the creation of data about its spread. While this is to some extent inevitable with a new disease about which little is known, our weaknesses in testing infrastructure meant we were slower than other countries in being able to track the spread of the disease and were more reliant on

hospitalisation and death data, which are of course lag indicators. As our testing architecture ramped up, our ability to track the virus improved markedly. A secondary problem was being able to bring data together in one place in an easily accessible form. This again improved markedly with the creation of the No. 10 Dashboard, a standardised presentation of data at meetings at No.10, that helpfully illustrated data from across government in a helpful and accessible manner.

Removal of Individuals from Posts

54. I am asked whether I was aware of any plans to remove individuals from posts, in particular the Secretary of State for Health and Sir Simon Stevens, who at that time was the Chief Executive of NHS England. I do not recall being consulted on any proposal to remove or reshuffle the Secretary of State. I would not normally be expected to be consulted on such a decision. I am sometimes asked for feedback on ministers by the Cabinet Secretary or others, asked for views on ministerial portfolios, and I am occasionally given advanced warning of reshuffle thinking or that one is imminent (CW9/30 - **INQ000279935)** I do not recall a reshuffle involving the Secretary of State being discussed with me until he resigned from post on 26 June 2021.

55. There was a discussion, which predated the arrival of COVID-19, about when Sir Simon Stevens should end his term of office, having been in post since 2014. These discussions involved the Chair of NHSE who had discussed the question with Sir

Simon Stevens without reaching a final conclusion. Prior to the pandemic being declared, I recall being involved in a discussion on this subject with the Prime Minister, the Secretary of State and Dominic Cummings, but I am uncertain as to when it occurred, possibly in the margins of the stocktake meeting on 4 February 2020. The conclusion was that the timing of any departure of Sir Simon Stevens should be by mutual agreement. I do not recall any further discussion to which I was party about removing Sir Simon Stevens from office during the pandemic.

Public Health England

56. I am asked a series of questions about the effectiveness of PHE. I discuss PHE's role in my third witness statement at paragraphs 6, 79 to 112, 149, and 176 to 301 and in my fifth witness statement at paragraphs 16 to 31. Overall, PHE made, in my view, a significant contribution to the pandemic response and its staff acted with diligence, commitment and professionalism. It was particularly strong in the scientific response to the pandemic, for example in its work developing early COVID-19 testing.

57. However, with hindsight, I believe that the creation of PHE in 2013 was a mistake. It is better to have an organisation – like the Health Protection Agency pre-2013 and UKHSA now – whose primary focus is on health protection as opposed to the full spectrum of public health issues, given the different skill sets and organisational cultures involved. As was described by a number of witnesses in Module 1, public health had faced a decade of very challenging funding settlements. As a consequence, PHE had

great difficulty scaling up operations. This pushed PHE's focus to delivering existing services more efficiently as opposed to developing new approaches in health protection or elsewhere. It was also often seen, again often unfairly, as the symbol of 'nanny state' approaches to Government amongst some public commentators. For these reasons I believe many of the criticisms made of PHE were unfair.

58. On the other hand, while some issues were not of PHE's own making, there were also areas in which PHE faced challenges. My impression was that PHE was often perceived as reactive rather than proactive in COVID-19 response and ministers felt it sometimes failed to show leadership during the pandemic. While PHE was facing resourcing restraints which, understandably, any organisation would have found difficult, some ministers had the impression that PHE lacked the necessary urgency and ambition to scale up testing quickly. This, to my mind, was central to ministers' decision first to drive testing expansion from the Department, remove testing responsibility from PHE, and then to establish a separate Test and Trace function under separate leadership.

59. Further, as NHS Test and Trace became more and more central to local public health strategies it became increasingly difficult for the two organisations to run in parallel – despite the considerable efforts of their leaderships.

60. Ultimately, while many individuals in PHE were rightly highly regarded by ministers, the organisation as a whole struggled to win and retain the confidence of ministers. In my view, this explains in part why the Joint Biosecurity Centre (JBC) was established, as well as the reasons already identified above. The JBC drew on the extensive wealth of expertise that the PHE already had but was better able to forge a trusted relationship with ministers. At the same time, while Duncan Selbie did not agree with the decision to create what became UKHSA, once it was made, he and the leadership of PHE implemented the decision with the upmost professionalism.

61. The Office for Health Improvement and Disparities (OHID) was set up following the disestablishment of PHE. The corollary of re-establishing a health-protection focussed organisation was that a new approach was needed for health improvement. It was the Secretary of State's decision to set up OHID, so that DHSC would have direct responsibility for and oversight of health improvement. It was also given a particular focus on health inequalities.

62. I have also been asked to consider why a surveillance operation was not launched by PHE earlier than mid-February. My understanding is that surveillance was being conducted prior to mid-February, but the real challenge was scaling up surveillance.

63. In summary, my view is that there was good cause to close PHE and create a new organisation with a primary organisational focus on health protection in the form of UKHSA, even if all of the criticisms levelled against PHE were not always fair. The speed of its establishment was driven by the operational need to have an integrated public health and test and trace system in place as soon as possible in the pandemic.

C. Initial Understanding and Response to COVID-19 (January 2020 – March 2020)

64. I have set out in some detail the Department's response (including those of its arms' length bodies such as PHE) to COVID-19 between 31 December 2019 and the decision to "lockdown" made on 23 March 2020 in my third witness statement at paragraphs 78 to 126, and I will not repeat that chronology in this witness statement. I set out my understanding of pandemic planning before and in January 2020 in my first witness statement (CW9/7 - INQ000184643) in paragraphs 224 to 416. I also gave evidence on 19 June 2023 at which I discussed pandemic preparation and planning.

65. I also set out in some detail the state of knowledge about the transmissibility of the virus in my third witness statement at paragraphs 147 – 152. I have nothing further to add to that chronology, as my understanding was informed by and limited to that set out within that documentation. I will instead focus on my role and recollections of the key events in which I was personally involved.

66. My overall observations on decision-making in this period are as follows:

a. Throughout this period, decisions had to be made in the context of circumstances that were rapidly changing and when there was generally a lack of information about the disease and the societal consequences of NPIs, or information was otherwise imperfect and evolving. As a consequence, many of the decisions reached were inevitably judgement calls.

b. The Government was also frequently in the position of needing to make choices in circumstances where there were no good options available and were instead seeking to choose the least bad of unattractive options. This is most pertinent in relation to the decisions on what social restrictions or lockdowns to implement and when. It was, I believe, well understood that all options would do harm, either through the spread of the disease if restrictions were light, or through the wider social, economic, and health consequence if the restrictions

were heavy. Quantifying those effects in advance was either impossible or carried very wide levels of uncertainty.

c. The structure of the Government in the UK means decisions are reached and policies often progressed by the departments advancing different, and sometimes conflicting, positions on particular issues. In the context of the pandemic, DHSC often put more weight on health considerations while the Treasury emphasised the fiscal and economic consequences of particular courses of action. In the end, it was only the Prime Minister who could weigh up where the public interest best lay and those decisions were often finely balanced.

d. While the traditional structures of government decision-making offered a useful starting point for coronavirus response, they struggled to cope as the pandemic progressed. As new systems evolved, decision-making inevitably became strained and sometimes lacked structure. Nevertheless, the decisions ultimately reached were rational given what was known at the time and the voices of scientists were suitably prominent. In this regard, I would distinguish between decision-making structures being painful and taking the wrong decisions.

e. Despite disagreements on strategy and policy, the guiding focus of key decision makers was to minimise deaths and prevent the NHS being overwhelmed. The key points of debate were how to do this while minimising wider social and economic harm.

f. Even with hindsight it is difficult to conclude whether lockdowns were introduced too early or too late or whether they were used too extensively or not enough. Opinion remains divided on those points.

g. When the decision was reached to introduce a legally-enforced (as opposed to voluntary) lockdown, it set a precedent that future lockdowns would likewise be legally-enforced. Having adopted that approach, it became difficult, in my view, to return to a voluntary framework as an expectation was set that future lockdowns would be underpinned by legal enforcement.

67. I now turn to my personal involvement in decision-making from January to March 2020. I will not repeat the evidence presented in my third witness statement but will focus on my personal role at the key decision points.

January 2020

68. I am specifically asked how familiar I was with the UK's preparedness plan in the event of a pandemic, in particular the key lessons learned from Operation Cygnus prior to January 2020. My familiarity with UK preparedness was discussed at length in my evidence to the Inquiry for Module 1, which I will not repeat here. However, I will note that I was familiar with the conclusions reached in the Exercise Cygnus Report in terms of the UK's preparedness and response, the programme of work that followed Cygnus,

and the workstreams that were actioned. Generally, preparation for the pandemic had been conducted on the basis of a flu outbreak which substantially shaped our initial response.

69. I first became aware of official concerns about a novel virus on my return from leave on 6 January 2020. I believe it was first mentioned to me by the CMO at my weekly senior staff meeting on 6 January 2020. My daily update first included news of a "suspected novel coronavirus" in Wuhan, China on 9 January 2020 (CW9/31 - **INQ000279871)**. However, at that point, I only understood the outbreak to be something we should keep an eye on. My personal involvement escalated on 20 January, when I chaired a DHSC officials meeting with the CMO, DCMO, the Strategic Incident Director and colleagues from PHE and NHS England – chaired by myself (CW3/92 - INQ000106057). At that meeting I had requested to receive the latest update covering trigger points, proposed responses, screenings, and the actions that had already been taken by the United States

70. I am unaware of what information the Cabinet Secretary or others in No. 10 put before the Prime Minister during this period of time, and I am therefore unable to comment as to what extent the Prime Minister reacted "appropriately" in January 2020 to the news of the epidemic in China.

71. From 20 January 2020, responding to COVID-19 was a significant and increasing part of my role. Daily, I received information known as "SitReps" which set out various forms of data about the number of infections, the number of patients in hospital etc (for example, see SitRep dated 23 January 2020 CW9/32 - **INQ000279874)** and SitRep dated 23 February 2020 CW9/33 - **INQ000279886)**

72. After 20 January 2020, I chaired regular meetings with the CMO, DCMO, the Strategic Incident Director and colleagues from the PHE and NHSE on the "Wuhan Novel Coronavirus" (see DHSC's chronology for Module 2). On 21 January, matters were discussed regarding port health measures, triggers for stepping up and down port health measures, and public communications (CW3/93 - INQ000106058). Off the back of that meeting, I became involved in drafted advice to the Secretary of State on proposed port health measures. Following changes in other countries' positions, and advice from the CMO, PHE, and the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG), the Secretary of State agreed with the recommendation to implement a package of port health measures and enhanced monitoring. These measures were announced and adopted on 22 January 2020.

73. On 22 January the Secretary of State made a request for a COBR meeting to discuss the evolving situation (CW9/34 - **INQ000279873)** I was asked by him to raise this with the Cabinet Secretary, and I exchanged messages with the Cabinet Secretary on this point (CW9/35 - **INQ000279872)** I would describe the Cabinet Secretary as being initially reluctant to raise the matter to a COBR meeting on the basis that it did not yet meet the criteria for one to take place. However, after the point was pressed, the Cabinet Secretary swiftly accepted that it should be held on 24 January 2020.

74. At the COBR meeting on 24 January 2020 (CW9/36 to CW9/39 - INQ000056200; INQ000056207; INQ000056161; INQ000056214), the CMO began by providing an update on the global situation and outlining five possible scenarios for the development of the outbreak. Additionally, the CMO summarised SAGE advice that there was no strong scientific rationale for screening based on a person's symptoms or temperature as a large proportion of infected persons would likely be missed. At that meeting, I summarised a paper presented by me on UK escalation triggers and response options (CW9/40 and CW9/41 - **INQ000279876** **INQ000279877)**. In brief, the paper anticipated a range of actions that would be triggered if the situation escalated, aimed at responding to the spread of the virus and controlling changes to public opinion. As for next steps, it was agreed that DHSC would coordinate the Four Nations advice for student populations and manage the manner for which cases were reported and data shared with the Devolved Governments. From my personal recollection this was a

calm, well run meeting in which the COBR process ran properly and clear decisions were taken. At this point chairing of these meetings was by the Secretary of State (as opposed to the Prime Minister), which seemed to me to be appropriate. The mood was sombre as many of the attendees were engaging with these issues for the first time.

75. I attended a following COBR meeting which took place on 29 January (CW9/42 to CW9/45 - INQ000056164; INQ000056165; INQ000056163; INQ000056226). A current situation update was provided by the CMO, and assisted departure plans, reasonable worst-case scenario (RWCS) planning and communication and parliamentary handling were discussed. It was agreed that DHSC would share with the Devolved Governments legal advice regarding options for isolating passengers from chartered flights. Additionally, it was agreed there should be a clear communications plan, with communications being led by DHSC with No.10 input where needed. I have nothing to add to the official record of this meeting from my personal recollection.

76. I have been asked about the Government's priorities at the end of January 2020 and where COVID-19 fell within this. At this point, the Government's priorities corresponded to the commitments made in its manifesto during the election campaign of December 2019 (CW9/46 - **INQ000279875)**. Additionally, the minutes of the Departmental Performance "stocktake" meeting with the Prime Minister on 4 February 2020 (CW9/47 -

INQ000106093) give a clear description of the health and social care issues that were at that point on top of the Ministerial agenda:

a. To recruit 50,000 additional nurses by autumn 2023, overhaul nurse training, and improve retention within the healthcare system in general.
b. To recruit 6,000 GPs and deliver an additional 50 million GP surgery appointments each year.
c. To begin construction on the ground of 40 hospitals by March 2024.

77. Unsurprisingly, whilst there were manifesto commitments in respect of public health, there was no particular commitment in respect of pandemic response.

78. On 30 January, the World Health Organisation (WHO) declared COVID-19 to be a public health emergency of international concern (CW9/48 - **INQ000279878)**

February 2020

79. On 4 February I attended a stocktake meeting with the Prime Minister, the Secretary of State and others on DHSC Departmental Performance (CW9/47 - INQ000106093). This was a general stocktake meeting, so COVID-19 was not the focus of the agenda. However there was an update from the CMO about the current state of play at the beginning of the meeting. As far as I know this was the first oral briefing the Prime Minister received from the CMO.

80. I have looked at the minutes of this meeting (CW9/47 - INQ000106093) and I recall there also being a discussion about possible fatality numbers. I recall the CMO advising that on the basis of current figures of spread in other countries, there could reasonably be between 100,000 to 300,000 deaths in the United Kingdom. I discussed this figure further with the Cabinet Secretary after this meeting, via WhatsApp (CW9/**47A** - **INQ000292665**). The exchange also notes that others in the meeting including the Secretary of State had used higher numbers. My recollection of the conversation is that the Prime Minister was very much in listening mode. While I do not recall his exact words, I do remember him noting (correctly) that particularly high fatality figures had been given for previous incidents, such as BSE and swine flu, which did not materialise. My overall recollection of the meeting was concern mixed with a level of scepticism. I am unaware whether No. 10 did anything with the advice given immediately after this meeting, save that I am aware that the CMO and the GCSA met with Dominic Cummings at around the same time. I don't know what was discussed at that meeting as I was not there and was not provided with any minutes of it.

81. I attended a further COBR meeting held on 5 February (CW9/49 to CW9/54 - INQ000056167; INQ000056168; INQ000056149; INQ000056148; INQ000056157; INQ000056215). The CMO presented the latest evidence on infection and fatality rates, based on limited information from China. The CMO further observed that the

"*two most high-risk groups appeared to be the elderly and those with pre-existing illnesses."* A discussion was led by the CMO on options for limiting transmission. Having regard to advice from SAGE it was estimated that "*that if the UK reduced imported infections by 50 per cent, it was expected that the onset of any epidemic in the UK by would be delayed by about five days; if this was increased to 75 per cent it would be delayed by ten days; to 90 per cent 15 days and 95 per cent plus delayed for potentially a month.*" It was agreed that the UK borders would not be shut, but that all measures would be kept under review. I contributed on the plans to isolate UK nationals arriving from Wuhan and DHSC was actioned to collaborate with relevant government departments, local authorities, and the Devolved Governments on communications planning regarding a second UK assisted departure flight. Priorities were further set out for RWCS Planning, led by the CCS (CW9/51 - INQ000056149). These priorities included to minimise serious illness and death, reduce spread through reducing mass gatherings and travel, and developing support measures for primary care workers and patient triage planning, including NHS surge activity. Other than those noted above I have no additional recollections to add to the official readout of the meeting.

82. On 6 February 2020, I chaired the Department's ExCo which considered the models for managing DHSC's response (CW9/55; CW9/56; CW9/57; CW3/11 - **INQ000279881** **INQ000279882** **INQ000279880** INQ000106136). A three-phased approach to COVID-19 was agreed, involving only the ORC in phase 1,

the ORC and some of the Department in phase 2 and the entire Department in phase 3, (CW3/11 - INQ000106136). The second phase was moved to in mid-February 2020, and the third phase moved to on 4 March 2020. This discussion reflected my and others growing concerns about the impact of the virus on the Department's work. At this time, a scenario where the outbreak was contained in China was still seen as a realistic possibility and it was not yet assumed that a pandemic was inevitable. Nevertheless, the discussion was a turning point in our consideration of DHSC model of response, becoming increasingly a whole Department response rather than something just done by the ORC.

83. On 11 February 2020, I chaired a meeting to consider the response to COVID-19 in adult social care (CW9/58 - INQ000049363). I recall this meeting arose from my concern that there had been less focus in discussion on adult social care than on the NHS. The minutes of this meeting make clear that the model we were working to at the time was a primarily local authority-led (LA-led) response with national support. This was in line with both the legislative framework and the arrangements set out in the Flu plan (as well as the Secretary of State's steer). I further raised queries as to whether any new powers were required to manage the response in care homes and what legislative changes would be required to support the LA response. My recollections of this meeting are two-fold. First, at the time the locally led approach being undertaken seemed like the logical way forward. In retrospect, the locally led approach to the social care

system was demonstrated to be insufficient for the scale of the challenge and we adopted increasingly nationalised approaches to social care as the pandemic continued. Second, I remember being concerned about the ethical questions that were raised by approaches to social care and the lack of infrastructure to consider ethical issues – hence the commissioning of an ethical framework for adult social care (CW3/402 - INQ000106252).

84. On 11 February 2020 and 13 February 2020 (CW9/59 - **INQ000279883** I chaired meetings on the proposed publication of the Coronavirus Action Plan. It was agreed that a public facing document should be developed for public reassurance, following the same structure as the existing national pandemic flu plan. It was agreed that the Plan would coincide with the publication of the Coronavirus Bill. My office was specifically tasked with working with the Devolved Governments.

85. On 18 February 2020 I attended a meeting of COBR, focussing on domestic preparedness for COVID-19, including a discussion on the preparation of the Coronavirus Bill and additional steps needed to prepare for RWCS planning (CW9/59 to CW9/65 - **INQ000279883; INQ000056170; INQ000056171; INQ000056150; INQ000279884;** INQ000056227). It was determined that a detailed agenda of decisions and actions for the following twelve weeks was required in light of an estimated peak in three months.

While it was accepted that reliance would be placed on the voluntary sector to pick up aspects of social care provision, concerns were raised that there could be exploitation of vulnerable people who had not been suitably checked by the disclosure and barring service. I have nothing to add to the official record of this meeting.

86. On 26 February 2020, I attended a meeting of COBR for which a SitRep was provided, and matters were considered regarding schools, public order and communications (CW9/66 to CW9/69 - INQ000056174, INQ000056152, INQ000056151, **INQ000279887** It was agreed that guidance would be created for schools and educational establishments. SAGE presented a report on the risk of public disorder in a COVID-19 RWCS (CW9/68 - INQ000056151), emphasizing the need to (i) provide clear and transparent reasons for different strategies, (ii) set clear expectations on how the response will develop, and (iii) promote a sense of collectivism. DHSC was actioned to prepare a plan for communicating with local responders on preparations for COVID-19 including guidance on excess deaths management and the Coronavirus Bill. I have nothing to add to the official record of this meeting.

87. On 28 February 2020 I met with the Prime Minister, Health Secretary, Foreign Secretary, Chancellor of the Exchequer (CX), and the CMO (CW9/70 to CW9/72 - **INQ000279888; INQ000279891; INQ000279890)** The CMO and Health Secretary

gave a general update on the situation in the UK and a paper was presented on the UK's preparedness (CW9/70 - **INQ000279888)** The CX gave an overview of the potential economic impact and choices available in these circumstances. It was concluded that there was a need for a major ramp-up of other government department activity on domestic preparedness. The Prime Minister agreed with the need to publish an action plan the following week and the need for early emergency legislation. A governance structure was agreed as follows (CW9/71 - **INQ000279891) :**

a. COBR(M), twice weekly. Chaired by the Prime Minister or Secretary of State for Health and Social Care (DHSC). COBR(O), twice weekly.
b. Regular COVID-19 updates at Cabinet.
c. Daily meetings with Health System (DHSC, PHE, NHSE), chaired by Secretary of State for Health and Social Care or DHSC Permanent Secretary.
d. Regular press briefings lead by Secretary of State for Health and Social Care and CMO (and relevant lead officials as appropriate).
e. Joint Government communications hub in 10 Victoria Street.
f. Designated COVID-19 Junior Minister from every Department.
g. All DHSC Ministers working on COVID-19 across respective portfolio areas.

March 2020

88. On 2 March I attended the first COBR meeting chaired by the Prime Minister. An update was provided of the present situation, including the latest advice from SAGE on RWCS

planning that 80% of the UK could become infected, with an overall 1% (525,000) fatality rate in those infected (CW9/73 to CW9/76 - INQ000056175, INQ000056176, INQ000056224, INQ000056217). The Coronavirus Bill (CW9/77 - INQ000056156), the Coronavirus Action Plan (CW9/78 - INQ000056154) and the next steps to be taken were also on the agenda. DHSC was actioned to ensure that communications relating to the Coronavirus Bill made clear that the exceptional powers it included would only be used when and where necessary. From 2 March 2020, it would be accurate to characterise all major decisions made as part of the Government's response to COVID-19 as having been taken on a whole-of-government basis. My recollection of this meeting was that it was an engaged, sombre and significant moment. There was a general recognition that the situation in the UK and internationally was deteriorating. This was the first occasion in my recollection when there was a general concern across government that the disease might not be contained. The Prime Minister stressed that the Government's approach would be guided by science and would have to focus on helping the most vulnerable and the elderly. There was, I recall, limited discussion of the Action Plan – the content of which had largely been agreed in discussions before the meeting including with the Devolved Governments. There was, however, considerable debate on the CCA. It was clear that there was a level of misunderstanding about the application of the CCA and particularly whether it was of limited use if there was time for bespoke legislation. CCA guidance provided that emergency powers could not be employed if a bill could be fast-tracked through Parliament. It was considered that there

was time to do so, and that bringing a bill through Parliament would also have the added benefit of avoiding future legal challenge (at least on a CCA basis).

89. I attended a COBR meeting on 4 March 2020 (CW9/79 to CW9/84 - **INQ000061641** **INQ000279893,** INQ000056225, **INQ000279894,** **INQ000279895,** INQ000056218), chaired by the Secretary of State. The first item on the agenda was to provide a situational update on schools, LRF readiness, businesses, and statutory sick pay. The other items included an update on repatriation criteria for UK nationals overseas, discussion of NPIs, and communications, media, and parliamentary handling. DHSC had particular involvement in the repatriation of British Nationals and further consultation with the Devolved Governments on the Coronavirus Bill. On NPIs, the Director for the Government Office for Science suggested a number of interventions, including social distancing, closing schools, and discouraging mass gatherings that could be taken to delay and flatten the peak of the outbreak. There was a lot of uncertainty noted by behavioural scientists as to the extent of compliance which could be expected. It was emphasised that the public needed to understand why certain measures were being undertaken.

90. I chaired the Departmental ExCo meeting on 5 March 2020 (CW9/85 to CW9/90 - INQ000106134; INQ000106133; INQ000106132; INQ000106135; INQ000106137; **INQ000279903),** which considered the demand in health and social care and the implications of the coronavirus plan for the Department. It was agreed that the main and

primary focus of the Department would become the response to coronavirus and that we might move out of the Contain phase shortly and into the Delay phase. The latest SAGE advice on self-isolation was also considered.

91. SAGE had discussed on 5 March 2020 the possibility of home isolation for seven days of symptomatic cases, whole household isolation for 14 days if someone was symptomatic and enhanced measures for vulnerable groups for 13 weeks. The SAGE paper was developed by the Department into proposals for NPIs and submitted on 6 March 2020 to the CCS (CW3/155 - INQ000106158). An initial package of three interventions were identified: (i) home isolation for 7 days of 'symptomatic' cases; (ii) whole household isolation for 14 days where anyone living in that household is 'symptomatic'; (iii) social distancing for elderly or vulnerable groups for a period of up to 13 weeks. The paper was provided to a COBR – Officials (COBR-O) meeting on 10 March 2020. COBR-O was designed to discuss and finalise policy, advice on timings and communications ahead of the COBR-Ministerial meetings (COBR(M).

92. The proposals for NPIs were further discussed with the Secretary of State on 8 March 2020 (CW3/159 - INQ000106160), and then discussed at the COBR on 9 March 2020 (CW9/91 to CW9/95 - INQ000055948, **INQ000052391** INQ000056178, INQ000056206, INQ000056219). Included in the agenda for the meeting was a situational update, update on interventions to delay the peak, international engagement, and communications and parliamentary handling (CW9/96 - INQ000056177).

Preparations were identified for moving to the delay phase, including planned interventions to delay the virus' peak. Relying on the Commonly Recognised Information Picture, it was advised by the CMO that the UK was "*near the bottom of the upward scale of the peak.*" An emphasis was placed on determining measures to safeguard the elderly and vulnerable individuals and the CMO advised that self-isolation and safeguarding were more likely to be effective than full household isolation. The next steps included advising mildly symptomatic people to self-isolate, in combination with shielding for the elderly and the vulnerable. It was also noted that there were a number of specialists working on research to help those with weaker immune systems. My recollections of this meeting are that discussion focussed largely on the second item of the agenda. It was widely expected at this point that we would move from contain to delay. There was much discussion of the right timing for particular interventions and the importance of protecting the vulnerable. The minutes of the meeting note the CMO's views on timings of interventions which I heard him make on a number of occasions.

93. It was following the 9 March 2020 COBR meeting that the Cabinet Office set up a cross-government team including the Cabinet Secretariat, DHSC, SAGE, the CCS and some communications professionals to further develop these policies, how they would be communicated, and when they would be activated.

94. By 10 March 2020, NHS Modelling capacity under various scenarios had been sent to the Secretary of State for Health (CW3/169 and CW3/170 - INQ000106180 and INQ000106181). Modelling was presented of the impact of the three selected NPIs on bed demand within the NHS following SAGE assumptions of a RWCS with 81% of the UK infected. With no mitigation in place, it was predicted that over 800,000 people would be in need of hospital beds, with only 100,000 available, and over 80,000 in need of a critical care surge bed, with only 7,000 available. With home isolation, household quarantine and social distancing for those aged 65 and over, the curve was modelled as "flattening" to around 250,000 in need of hospital beds, and 25,000 in need of critical care surge beds by the pandemic's peak. The estimate of 100,000 NHS beds being available was based on at least 30,000 beds being "freed" from those with (i) non-urgent cases (surgery and diagnostics), (ii) people who would have already been discharged from hospital to social care or care in their home.

95. WHO declared a pandemic on 11 March 2020.

96. On 11 March 2020 I attended a COBR meeting chaired by the Secretary of State to reach collective agreement about the Coronavirus Act (CW9/97 to CW9/99 **INQ000279900,** INQ000056180, INQ000056220), including its content, timing, and handling. This meeting also discussed the current situation, communication and

parliamentary handling and next steps. The CMO stated that UK COVID-19 cases were on an upward trajectory, with an estimated 5,000 to 10,000 cases in the UK at the time. It was predicted that the peak would arrive in 10-14 weeks, with cases rising from 6 weeks, but there was low confidence in the figures. I have no personal recollections to add to the official record of this meeting.

97. On 12 March 2020, I attended a COBR meeting chaired by the Prime Minister, concerning a situational update and the package of interventions to be delivered (CW9/100 to CW9/105 - INQ000056193, INQ000056194, NQ000056223, INQ000056209, INQ000056181, INQ000056221). A SAGE paper was submitted for review (CW9/103 - INQ000056209) proposing four interventions for implementation in the following three to four weeks:

    a. Individuals to stay at home for 7 days from the point of displaying mild symptoms;
    b. Households stay at home for 14 days from the point that any member of the household displays symptoms;
    c. Most vulnerable individuals stay at home for a period of 13-16 weeks; and
    d. Significant reduction of social contact by the over 70s and at-risk groups.

98. The GCSA contended that the aim of intervention was not to completely suppress the spread of the disease (which was not possible), but to change the shape of the curve,

ideally delaying the peak to later in the year and flattening the peak so as not to completely swamp NHS resources. Discussion was had as to which of the interventions should be implemented immediately. My recollection of the meeting was that discussion focussed mainly on the timings of particular interventions, particularly for the protection of the most vulnerable. The minutes suggest there was considerable discussion of the importance of timing interventions correctly and the trade-offs between measures to protect against infection and the wider socioeconomic impacts. There was concern that if vulnerable persons and the elderly were requested to isolate immediately, their resilience would flag during later weeks of the pandemic when it may be the most important. The GCSA set out very clearly the four options SAGE had considered and its advice. It was considered that scientific evidence supported implementing option one soon, and options two and three at some point in the coming weeks. It was agreed that government guidance should change from 13 March 2020 so that anyone with symptoms compatible with COVID-19 should stay at home for at least seven days; those over 70 and with serious medical conditions were advised not to go on cruises; and advice was given that international school trips should not take place. From 12 March 2020, the Government had moved into the "delay" phase.

99. Within the minutes, the GCSA is recorded as stating that "*the strategy should also aim to protect the most vulnerable, with a good outcome being that by September 2020, herd immunity would be established.*" I do not recollect the GCSA's exact words on this point but, in the interest of being clear on the extent to which herd immunity was

considered at this time, my recollection is that it was mentioned not as an "aim", but as a by-product. It was understood that complete suppression of the virus was not possible and that we had to aim to minimise the impact on the NHS and manage the number of persons infected at any given time. As a necessary consequence of the "Contain, Delay, Mitigate" strategy, herd immunity was recognised as a possible by-product in the long-term. Of course, if herd immunity did occur, that would be a benefit to the general population, including vulnerable people. However, at no point was herd immunity considered to be the strategy nor were the interventions intended to achieve herd immunity. This is expanded upon further below.

100. Later on 12 March 2020, I attended a meeting to discuss NHS resilience with the Prime Minister, Sir Simon Stevens, the Secretary of State for Health and Social Care and others (CW9/106 - **INQ000279904).** Sir Simon Stevens set out the NHS's plan, including stopping non-urgent operations and being more assertive on long stays to free up 30,000 beds, increasing the aggregate supply of oxygen, reconfiguring hospitals as required and getting the right number of machines and trained staff to operate them. I refer to this again in paragraph 175 in relation to hospital discharge policy.

101. On 14 March 2020, I attended a meeting in the Prime Minister's Office, providing an update on coronavirus with the Secretary of State, Cabinet Secretary and the Chancellor of the Duchy of Lancaster on (CW9/107 - **INQ000279906).** A variety of

actions were agreed, including the compilation of a list of vulnerable groups and a package of cross-governmental measures for shielding the vulnerable and the elderly that would be ready for implementation. Additionally, it was agreed that advice would be obtained for future review in connection with (i) action on mass gatherings to support public resilience, (ii) social distancing options based on epidemiology ranging up to a full lockdown, and (iii) household isolation guidance. Such advice was also requested to have a regional overlay, specifically a proposed plan for taking early action in London.

102. I cannot recall whether the GCSA, specifically raising the possibility that the UK was further along the curve than had been initially thought at this meeting. However, the minutes record that the CMO/CSA provided an update on information received from SAGE which suggested that the time to implement measures was sooner than previously envisaged on prior analysis. In any case, the minutes from the 12 March 2020 COBR are clear that the GCSA had initially advised at that there was an estimated 5,000 to 10,000 cases in the UK and that the UK was approximately four weeks behind Italy. I recall that by 16 March 2020, there was a change of view that we were potentially further up the curve than previously believed. I am asked whether I 'told off' the GCSA for the line he took at this meeting, or if others did. I do not remember doing so, nor do I recall others doing so. However, I am confident that even if the GCSA was "told off", he would not have been discouraged from raising his concerns. By the end

of the weekend (16 March 2020), it was accepted that the UK was at the cusp of a fast upward swing of the infection curve (CW9/108 - INQ000056210).

103. On 15 March 2020 I attended a series of strategy meetings in No. 10 to consider the package of measures that was to be put to the COBR meeting on 16 March (CW3/196 to CW3/198; CW3/200 to CW3/202; CW9/109 to CW9113 – INQ000106212; INQ000106213; INQ000106214; INQ000106216; INQ000106217; INQ000106218; **INQ000279910, INQ000279908, INQ000279909, INQ000279907, INQ000279911).** The decisions that were to be taken included (i) whether to announce and implement household 'stay at home' within one week; (ii) what advice to give for different vulnerable groups and shielding of the most vulnerable; (iii) what advice to give the whole population; and (iv) to what extent to restrict mass gatherings. A variety of papers were presented to inform the decisions that had to be taken the next day and after, including on household isolation policy (CW3/201 - INQ000106217), on shielding/ vulnerable persons (CW3/202 - INQ000106218), on social distancing (CW3/198 - INQ000106214), on school closures (CW3/205 - INQ000106221), and on mass gatherings (CW3/196; CW9/110; CW9/111 - INQ000106212; **INQ000279908; INQ000279909).**

104. My recollection is that these meetings were tense but business like. It was clear that the disease was advancing in the UK faster than many had hoped and that more radical decisions would need to be taken. I remember that the papers for the meeting were not complete when I arrived. I worked with the CMO and Mark Sweeney (Director General, Cabinet Secretariat in the Cabinet Office), to complete the summary slide pack (CW9/109 - **INQ000279910).** There was then a small meeting with the Prime Minister which I attended to go over what the main meeting was to cover and then a larger meeting at 5 attended by a wider cast list. I introduced the papers for the meeting and the options for action. I remember the CX was concerned that press rumours of 'lockdown' were having adverse market reactions and the Prime Minister stated that 'lockdown' was not language he wanted to use. There was, I recall, considerable discussion of measures to protect the vulnerable and shielding as set out in the CMO's paper.

105. On personal reflection, I believe I placed too much store in shielding at this time as being the key measure in reducing deaths from COVID-19. I remembered thinking that while other measures could help to reduce pressure on the NHS, shielding provided the clearest way of protecting the most vulnerable and saving the most lives. However, as the pandemic progressed, it became clear that it was overall community infection rate that was driving the infection rate for those who were vulnerable, and it was not possible or realistic to shield your way out of the pandemic. While shielding

had an initial role to play in saving lives and delaying the peak, it was not realistic to expect people to live in vigilantly self-contained bubbles for the entire duration of the pandemic.

106. At the conclusion of the strategy meetings, there was a broad consensus as to the final package of measures to be proposed at the COBR meeting on 16 March 2020, as recorded in the minutes (CW9/114 - **INQ000279912).** These were: (i) to announce and launch the household stay at home policy from Monday 16 March, (ii) to announce a package of 'soft' social distancing advice for the general public (i.e. advising against social mixing in the community, receiving friends and family, working from home), (iii) to communicate to vulnerable groups that social-distancing measures should be more rigorous, and (iv) that shielding for the c.1.4 million individuals would commence within one week. However, I recall one area of contention as being whether a stricter set of measures were necessitated in London, akin to those implemented by the Italian government in Lombardy, where outbreaks had had significant negative effects. I could not, nor could others, see anything in the data that supported such a course of action and the meeting concluded against it.

107. I have also been asked when lockdown was first raised as an option during this period. My recollection is that the possibility of local lockdowns had always been part of the thinking, were discussed from the point they were implemented in China,

became more seriously discussed after the outbreak in Lombardy and became for me a realistic policy in the UK as a national policy possibility after the 16 March 2020.

108. In any event, part of the challenge at this time was that the advice from SAGE seemed to frequently change, and it was not always clear whether this was on the basis of new evidence. I raised my concerns regarding SAGE with the Cabinet Secretary on 18 March 2020, including aspects of the operation of SAGE and the consistency of its views at this time (CW9/29 - **INQ000279915).** I also remember discussing my concerns with the CMO and Steve Powis (National Medical Director of NHS England). I do not recall discussing them with the GCSA.

109. The package of measures discussed in the No.10 strategy meetings was agreed at a COBR meeting which I attended on, 16 March 2020 (CW9/115 to CW9/119; CW9/101; CW9/108 - INQ000056195; INQ000056183; INQ000233766; **INQ000279913; INQ000279914; INQ000061687**; INQ000056210). The summary of the measures agreed are set out in the 'summary and recommendation' slide of the 'Commonly Recognised Information Picture' (CW9/120 - INQ000056184). There was discussion as to the need for clarity in language and the possible confusion between 'strongly' advising one group and simply advising another. The Mayor of London raised two key issues, the first regarding the potential issues of restricting religious

congregations, the second being that rough sleepers were an affected group. The latter point was reiterated by the Secretary of State for the Ministry for Housing, Communities, and Local Government, who observed that 65% of rough sleepers have respiratory issues and were a key vulnerable group. The potential economic impacts were additionally discussed, including the huge impact that would hit the hospitality sector.

110. I attended a further COBR meeting on 18 March 2020 (CW9/121 to CW9/127 - INQ000056196, INQ000056186, INQ000056187, INQ000056188, INQ000056189, INQ000056185, INQ000056211), where policy measures for schools were discussed first. The GCSA stated that even if social distancing measures were increased, London would remain at risk of exceeding its ICU capacity, but that school closures could potentially reduce the instance of COVID-19 cases by 10 to 15 per cent. SAGE modelling assumed that schools should be kept partially open to ensure that key workers could continue to contribute to the national effort. A proposal was agreed for schools to close on 20 March for Easter and that a minimal school service would be made available for children of key workers and vulnerable children. On 18 March 2020, the Prime Minister announced that schools would close from 20 March 2020, except for the children or key workers and vulnerable children (CW3/208 - INQ000106250).

111. I was heavily involved in the development of the first version of the Department's battle plan, which was intended to organise the work of the Department during the pandemic. This was commissioned by the Prime Minister at a meeting on 20 March 2020 (CW3/14 and CW3/15 - INQ000049742; INQ000049743), but had already been built on from discussions I had had with the CMO, identifying and organising key workstreams. As set out in my third witness statement, the battle plan identified six workstreams, being (i) resilience for the NHS and social care (ii) supply of key products and equipment, (iii) testing widespread across the population, (iv) technology accelerating new interventions, (v) social distancing to slow the rate of transmission, and (vi) shielding.

112. A draft of the battle plan was scrutinised by the Ministerial Implementation Group (CW3/17 - INQ000106280) and agreed by the Prime Minister on 22 March 2020 (CW3/16 to CW3/19; CW9/128; CW3/41; CW3/83; CW3/20 - INQ000106279; INQ000106280; INQ000106281; INQ000106282; INQ000106283; INQ000106286; INQ000106288; INQ000106289). The nature of the battle plan and its various versions are set out in the corporate witness statements for this module (my third witness statement at paragraphs .57 – 70; my fifth witness statement at paragraphs 45 to 51; and my eighth witness statement at paragraphs 39 to 41). In my view, the battle plan was central to how we managed the Department. It was clear that public and political focus would move from issue to issue during the pandemic and the battle plan workstreams

were there to ensure that regardless of that, our focus remained targeted on the matters that would actually make a difference. Additionally, it was also our way of identifying what could be deprioritised.

113. I attended two further strategy meetings with the Prime Minister on the morning of 23 March 2020 at 9.15 and 9.45. In the first he was briefed on the need for further social distancing measures (CW3/219 and CW3/220 - INQ000106290; INQ000106291). At those meetings, government policy was decided that all persons should stay at home for non-work related activity, unless taking a trip to shops for food, a daily physical activity, medical appointments, or it is not possible to work from home. Further measures were then discussed at a COBR meeting the same day, which I also attended, alongside a number of other individuals and all the Devolved Governments (CW3/221 - INQ000106293).

114. The Prime Minister then addressed the nation to, in effect, start what we now call "the first lockdown", which was put into place through the Health Protection (Coronavirus) Restrictions (England) Regulation 2020 and came into effect on 26 March 2020. Clearly the decisions taken and announced on 23 March marked a significant change of policy and a movement away from the framework of voluntary NPIs set out

in 2011 UK Influenza Pandemic Preparedness Strategy. I set out my view of the reasons for this change in paragraph 120 below.

Herd Immunity

115. I have been asked about whether or not a concept of "herd immunity" was seen as a strategy for the response to COVID-19 during this period of time. Immunity and its relation to government strategy was discussed within government – and indeed was described publicly by the GCSA at a press conference on 12 March 2020. As a matter of logic, it would have been remarkable if it had not been discussed given the importance of understanding immunity (whether acquired by infection or vaccination) to disease management. It is mentioned in texts and emails I received from the Cabinet Secretary and emails from David Halpern (CW9/129 to CW9/131 - **INQ000279921; INQ000279901; INQ000279916)** and was referred to by the GCSA in the COBR minutes of 12 March, as discussed above at paragraph 99.

116. To my knowledge, however, it was discussed as a possible by-product of the Government's approach and was neither proposed to ministers or adopted as an objective of government policy. As noted above, in meetings I attended, decision-makers remained focussed on preventing deaths and preventing harm through the NHS being overwhelmed. These remained the key drivers of policy. This meant there was a particular focus in discussions about how to protect the clinically vulnerable, in particular

through shielding. Given the Government was not pursuing a zero COVID policy, it was understood that there would be low levels of COVID-19 transmission in the community, in line with the approach taken in most European countries.

117. As referred to above in paragraph 115, I had an exchange with the Cabinet Secretary about herd immunity on 12 March 2020 (CW9/130 - **INQ000279901).** I clarified that herd immunity could not be relied upon to secure immunity for the public in the future on 1 April 2020 (CW9/129 - **INQ000279921).** I also had an exchange with Matt Hancock on 14 March 2020 (CW9/132 **INQ000279905).**

NPIs

118. As noted above, my role in relation to decisions on NPIs varied over time. For the first lockdown, I was in a number of the formal meetings where decisions were taken and thus a participant in decisions. For the subsequent lockdowns my role was contributing within the Department to views given to the Secretary of State which he would then contribute to cross-government decision making. The role of the Department in decisions on NPIs has been covered in detail in my corporate witness statements for this module.

119. Throughout the pandemic my views on the use and appropriateness of NPIs were largely driven by the views of the CMO and the DCMOs. NPIs have always been a part of pandemic planning and were central to the 2011 UK Influenza Pandemic Influenza Strategy (CW/3 - INQ000022708) and to the Coronavirus Action Plan of 3 March 2020 (CW3/8 - INQ000057508). They had therefore always been part of the approach to pandemic strategy. In both these documents, NPIs were envisaged as a voluntary measure driven by public messaging. This approach was maintained in the package of measures announced on 16 March and into the following week. However, a different approach was adopted in the 23 March 2020 "lockdown" package, where measures moved from voluntary NPIs to compulsory NPIs backed by law.

120. From my recollections of the discussions at the time there were essentially three reasons for this change:

a. New scientific advice that we were further along the infection curve than had previously been thought, and consequently we were closer to the NHS being overwhelmed, requiring stronger action (CW9/108 - INQ000056210);

b. The realisation that we were out of line with most European countries, who were increasingly imposing lockdowns; and

c. Media reports that the voluntary measures were not being sufficiently followed.

121. I am asked a series of questions about the timeliness of the first lockdown, its implementation, and its purpose. In my view, the Government's purpose was exactly as described at the time: it was to prevent harm or death from the disease by protecting particularly the most vulnerable from infection; and to prevent the NHS from being overwhelmed to the extent that it was unable to treat new patients with COVID-19 or other conditions (which would impact most severely on the most vulnerable.) As set out in the Coronavirus Action Plan published on 3 March 2020 (CW3/8 - INQ000057508), there were subsidiary advantages to measures that delayed any COVID-19 peak until the summer, both to reduce the coincidence of COVID-19 with periods of high pressure on the NHS and to allow for the development of clinical countermeasures.

122. In terms of timeliness, I believe both the package introduced on 16 March and the full lockdown implemented on 23 March were timely and appropriate given what was known at the time. I accepted the positions set out at COBR on 12 March about the progress of the disease, the importance of the timing of interventions and the dangers of intervening too early. With hindsight I think that each could have been considered at least a week, possibly more, earlier as the disease was further advanced than we knew at the time. It is unknowable whether public opinion would have accepted such restrictions had they been implemented earlier.

123. My personal view, with the benefit of hindsight, is that voluntary NPIs were introduced too late in March 2020. At the time, key decision-makers had understood the UK to be further back in the curve than what was actually the case. Had we done so, it is possible that we might have reduced the reliance on legally enforced NPIs. However, it is impossible to know whether a full lockdown could have been avoided. The experience of other European countries suggests not. Additionally, once we had gone down the route of legally-enforced NPIs, it became very difficult to revert to voluntary measures and the UK was effectively locked into a compulsory approach. The lessons I personally learnt from the first lockdown are reflected in my first witness statement on pandemic preparedness (CW9/7 - INQ000184643).

124. I am also asked about the second lockdown. It is important to note that the purpose of lockdowns evolved as the pandemic went on and as other counter measures became available. As described in my third witness statement (paragraphs 78 and 153), my fifth witness statement (paragraph 74) and my eighth witness statement, pandemic strategy can be characterised as having essentially four weapons for fighting disease-related harm and death: NPIs; testing, tracing and isolation; therapeutics; and vaccines. Early in the pandemic, only the first weapon was available, leaving the Government a simple choice: use NPIs or do nothing. At the same time, one of the biggest challenges with the use of NPIs, especially lockdowns, is exit strategy. It is difficult to know when and in what way the public can transition out of measures, as

many countries following "zero-COVID" strategies have found. However, once vaccines and therapeutics are realistic possibilities, lockdowns can play a role in buying time for countermeasures to be completed and deployed, and the problem of the exit strategy falls away.

125. My view at the time was that the second lockdown was implemented too late. In saying this I am very conscious that I was looking entirely from the health perspective and was not – as the Prime Minister had to – juggling these effects with the economic, fiscal and social consequences of lockdowns. However, given the Government's objectives at the time and the realistic prospect of vaccines and treatments that were emerging, I think an earlier and more consistent lockdown would have been more in line with those objectives. I gave my view of the issues to the Cabinet Secretary in early September 2020, as I expressed in texts with Simon Case on 6 September 2020 (CW9/133 and CW9/134 - **INQ000279932; INQ000279933):**:

"CMO and I discussed and got to (1) no jumping to decisions – considered advice next week (2) gut feeling on what that advice might be: (a) double down on existing policies – so marginal decisions on local lockdowns etc should err towards safety (b) step up Messaging and enforcement of existing social distancing rules (c) prepare public opinion for maybe having to introduce new national rules in 3 to 4 weeks time – esp if people flout existing rules and (d) the trickiest one – dialling back on

the 'back to normal' rhetoric esp around Xmas and return to workplaces. They Cld both look own goals in a few weeks. But all for discussion/judgment."

126. I set out in the corporate witness statements for this module the role that the Department played in respect of various subtypes of NPIs throughout those statements and would refer the Inquiry to that information which is detailed in nature, and which sets out how the Department acted and with what information. I would identify, however, that from March 2020 all decisions about NPIs were made collectively by the Government and not just by the Department. Generally, when advising on decisions concerning the imposition of, easing of, or exceptions to NPIs, I was driven by the guidance given by the CMO and DCMOs. Some of the decisions which the Inquiry asks about – such as the closure of schools, and the use of border controls – were not decisions primarily made, advocated for or advised by the Department, although the Department may have advised on them from a health perspective. I cannot recall being asked or providing any advice about "Eat Out to Help Out" to the Treasury.

127. I am asked whether I heard (or had reported to me) the Prime Minister expressing the view that there should be "no more fucking lockdowns – let the bodies pile high in their thousands" or any words to that effect. I did not. Likewise, I never witnessed the Prime Minister saying that SAGE had manipulated him into imposing the first lockdown.

The Tiered System

128. I am asked about the policy of 'tiering' established on 14 October, the background of which is set out in my fifth witness statement at paragraphs 168 to 248 and 257.

129. My view with the benefit of hindsight is that tiering was a well-intentioned policy but with flaws that limited its effectiveness. I saw the intention of the policy as being to avoid national lockdowns by implementing local ones. I continue to believe that this principle was a sound one. Given the damage done to society and economy by national lockdowns, it would clearly be preferable to limit the effects to a smaller number of places if the disease could be maintained that way. Tiering was also backed by an extremely rigorous approach to data.

130. The challenges with tiering were in my view not with the principle but with the implementation. With hindsight, I would make the following observations:

a. The system was too complicated and was difficult to explain and understand;

b. There was not enough consistency about what size of an area was tiered. In general, we tried to do them on too small a geographical footprint;

c. There was too much negotiation with local places about the restrictions that would be in place and the support that would be available; and

d. The Alpha variant, which first appeared in the UK in November 2020, proved to be too transmissible for the restrictions in the top level of tier to hold.

131. In hindsight, were the tiered system to be implemented again, I would argue for a bigger geographical footprint and a standard package of restrictions and support.

Global Lockdown

132. I have been asked questions about whether a "global lockdown" was ever considered. On 18 March 2020, I received a copy of an email sent by David Halpern, Chief Executive Officer of the Behavioural Insights Team, sent to the Cabinet Secretary and Dominic Cummings about his concerns about SAGE modelling and suggesting that a global 3-4 week lockdown should be considered (CW9/131 - **INQ000279916).** The Cabinet Secretary replied on the SAGE questions raised. David Halpern was, of course, a member of SAGE and was therefore free to raise any concerns he had with the GCSA. I do not know if he did so.

133. In response to his query on 18 March 2020, I asked 3 questions about the idea of a global lockdown namely:

"1. What do you estimate our percentage chances of organising a simultaneous global shutdown in every country in the world? I can see we might be in a better place in 4 weeks time, but most countries will not so why would they do it?

2. What happens at the end of the shutdown? The virus will still exist in 3-4 weeks time and won't we just start again with reinfection and re-spread? And

3. How many people die from not receiving other medicines over the 3-4 week period?"

134. I considered (and still consider) these questions to be reasonable ones to ask. However, none of my questions were satisfactorily answered in response by David Halpern. In truth, I considered then, as I do now, the idea that the UK, or indeed any country, could organise a global lockdown to be plainly impractical. A global lockdown is not something which the UK or anyone could impose on other countries in the world. It would require a global governing structure that evidently does not exist. To my knowledge no other governments or international bodies such as WHO were exploring such options.

135. As far as I am aware, there was no further consideration of a global lockdown either in the UK or anywhere else. I am not aware that either the Cabinet Secretary or Dominic Cummings ever responded to the idea. My view was that it was not a thought-through or serious suggestion.

High-tech Contact Tracing

136. I am asked various questions about contact tracing and suppression of the virus using modern technology. There was interest in using technology and particularly App-based contact tracing from very early in the Pandemic. On 10 March 2020, the Secretary of State agreed to proposals from the CEO of NHSX (who were responsible for digital developments) to begin testing whether a contact-tracing app would be feasible (CW9/135 and CW9/136 - **INQ000279898; INQ000279899).** A coronavirus track and trace app was launched on the Isle of Wight on 5 May 2020, developed by NHSX. The development was deemed not to be successful, so an alternative approach was taken. The NHS COVID-19 app was subsequently launched across England and Wales on 24 September 2020.

137. I am asked to consider whether technology-based solutions could have been adopted earlier. During March 2020, various discussions were held about using modern technology for contact tracing. Our approach has been contrasted with some other countries such as South Korea. I would make the following points:

a. There was no lack of effort to develop technological solutions – indeed they figured heavily in thinking.
b. We were undoubtedly slower than some countries – and our attempts to develop a bespoke app was with hindsight a mistake;

c. An App based tracing system is still reliant on testing infrastructure and the wide availability of tests. These took time to put in place;

d. Even when we did have a functioning App and mass testing it proved only partially successful at getting public compliance. Indeed, the most significant resistance and compliance issues we had to any of our policies was during the so called 'Pingdemic' of July 2021; and

138. I would further endorse the evidence given by Professor Sir Chris Whitty in Module 1, that the lesson learned from the South East Asian and East Asian experience of coronaviral pandemics was not to adopt any particular countermeasure, but to focus on systemic improvements:

> *"I certainly think that we should do more to learn from approaches which are not the standard European, North American, if I can simplify, approaches to things which tend to dominate a lot of our thinking. So I certainly think we should be communicating as much as we can with other countries, including in South East Asia and East Asia which have outstandingly good scientists, who often come at things with a very different perspective However, some of the very specific learnings that people raise are, in my view, technically incorrect. I don't want to go through them in great detail, but for example, you know, I've spoken to my colleagues in South Korea about MERS. Their principal problem was an issue of hospital transmission, that's where most of the transmission – well, the large part of the transmission – force of transmission came from. What that did*

though is it made them think they had simply under-invested in, both intellectually and financially, public health, and they did so. They completely changed the way – they were much more systematic.

… I think that it was much more the generic "We need to strengthen public health responses to infections and take them very seriously at the earliest possible stage and scale", rather than "These particular learnings we took away from this particular virus".

139. For these reasons, while better contact tracing technology earlier would have been helpful, I do not believe it would have substantially affected the course of the disease or the March lockdown decisions. Technology was never going to be a silver bullet, and any technology to be truly effective would require significant investment in all areas of public health.

Vulnerable Groups

140. With a disease which for many individuals causes only a mild infection but for a small number has very serious consequences indeed the only purpose of NPIs is to protect the vulnerable; large numbers of people who are not at great risk are asked to give up elements of their liberty to protect those that are. NPIs were suggested and implemented to protect the vulnerable. I exhibit papers written by the CMO on the impacts of COVID-19 on excess deaths and morbidity (CW9/137 and CW9/138 -

INQ000220212; INQ000220213) which sets out the considerations to be taken into account in respect of the long-term impact upon health of the NPIs. Consideration was made of the length of the NPI is simply on the basis that the longer that they went on, the more difficult it may be to maintain them.

141. I further endorse the views expressed in the 'Technical Report on the COVID-19 pandemic in the UK' (the Technical Report), an independent report published on 1 December 2022 and prepared by the UK Chief Medical Officers (CMOs) (England, Scotland, Wales and Northern Ireland), the GCSA, the National Health Service (NHS) National Medical Director and the relevant Deputy Chief Medical Officers (DCMOs) with input from many distinguished scientists to inform their successors (CW2/1 - INQ000087225).

142. The minutes of the COBR meetings particularly during March 2020 show that consideration of vulnerable groups and individuals were top of ministers and advisors minds throughout this period. This involved discussion of the direct effects of the disease and the need for specific policies (particularly shielding) to protect those most at risk. It also involved discussion of the indirect effects of NPIs on the wider well-being of the vulnerable, particularly in the discussions around the dangers of implementing NPIs too early. Policies to prevent the NHS being overwhelmed were also driven by

the need to protect the vulnerable as they would suffer most if regular NHS services were unavailable.

143. So, from what I saw there was a clear focus on protecting the vulnerable right from the outset of pandemic decision-making. Initially, DHSC's approach to who was "vulnerable" was essentially clinical, focussing on the elderly and persons with co-morbidities. As clinical understanding grew, who was understood to be vulnerable also changed. As noted by the Technical Report, we came to understand that persons living in deprived areas were also:

a. The least likely to be able to work from home;

b. More likely to use family or neighbour care-givers;

c. More likely to use public transport;

d. More likely to live in high-density accommodation; and

e. More likely to have insecure employment and minimal or no financial resilience.

144. As the Technical Report observes, all of these factors increased the risk of exposure in a population which was also more likely to have the co-morbidities which increased the chance of hospitalisation or death. In this regard, the pandemic reflected and, in many cases, exacerbated existing inequalities. Likewise, the PHE Report, '*Beyond the Data: Understanding the Impact of COVID-19 on BAME Communities*'

demonstrates that the impacts of the COVID-19 pandemic were disproportionately felt by those from minority ethnic backgrounds (CW3/524 - INQ000106482). Understanding how the combination of existing inequalities and pathogen-specific vulnerabilities affect individuals across the population will be essential to inform future policy and public health responses.

145. At the same time, for a highly transmissible infection with often minimal symptoms it was extremely difficult during the pandemic to target specific people or groups successfully. As already noted above, over the course of the pandemic there was a movement away from shielding to the need to keep overall infection numbers down as most important. Ultimately, the most effective way to reduce the risk of hospitalisation and death for the vulnerable was to reduce overall community transmission.

146. The Department has filed witness statements on equalities (my fourth witness statement) and the impacts of legislation (Clara Swinson's fourth witness statement) which set out the consideration given to at risks and other vulnerable groups during the time in question and where equality impacts assessments were made (CW9/139 and CW9/140 - INQ000192271 and INQ000212314).

147. The Department was aware, and knew as a matter of common sense, that the imposition of NPIs would lead to social isolation, children not being at school, those with mental and physical disabilities not being able to undertake community activities in the same way, and restrictions on visiting for those in residential care, and supported living. The exact nature of the impact was not known at the beginning of the pandemic because it was not clear how long these measures would need to be put in place and on what basis. It was also clear that those in domestically abusive situations and children at risk of harm from their caregivers may be at particular risk, and the Department for Education and the Coronavirus Act sought to ensure that those children still had oversight from social workers. It was not the case that these issues were not thought about or considered – but the balance was seen when such measures were imposed to be outweighed by the risk of death in vulnerable groups.

148. On the other hand, the risk of long COVID was not known until after the first lockdown and it took some time for the full range of symptoms which some people had experienced following an infection to be recognised as "long COVID." I cannot recall the risk of long COVID being taken into account for the decisions taken in relation to the second and third lockdowns.

149. As to the risk of asymptomatic transmission and the nature of COVID-19 as an airborne disease, the need for social distancing and reduced interaction between individuals, as well as frequent handwashing and mask wearing were all introduced to reduce the risk of transmission expressly. I refer the Inquiry to the Technical Report where these issues are discussed in some detail in Chapter 8.

PPE

150. PPE is discussed in my third witness statement at paragraphs 179 to180 in respect of adult social care, and paragraphs 199 to 220 with regards to PPE generally. It is further discussed in my fifth witness statement at paragraphs 381 to 390, and in my eighth witness statement at paragraphs 253 to 264.

151. At the start of the pandemic, the Department had a stockpile of 323 million items of PPE as part of the Pandemic Influenza Preparedness Programme (PIPP), including masks, aprons, gloves, respirators and eyewear. This stockpile was established in 2009, after the swine flu outbreak. It was based on assumptions that (i) an influenza pandemic would last around 15 weeks; (ii) that PPE would be needed for hospitals only and for those patients with influenza (who would be symptomatic). This stockpile had been maintained by PHE in a central stockpile on behalf of the Department and bought on advice from NERVTAG. The approach to stockpiles pre-pandemic

is set out in paragraphs 245 to 254 of my first witness statement (CW9/7 - INQ000184643).

152. The stockpile proved invaluable but ultimately insufficient for the COVID-19 pandemic which resulted in unparalleled increases in global demand for PPE. The size of any future stockpile will obviously be a key decision for the Government to decide. Such a consideration has to be weighed against the significant financial costs of maintaining a stockpile and the possibility that the Department could spend very large sums of money on a stockpile that is never used or turns out to contain the wrong items for the next disease. Equally, PPE degrades over time, which means the Department must consider disposal options in parallel with defining the size of a stockpile it intends to hold. The Department has estimated that maintaining a stockpile of the size needed for the COVID-19 pandemic would have been substantially more expensive than buying in the pandemic even at inflated prices (CW9/141 - **INQ000279940).**

153. The Department's response to the rapid rise in PPE demand is detailed at length in my third witness statement in paragraphs 199 - 220 and in my fifth witness statement in paragraphs 381 - 390. The outline provided here pertains only to my personal recollection as events unfolded.

154. The challenges encountered are set out in my third and fifth witness statements, but in summary were (a) trying to buy sufficient stock (b) which would arrive in time and (c) which met the relevant quality standards. Every country around the world was trying to buy the same thing, largely from China and other countries which made these materials. We did have to develop protocols for how PPE was distributed to clinical settings and for the prioritisation of PPE deliveries. We also worked across four nations of the UK to share stocks of PPE. In April, a Four Nations protocol was developed that shared PPE stocks across the four nations of the UK on the basis of population (CW3/448 to CW3/450 - INQ000106392; INQ000106394; INQ000106398). The principles underlying the protocol were:

a. UK Government procured PPE would be shared on a population basis between each of the UK four nations;
b. Each nation will continue to be ultimately responsible for and pursue PPE to meet its own population needs;
c. There will be transparent sharing of stock and supply information by the four nations to enable UK Government procured PPE to be shared on an equitable basis;
d. Mutual aid will operate alongside the protocol; and
e. The scope of the protocol is Health and Social Care only.

155. We also developed an acute shortage protocol advising clinicians on steps to take if specific PPE items were not available to them (CW3/457 - INQ000106358). This protocol was published via a central alerting system alert on 17 April 2020 and withdrawn on the 9 September 2020.

156. Alongside the challenge of securing international supply there were significant challenges in distributing PPE to social care as a consequence of the sheer number of providers all over the country. Very few of these providers had their own stocks already in place, which further exacerbated the demand. There was no established central mechanism for distribution of PPE (or other supplies) to social care. Social care providers relied on private sector wholesalers for their supplies. In March the Department arranged for all care homes and home care providers to receive 300 IIR facemasks from the PIPP stock. We also supported a number of independent wholesalers through access to PIPP stock PPE. The National Supply Disruption Response 24/7 hotline began on 16 March to allow health and social care providers to obtain PPE in an emergency. At this time, we received invaluable help from the military through Military Aid to the Civil Authorities (MACA) procedures. The scale of the challenge faced in PPE deployment was unprecedented, perhaps most reflected by the Chief of the Defence staff's (Sir Nicholas Carter) comments at the time, "*I would say in all of my 40 years of service this is the single greatest logistic challenge I've come across*" (CW9/142 - **INQ000279949).** The Department responded to the challenges in PPE supply to social care by supplying PPE to local authority LRFs to allow them to provide PPE to local

users including social care. This commenced on 6 April. We also established an online PPE ordering system (the PPE portal) to allow social care, primary care and other small providers to access PPE. The PPE portal was piloted in April and by 5 June smaller adult social care providers had been invited to register on the PPE portal. By the end of June 2020, the majority of eligible GPs and smaller adult social care providers were able to register on this portal. In July 2021, LAs and LRFs were invited to register for the PPE Portal.

157. While I was not directly involved in the substantive decisions on PPE procurement or deployment, I was aware of the direction of PPE policy and I was CC'd in emails providing updates. I also would have attended meetings where the issues were discussed with Ministers. On the other hand, I was particularly involved in the structural reorganisation of PPE procurement and distribution. This culminated in the appointment of Lord Deighton on 19 April 2020 as chair of the PPE Taskforce to lead the national effort to produce PPE for frontline health and social care staff. Lord Deighton was tasked with co-ordinating the end-to-end process of design through to manufacture, including streamlining the approvals and procurement process to ensure domestic PPE supplies were rapidly approved.

158. At the beginning of the pandemic, PPE struggled to keep pace with changing advice. For example, on 19 March 2020, infection prevention and control guidance on

PPE was tailored to reflect different care settings, whether the patient was known or likely to have COVID-19, and upon the nature of the clinical procedure (CW3/439 - INQ000106267). On 2 April 2020, a significant change was made when PPE was advised for all episodes of care rather than known or suspected COVID-19 patients, reflecting the fact that coronavirus was already widespread in the community (CW9/143 - **INQ000279922).** By 15 June 2020, guidance introduced universal face mask and face coverings in health and social care settings (CW3/458 - INQ000106399).

159. I would describe the PPE situation between early March 2020 – July 2020 as extremely difficult and tight. The situation in respect of PPE was particularly problematic in April 2020 as the guidance had changed to encompass new evidence of widespread asymptomatic transmission. As a consequence, a vast amount more PPE would be required in a large number of settings, including all aspects of clinical and social care, as well as in schools. This put pressure on stocks and distribution and there were local shortages. Correspondingly, there were frequently problems with the distribution of PPE into care homes at this time. While there was never a point where there was no stock of relevant items held nationally, shortage protocols were needed, shortages were real locally and there was understandable concern and anger from individuals who did not feel they were being protected properly. This was of considerable concern to us nationally.

160. I do not remember the Secretary of State telling the Prime Minister or anyone else that "everything was fine on PPE" in April 2020. If such a statement was made by anyone it was not accurate. .

161. There was a dispute between the Secretary of State and Sir Simon Stevens in April 2020 about PPE distribution. I remember that the Secretary of State was due to be at a meeting in No. 10 alongside Emily Lawson, who was the head of commercial at NHS England and who, alongside Jonathan Marron, Director General within DHSC, were responsible for sourcing and organising PPE. Emily Lawson did not attend that meeting. The Secretary of State believed that Sir Simon Stevens had ordered her not to attend this meeting as he did not want the NHS associated with the PPE challenges at the time. I remember that Matt Hancock did lose his temper in the meeting and asked where Emily Lawson was. I do not remember, however, Matt Hancock ever blaming Sir Simon Stevens for shortages. Sir Simon Stevens and Matt Hancock did have disagreements about PPE and the role of the NHS on reporting on it, but not about shortages, as everyone agreed it was a joint problem for the NHS and the Department to solve together. We set up a "joint cell" to work on this involving both NHS England and the Department working under Lord Deighton. This joint cell did exemplary work in sourcing and distributing PPE. I cannot remember Matt Hancock ever saying that the Treasury had "blocked approvals".

162. The decision to enter lockdown in March 2020 had in my view nothing to do with shortages of PPE or distribution, and decisions were not to my knowledge made about using NPIs on the basis of what PPE was available. However, PPE was a relevant component of lockdown exit strategy and the need for confidence in PPE was included as one of the five criteria needed to be achieved before the Government lifted lockdown measures in April 2020.

Adult Social Care

163. Adult social care was one of the most challenging areas of the whole pandemic and one of the areas where our approach evolved most. The progress of the disease within care homes caused high levels of concern within government. It has also provoked entirely understandable anger both from those who lost loved ones to COVID-19 and from those for whom COVID-19 restrictions prevented contact with friends and relatives, in the last few months or weeks of their life for COVID-19 or non-COVID-19 related reasons.

164. I once again endorse the observations made in the Technical Report. The first and second waves of the COVID-19 pandemic had a profound impact on the health of residents of care homes for older people, where high attack rates and a large number

of deaths occurred. In this pandemic, residents of care homes for older adults were particularly vulnerable due to their age, the presence of multiple high-risk co-morbidities, and the transmission potential inherent in frequent close physical contact through care (which resulted in large numbers of outbreaks). The measures taken to reduce transmission, like reductions in visiting, also impacted residents – in particular loneliness, isolation and deconditioning as well as stress and distress for residents, staff and loved ones.

165. However, there were no easy decisions. The Government was constantly faced with making policy decisions in the interests of managing the pandemic, in a context where everyone was adversely impacted. Decisions had to be considered and reconsidered at extreme speed and under extreme pressure. Ultimately, the Government had to base its decisions on what, given the scientific understanding at the time and what was feasible, it believed would save the most lives, and benefit the most people. The risks included both direct and indirect risks. At all times, mitigating steps had to be balanced against the need to protect against indirect mortality caused by the interruption of health services.

166. Government management of adult social care was further challenged by its limited role in relation to care homes. The adult social care system is a hugely complex

system in the UK which relies mainly on private and third sector providers, commissioned by local authorities, the NHS, and individuals to meet a range of care needs. As of April 2021, there were over 15,000 care homes run by approximately 6500 providers. The response to COVID-19 required a whole system response involving many organisations working together to protect individuals.

167. I discuss the challenges associated with Adult Social Care in the corporate statements for this module, in my third witness statement at paragraphs 172 to 173, 182 to 192, and 228, in my fifth witness statement at paragraphs 343 to 361, and in my eighth witness statement at paragraphs 208 to 220. The Department will also provide a supplementary statement on adult social care (CW9/144 - INQ000000000).

Adult Social Care Context January to March 2020

168. The Government's starting point in early 2020, was that local authorities would manage and deal with the risks in adult social care of any infections on a local basis, in line with the statutory framework. Scientific evidence was that transmission of the virus was greatest via symptomatic individuals in the first few days of symptoms, through close contact and droplets. This was set out in the PHE paper, "Are asymptomatic people with 2019nCoV infectious?", dated 28 January 2020 (and considered by

SAGE on 4 February 2020), which stated that, "*The currently available data is not adequate to provide evidence for major asymptomatic/subclinical transmission of 2019nCoV. Detailed epidemiological information from more cases and contacts is needed to determine whether transmission can occur from asymptomatic individuals or during the incubation period on a significant scale*" (CW9/145 - **INQ000279879).** Although the possibility of asymptomatic transmission was noted early on in the pandemic, it was thought to be low due to low levels of asymptomatic transmission with similar respiratory viruses, although it could not be ruled out in its entirety.

169. On 11 February 2020, I chaired a DHSC Adult Social Care Coronavirus Response meeting with the Director General and Director for Social Care and DCMO, alongside other officials (CW9/58 - INQ000049363). At this meeting, the Department discussed the necessary COVID-19 response for the adult social care sector, including social care providers. Key issues discussed in this meeting were: raising awareness of the COVID-19 risks in the sector to promote prevention; preparing for RWCS planning assumptions; and, putting in place appropriate staffing and resourcing for the adult social care team in the Department. This meeting started from the principle that LAs would lead the response (and it was noted in the minutes that this was also the steer from ministers). The responsibilities of the Department in supporting LAs and LRFs were discussed. It was noted that any emergency powers must still enable LAs to react appropriately to local circumstances.

170. Following from this meeting, I asked that an ethical framework be put in place that was specific to adult social care. This was led by the Chief Social Workers and published on 19 March 2020 (CW3/402 - INQ000106252). Its purpose was to provide support to ongoing response planning and decision-making to ensure that proper consideration was given to particular ethical values and principles, when organising and delivering social care for adults.

171. From March onwards it became increasingly clear that the locally led approach to the Adult Social Care sector was not up to a challenge of this scale and increasingly national approaches had to be adopted for guidance, funding, testing, PPE and data collection and monitoring. I was not directly involved in the substantive development of the adult social care guidance referred to in paragraph 176 of my third witness statement, but I would have been aware of the details of the policies, having been CC'd in emails on them and attended meetings where they were the substance of discussion.

172. I am asked about the contention that a "protective ring" was put around care homes. This is not a phrase I have used or advised on.

25 February 2020 PHE Guidance

173. On 25 February 2020, "*Guidance for social or community care and residential settings on COVID-19*" was published on PHE's website having been signed off by DHSC (CW9/146 - INQ000051209). The February PHE Guidance reflected the understanding at the time and stated that "*there is currently little evidence that people without symptoms are infectious to others*" (section 4). While I was aware of the work and the direction it was taking, I was not directly involved in developing or advising on the substance of this guidance which was developed by officials in DHSC and PHE. For example, my office was copied into an email on 3 March 2020 from PHE with edited versions of previously published guidance, including the 25 February 2020 guidance (CW9/147 - **INQ000279897).** My office did not respond because we were not being asked to provide advice or to clear it.

174. The February PHE Guidance developed against the backdrop of no evidence of community transmission of COVID-19 in the UK and did not call for any major changes in the way that care homes were operating at the time. Whilst the risk was perceived as low, the document went on to provide extensive guidance on what measures care homes should take to protect residents so that they could plan and prepare. For example:

a. It provided detailed guidance on the virus and its management, including section 17, which was headed "*Specific actions for social and community care staff visiting patients … providing care to residents*";

b. It built on existing good practice for managing infectious disease in care homes, including: guidance on the circumstances in which self-isolation was required, both in respect of staff and care home residents; infection prevention protocols; and, decontamination advice;

c. It signposted that advice on managing and controlling outbreaks of infectious diseases could be obtained from local Health Protection Teams;

d. It reflected the current UK policy about imported transmissions and risk. In section 18, on "*What social, community and residential care settings need to do now*", it stated that, "*If any of your staff do become infected through travel to affected countries you will be contacted by your local Health Protection Team to take you through a risk assessment for your particular setting*." In section 8, it said, "*If staff, member of the public or resident becomes unwell in the workplace and has travelled to China or other affected countries, the unwell person should be removed to an area which is at least 2 metres away from other people*."

March Hospital Discharge Policy

175. The March hospital discharge policy was announced on 17 and 19 March 2020 (CW3/389 and CW9/148 - INQ000106453; INQ000049702). This was done by

combination of (a) a letter from NHSEI on 17 March 2020, requesting every part of the NHS to free-up the maximum possible inpatient and critical care capacity, and (b) the Government's Hospital Discharge Service Requirements, dated 19 March 2020, setting out the actions that should be taken to enhance discharge arrangements capacity. I was not personally involved in preparing the guidance on hospital discharge issued in March 2020. Again I was fully aware of the direction of travel of the work and attended the meeting on 12 March (CW9/106 - **INQ000279904)** with the Prime Minister, Sir Simon Stevens, the Secretary of State for Health and Social Care and others where hospital discharge policy was discussed.

176. This was not a new policy. Discharging individuals as soon as they no longer meet the criteria to reside in hospital (in other words, when they no longer need acute hospital care) has been increasingly recognised as the most effective way to support patient outcomes. This approach has been promoted as good practice for several years. Indeed, the impacts of delayed or prolonged hospital admission, even in normal times, are well documented, particularly for those who are frail or elderly. Spending a long time in hospital can lead to a higher risk of infection, mental and physical deconditioning and increased risk of falls. This can leave individuals permanently less able to perform tasks than prior to admission.

177. The policy objective of the March hospital discharge policy was to prevent critical care services from being overwhelmed – and, therefore, catastrophic consequences for anyone needing those services, including older people and other vulnerable groups who were more likely to be hospitalised by COVID-19 – whilst ensuring the safe discharge of individuals during the pandemic. It sought to do so by ensuring the timely discharge of those considered to be fit for discharge, based on the clinical assessment of clinicians, in line with existing good practice. Crucially it also provided funding for discharge.

178. The March hospital discharge policy was expected to free up at least 15,000 beds to deal with severely ill patients. For the majority of patients (over 95%), they were expected to be discharged home with follow-on care being provided where required; and for those who had greater needs, they would be provided with a rehabilitation bed or care home bed. A person's 'home' in this context could also include a care home where they were an existing resident.

179. By 26 March 2020, DHSC was able to report that hospitals were running at 70% capacity due to the steps that had been taken, albeit that significant challenges remained. The ultimate objective of the March hospital discharge policy was, therefore, achieved. Hospitals did not become overwhelmed. All those who required treatment

for COVID-19 or other emergency conditions were able to be provided with it. This directly benefited the elderly and those with underlying conditions who were most at risk of requiring hospital treatment.

180. With regard to testing, the March hospital discharge policy provided for COVID-19 test results to be included in the discharge documentation. Where individuals showed symptoms of COVID-19, they would have been tested in hospital in line with the testing prioritisation criteria, and this information would be shared on discharge in order to advise appropriate isolation procedures.

181. Discharges to care homes were not made contingent on receiving a negative COVID-19 test. The main reason for this was lack of testing capacity. PHE developed clinically agreed priorities for testing capacity on 11 March 2020 (CW9/149 - **INQ000279902).** This guidance had been reviewed by the DCMO (Jonathan Van Tam), PHE Medical Director, PHE NIS Director, NHS England Medical Director, NHS England Strategic Incident Director. I was not directly involved in the development of this guidance, but I was aware of its substance. It was agreed that, given the current constraints within capacity, PHE should publish the top three priorities, but the full guidance was as follows:

"Group 1 (test first): Patient requiring critical care for the management of pneumonia, Acute Respiratory Distress Syndrome ("ARDS") or influenza like illness ("ILI"), or an alternative indication of severe illness has been provided e.g. severe pneumonia or ARDS.

Group 2: All other patients requiring admission to hospital for management of pneumonia, ARDS or ILI.

Group 3: Clusters of disease in residential or care settings e.g. long-term care facility, prisons, boarding schools.

Group 4: Community patient meeting the case definition and not requiring admission to hospital – over 60 years or risk factors for severe disease (recognising that this is challenging); over 60s should be prioritised over other risk factors.

Group 5: Community patient meeting the case definition and not requiring admission to hospital – under 60 years and no risk factors for complication.

Group 6 (test last): Contacts of cases."

182. I was not aware of any assurances being given by the Secretary of State or others that testing would be in place for patients discharged from hospital. Testing did not take place because there was insufficient testing capacity for the demand. Were such assurances given they would have been incorrect. Our challenges in surging testing generally were writ large in care homes.

183. A number of studies have since explored the role of discharge in care home outbreaks during the first wave across the four nations of the UK, including a retrospective analysis of outbreaks in England between 30 January and 12 October 2020 (CW9/150 - INQ000234332). The analysis in England followed a request from the Public Accounts Committee, on 22 June 2020, that DHSC and NHSEI review which care homes received discharged patients and how many subsequently had outbreaks. The various UK studies collectively used a range of methodology and, whilst the evidence is not conclusive and the studies were not available to decision-makers at the time the policies in scope of this claim were developed, they suggest hospital-associated seeding accounted for only a small proportion of all care home outbreaks.

184. On 26 May 2022, SAGE published "*Consensus statement on the association between the discharge of patients from hospital and COVID in care homes*" (CW9/151 - INQ000215624). After conducting a review of all of the available evidence, the following conclusion was reached:

> *"Any person infected with COVID-19 going into a care home could introduce infection into the care home. Hospital discharge to care homes connects 2 high contact environments, where contact rates with carers in the course of care are high, and potential consequences of COVID-19 in vulnerable populations severe.*

Overall, we interpret the identified studies as showing that at least some care home outbreaks were caused or partly caused or intensified by discharges from hospital.

However, based on the very much larger associations between care home size (a proxy for all footfall) and outbreaks, hospital discharge does not appear to have been the dominant way in which COVID-19 entered care homes.

Hospital discharge of people to care homes without testing early in the pandemic is highly likely to have caused some outbreaks or been one of the often multiple introductions of infection to care homes which experienced an outbreak. However, it is highly unlikely to have been the dominant driver of all care home outbreaks in wave 1."

185. The aforementioned conclusion was likewise echoed in the Technical Report:

"Epidemiological and genetic evidence from across the UK suggests that for COVID-19 while some care home outbreaks were introduced or intensified by discharges from hospital, hospital discharge does not appear to have been the dominant way in which COVID-19 entered most care homes. Prior to testing being widely available, the risk of keeping care home residents in hospital at a time of increasing nosocomial infection risk needed to be balanced with the risk that they might already have acquired COVID-19 and introduce it to the care home. Nevertheless, hospital discharge to care homes connects two high-contact

environments, and it was and should remain a high priority for preventive actions in similar pandemics."

Action Plan for Adult Social Care

186. I have been asked about my involvement in the Action Plan for Adult Social Care that was published on 15 April 2020 (CW3/407 and CW3/462 - INQ000106354; INQ000107086).

187. In April 2020, the scale of evidence around asymptomatic transmission began to increase. On 12 April, an introductory statement was added to the infection prevention and control guidance, confirming that the UK was experiencing sustained community transmission. On 13 April, I raised an issue about the guidance on hospital discharge with Sir Simon Stevens and the need for the Department and the NHS to come to agreement about what to say in the DHSC publication of the Action Plan on 15 April 2020.

188. In those texts (CW9/152 - **INQ000279943),** I remarked: "*For social care – I gather we are not quite agreed on discharge policy (not for bad reasons – just cause it's really hard and really imports). Where are you on this? For the 9.45 meet better to note we still have work to do to settle this than have the debate there I'd have thought. C".* Sir Simon Stevens responded stating "*Para 1.27 is completely loopy… it amounts*

de facto to adding up to 14 days length of stay in hosp/nhs settings… With no capacity modelling whatsoever to support!" This was in reference to a draft of 'COVID 19: Our strategy for Adult Social Care' (CW9/153 - **INQ000279923).** I responded by referring Sir Simon Stevens to a new version of the guidance.

189. The April Action Plan included a commitment to all patients being tested prior to discharge to a care home and was a turning point in our approach. This was estimated to be approximately 14,000 individuals per month. This had only become possible due to increased testing capacity. Moreover, it confirmed a move to testing all symptomatic residents in care homes, albeit this would be dependent on testing capacity and mechanisms for testing. Ultimately, the change to the testing advice came about due to a confluence of growing evidence regarding asymptomatic transmission and an increase in testing capacity, which was directed to the priority groups including care home staff and residents.

190. The April Action Plan also clarified that, if a care home could not provide appropriate isolation or cohorted care after discharge for individuals who had tested positive for COVID-19, it was the responsibility of the relevant local authority to provide appropriate alternative accommodation. The Action Plan confirmed that funding for alternative accommodation was available centrally, through the £1.3 billion funding for discharge via the NHS (which had been announced on 19 March 2020).

Adult Social Care Taskforce

191. On 8 June 2020, the Secretary of State announced the 'Social Care Sector COVID-19 Support Taskforce' (CW3/413 and CW3/414 - INQ000106467; INQ000106465), chaired by Sir David Pearson, to oversee the implementation of two packages of support: the Social Care Action Plan (CW9/154 - **INQ000279924)** and the Care Homes Support Package (CW3/408 - INQ000106440). In addition, the Taskforce was asked to support the Government's work on community outbreaks – areas of the country that needed particular help and intervention to deal with higher rates of infection – and advising and supporting local places to consider and respond to reducing the risk of infection in care homes and the wider social care sector. Its further remit was to provide advice on the requirements for the response to COVID-19 in the next few months, ahead of and into winter. The Adult Social Care Taskforce further was set up to ensure that concerted and determined action was taken to reduce the risk of transmission of COVID-19 in the sector, both for those who rely on care and support and the social care workforce. The Adult Safeguarding Forum was also created which brought together key sector partners to share good practice and learning, and address issues as and when they arose. The Taskforce was commissioned from June and reported in August 2020, "*Social Care Sector COVID-19 Support Taskforce Final Report, Advice, and Recommendations"* (CW9/155 - **INQ000279934).**

192. The Report set out a series of recommendations to be followed for pandemic planning for the next phase of the pandemic. Sir David Pearson updated me on his work on a number of occasions. While I do not have minutes of these meetings, I understand that I received updates from him on 5 June 2020, 15 June 2020, 14 July 2020, and 28 July 2020. I believe his work was excellent. I recall that this Report was instrumental to shaping pandemic response in adult social care over the course of the year that followed.

193. Between March and May 2021, Sir David Pearson conducted a further review with stakeholders of the implementation of the 2020 to 2021 winter plan in adult social care, "*Adult Social Care in England (COVID-19) A review of the 2020 to 2021 Winter Plan"* (CW9/156 **INQ000279947).** The Report observed that COVID-19 had had profound effects on the adult social care sector, with a high cumulative excess mortality rate, as well as a detrimental impact on the health and wellbeing of the population. The Report set out a further series of recommendations which were instrumental to pandemic response.

194. Additionally, the Report suggests that the NPIs implemented following the first wave had a significant impact during the second wave: *"While COVID-19 accounted for around 40% of all deaths of care home residents between April and June 2020 in*

the first wave of the pandemic, it accounted for only a quarter (26%) of all care home resident deaths between September 2020 and February 2021 in the second wave. This compares with a global average of 41% between March 2020 and January 2021 (This is based on 22 countries, from the start of the pandemic, updated to various different dates the latest of which is the 25 January 2021, from the International Long Term Care Policy Network report). Whilst cause and effect is difficult to unpick, the evidence strongly suggests that the actions taken since the beginning of the pandemic, including those outlined in the winter plan, have had a significant impact in reducing risk."

PPE in Care Homes

195. I am specifically asked about PPE in care homes and when I became aware that PPE was going to be an issue. As discussed above, I first became aware that PPE was going to be an issue in the context of care homes in February 2020. On 11 February 2020, I attended a DHSC Adult Social Care Coronavirus Response meeting with the Director General and Director for Social Care and Deputy Chief Medical Officer, alongside other officials (CW9/58 - INQ000049363). The focus of that meeting was the legislative response to Coronavirus within care homes, but "supply issues" were discussed. I have set out above in paragraph 156 the action taken to support social care providers' access to PPE.

196. In June 2020, the PPE 'Task and Finish' group was set-up for key adult social care stakeholders, offering a forum to discuss PPE issues (CW3/410 to CW3/412 - INQ000106340; INQ000106339; INQ000106326).

Data and Care Homes

197. I have been asked about the data that was available to me in the context of care homes. On data, I would refer the Inquiry to the Department's corporate statement concerning data and scientific expertise from 1 January 2020 to 31 July 2020 signed by Christopher Mullin (CW9/157 - **INQ000252722).**

198. For adult social care, I understand that key data sources for the Department included NHS Test and Trace data to assess COVID-19 prevalence and outbreaks in care homes, NHS data on hospital admissions from care settings, Care Quality Commission (CQC) and Office for National Statistics (ONS) data on deaths among care home residents, and daily reports from care providers via the Capacity Tracker (CT) on a range of topics including infection control measures, outbreaks and visiting, and later vaccinations and staffing pressures. As noted above, from April 2020, the Department produced a daily SitRep (CW9/158 - INQ000106353) that brought together these sources. This was developed over the course of the pandemic to exploit new data sources and to monitor new priorities.

199. There was also data gathered on PPE, including actual rates of usage in different settings, contracted volumes of PPE, current stock levels, outbound distribution, updates on product assurance, and broad sources of supplier. These data were developed during 2020: by the latter stages of 2020 the Department had available this broad set of data sources to support PPE policy decision making and operational management and planning.

200. I did not observe the work of any particular data teams. However, I can comment that the data system established at the centre to inform the morning meetings was excellent and drew data successfully across government in a consistent and easily accessible manner. The presentation of the information was very helpful and enabled ministers to more easily make decisions. I am unaware which data teams were involved in the preparation of this information.

201. I am further unable to comment as to what extent decision-makers were informed by the work of the UCL Vivaldi team. However, I note that on 3 July 2020, the "Vivaldi 1: COVID-19" care homes study found that 5,455 out of 6,747 of residents who took part in the Whole Care Home Testing Programme (of all 9,081 homes tested via pillar 2 between 11 May and 7 June) and tested positive for COVID-19 were asymptomatic. The aim of the Vivaldi study was to provide insights into which care homes were at greatest risk and which disease control measures were most effective in preventing

infection. The paper also provided preliminary evidence that some care homes experienced outbreaks that were undetected and that staff working across care homes - or other sectors – were a key risk factor for effective infection prevention and control.

Care Home Visits

202. As the pandemic demonstrates, NPIs that reduce personal contacts, particularly isolation from family and loved ones will have a considerable impact on residents' and families' quality of life. Balancing the benefits and harms is not straightforward. The length and extent of limits on visiting, on social interactions of residents, and the use of masks at all times by staff during the COVID-19 pandemic were unprecedented in care homes.

203. I was not directly involved in developing the substance of policies regulating and restricting access to individuals in care homes, although I was aware of the direction of travel and would have attended meetings and been copied into emails where these issues were discussed (CW9/16 - INQ000090180). I do not recall any institutional divergences. However, I do recall there being a significant amount of debate on striking the right balance between protecting disease and the well-being of individuals.

Personal Reflections

204. My personal reflections on the experience of COVID-19 in care homes are as follows. The initial approach of a locally led response in line with Local Authorities' statutory duties was legally correct, but in practice not effective. In practice national consistency and additional national resourcing were needed to meet the challenges. More national responses were required as we implemented measures and as the pandemic went on. In a similar situation again, it would be sensible to take a more nationally driven approach from the start.

205. The pandemic shone a spotlight on the existing fragilities of the social care system, particularly around fragmentation, data, funding and staffing. As the Technical Report concludes:

> *"Preventing ingress into care homes proved extremely difficult during periods of high prevalence in the community. High case rates in hospitals required careful management of discharges into care homes. The structure of the care sector presented challenges: there is enormous diversity of facilities and many staff move from one facility or care role to another within the same week or even day. The adult social care workforce, although trained to provide care, lacks the status of registered professionals and is relatively poorly paid and insecurely employed, with high vacancy rates and poor sick pay provision."*

206. The discharge policy introduced in March 2020 was rationally-based given what was known at the time and studies suggest was not the dominant contributor to

infection in care homes. Alternative policies, such as not discharging, would have been worse both for hospitals and for the individuals involved. However, public and private sector confidence was significantly damaged by the news of outbreaks and with hind-sight, we should have done more to work with care homes and to communicate to care homes how all new residents, whether discharged from hospital or not, should be treated.

207. Sir David Pearson's report and the subsequent action plan marked a significant improvement in our approach. His approach and the recommendations within his re-ports should form the basis of our staring response in any future pandemic.

208. Finally, the legislative framework particularly around data and oversight were not adequate for the needs of a pandemic. We have since legislated to change this in the Health and Care Act 2022.

Discussions and Decisions with Devolved Governments

209. The central government structures and bodies concerned with the UK's re-sponse to the COVID-19 pandemic and the relationship between the UK Government and the Welsh, Scottish and Northern Irish Governments (the Devolved Governments) are set out in my third witness statement at paragraphs 14 to 18.

210. In terms of what I personally did, I had regular meetings with the three Permanent Secretaries in the Devolved Governments, for example on 1 May 2020 (CW9/159 - **INQ000279944).** These were information exchange meetings to share experiences and identify potential upcoming issues. They were not decision-making meetings.

211. I had similar discussions with my opposite in the Republic of Ireland, for example on 2 March 2020 (CW9/160 - **INQ000279889).**

212. My view is that official level discussions with the Devolved Governments were always professional and productive. The four CMOs meeting was a particularly effective forum. Relations between health ministers from what I saw were also effective and professional – even when the administrations did not agree. There were some obvious and public tensions between approaches at some points, particularly between the UK and Scottish Governments over lockdown policy – but I did not have direct involvement with this.

213. In general, national and devolved remits were clear. The main exception was in the area of Borders policy where the constitutional settlement did not envisage the interaction of national border policy and devolved public health policy that took place in the pandemic.

D. Role in Relation to Medical and Scientific Expertise, Data and Modelling

214. I believe access to excellent medical and scientific expertise was one of the UK's great strengths in the pandemic. I would particularly point to the advice of the CMO and GCSA as well as that provided by SAGE, NERVTAG, the Government Office for Science, the DCMOs, JCVI, and the Medicines and Healthcare Regulatory Agency (MHRA). As has been said already by me and others during module one, our strong scientific research community in the United Kingdom was a real asset we could and did draw upon and who were able to provide us with the best possible information (where it existed or give probable answers where it did not) quickly and efficiently. The ability of SAGE to use the expertise of a vast range of different areas of specialism, and the willingness of scientists to divert their focus to government assistance on a voluntary basis – not just for the odd day or two, but in some cases for years, was a truly exceptional piece of public service to witness, which often came at great personal sacrifice to the scientists themselves. Scientific collaboration with the CMOs of the Devolved Governments was also both crucial and hugely positive.

215. I consider that No. 10 and the Cabinet Office did have access to all the advice available to DHSC. The CMO and GCSA carried out their role as being advisors to the whole of Government, and it would not be unusual for them to have several direct discussions with the Prime Minister and senior ministers a day. Crucially their advice was given to senior decision makers orally and in person and they were present and

active participants in all the key decision-making meetings of which I am aware. Scientific advice was fully and directly integrated into decision-making.

216. In my experience both the CMO and GCSA were consistently clear that their views were but one factor in the decision-making process. It was expected that their scientific and clinical advice would be weighed by elected politicians against other factors, particularly social and economic consequences. My view was that they expected science to an important guide to decision-making but not necessarily decisive.

217. I was of the view that the advice I received from the CMO, GCSA, JCVI, and other groups was effective, transparent, clear, and impressive in distilling complex scientific ideas into ones that lay persons could understand.

218. I considered the SAGE system to in general be effective and appropriate. As noted above there were just two points on which I raised concerns. The first being the consistency of SAGE advice between 12 and 18 March 2020, as discussed at paragraph 108 above. The second point was the appropriateness of Special Advisers attending SAGE discussions, as discussed at paragraph 51 above.

219. There could always be arguments about who should or should not be included on SAGE but there was a wide group of experts from a number of disciplines. The purpose of SAGE was to reach a consensus to be provided to decision makers, where

possible. SAGE was designed to have broad debates and discussion, and I understand that it did so, but I did not attend the meetings because it was not within my role. I would therefore not have been informed necessary of significant disagreements between SAGE members as the purpose of SAGE was to present a consensus view which may well not have been to the agreement of all members. I saw it as a core role of the GCSA and the CMO to present SAGE discussions in a fair way to inform decision makers about the scientific evidence, including whether it was strong and weak and whether there was a consensus or not. I consider that this system is better than politicians and officials, who do not have the necessary expertise, having to choose between different scientific opinions. I did not see any evidence of so-called Groupthink.

220. I did not consider that having the CMO also as the CSA for the Department was problematic, nor do I think having another person was necessary. I took the view that it was the CMO's decision when and who to recruit as a new CSA. In addition to the CMO, the Department also had access to advice from the DCMOs and specialist clinical advisors from PHE, UKHSA, JCVI, and NHS England all of whom provided a range of advice and information.

221. I am not a scientific expert and so do not consider that I could "challenge" the advice on scientific grounds and I would have been foolish to do so. I always felt able to discuss and explore the advice with CMO and others, and there were always wider considerations than just scientific conclusions as to what steps should be taken in

response, and my role was to draw these out and to ensure that the Department acted as a "critical friend".

222. I am not of the view that economists should be added to SAGE. Indeed, the usual criticism of government is that there is too little scientific advice not too much. I am not in favour of either scientific advice being diluted or that economic advice to government should come from a source that is neither from nor via the Treasury. For me the issue is not about the composition of SAGE, but how its advice is used by decision makers. In my view SAGE should provide advice based on the scientific analysis, advice, and options and decision makers should then weigh that advice against economic and other factors in taking final decisions.

223. I take the same view of representation of adult social care or other sectors on SAGE. SAGE members should be chosen for their scientific expertise. That is however not the same as saying that the Government did not lack social care expertise. As noted in paragraphs 83 and 204 above, early in the pandemic prior to the establishment of the social care task force under David Pearson we put too much reliance on local authorities to respond to the pandemic in social care.

224. As to economic decision making, the Treasury was understandably reluctant to attempt to model the impact of NPIs which impacted the whole country, beyond identifying that it would be very bad. That is wholly unsurprising as it is difficult to model

something which has never happened before. Indeed, projecting the economy is difficult enough in normal conditions. So, decisions made about such NPIs inevitably were made without being able to know the precise short- and long-term effects on the economy of undertaking these.

225. As I identified above, the key issue during the first wave of the pandemic was how to make good decisions in uncertainty with asymmetric data of uncertain quality. The data about the disease, its transmissibility and how it transmitted was incomplete. There was little evidence, modelling or data as to the economic and social effect of the pandemic at this time. In July 2020, the CMO provided the Department, the Secretary and State and the Prime Minister with a paper called *"Direct and Indirect Impacts of COVID-19 on Excess Deaths and Morbidity"* (CW9/138 - INQ000220213) at which he identified the unquantifiable matters that the advisers did not know, and which articulated the uncertainty. The decisions made were weighed carefully, but it was extremely hard to make evidenced decisions in this context.

Data

226. As I have identified in the corporate statements and this statement, we did not have sufficient data at the beginning of the pandemic to make a full assessment of the various risks involved. We had to use what we had and recognise the high levels of uncertainty. We could not, however, pause making decisions because of the absence of data or information, but had to do the best. Timing was of the essence and could be

as important as the substance of the decision reached. The Department has provided a corporate statement concerning data and scientific expertise from 1 January 2020 to 31 July 2020 signed by Christopher Mullin (CW9/161 - **INQ000252722),** which I would refer the Inquiry to.

227. Further, Chapter 4 of the Technical Report provides an overview of the data that was needed and used across government throughout the pandemic.

228. I did not directly observe the works of the No. 10 data science and analytics team, but I understand that the data system established at the centre to inform morning meetings was excellent. The No. 10 Dashboard was a particularly effective way of drawing in data from across the Government in a consistent and easily accessible manner. I am unsure whether this was work carried out by the No. 10 data science and analytics team, but I recall it being very helpful.

229. I am not a mathematical modeller, and so cannot answer questions about their efficacy. My broad understanding is that modelling is only as good as the underlying information you have. Moreover, the further into the future you seek to predict, the less reliable the model. The less information you have, the more assumptions have to be made which can turn out to be wrong. I understood that at times modelling was just that: a product of a series of assumptions. My recollection is that whenever models were presented the limits of the data were clearly explained.

230. I cannot speak about the modelling of other factors such as education or societal factors as that would not have been for my department. Again, any modelling relies upon data. As the pandemic went on, we commissioned surveys, information, and data from hospitals and other settings about the mental health impact and other impacts of the pandemic, but they could not be modelled in advance.

231. I can only speak for myself when I say that I always recognised that any scientific advice had to be balanced against the broader social and economic considerations of decisions made, and that everyone was "guided by the Science" but that did not mean that all scientific advice was always followed. Sometimes it could not be practically implemented, and on other occasions broader considerations were seen as more vital. That is to be expected.

232. I recall seeing very good information on international comparisons that was helpful when DHSC officials were advising ministers. I am uncertain whether this information was prepared by the ICJU, but it was excellent. I was not otherwise involved in the work of the ICJU.

233. The rationale for what is now called "lockdowns" i.e., whole society stay at home orders backed up with the force of the law were done to help those with vulnerabilities avoid infection with COVID-19. The entire point of the March 2020 lockdown

was to stop people dying both directly from COVID-19 and indirectly if the hospitals became so overwhelmed that they were unable to treat people who were unwell. The purpose of the lockdown was to protect the vulnerable. It was not a separate consideration – but the entire rationale for asking millions of people to give up their lives who were not at risk of serious ill health and death in order to protect those that were. All NPIs, even if not as extreme as "lockdowns" - such as social distancing, mask wearing, "tiering", remote working, and shielding were undertaken with the aim of protecting the vulnerable.

234. I am asked about any personal advice I gave to the Prime Minister or other core decision makers and if they were followed. As I identify above, my role is to contribute to debates and discussions held both within the Department and within the Government as a whole. Most big decisions are iterative, where different perspectives are debated and either a consensus is achieved, or the Prime Minister decides on the balance of the evidence he or she has assessed.

235. There has been widespread comment that the Prime Minister did not follow the advice given by the CMO and the GCSA about the November 2020 lockdown, about the relaxation of restrictions over Christmas 2020, reopening of schools in January 2021 (although the third lockdown subsequently followed), or about having a fourth lockdown in response to the omicron wave in December 2021. I was not in the room for any of these decisions so I will not comment on what considerations the Prime

Minister made. However, I would not necessarily have expected the Prime Minister to always make the decisions advocated by DHSC or by scientific advisors. The role of DHSC was to provide the health perspective on events: it is the role of the Prime Minister to weigh that advice against any other advice he was given and about for example the economic and social consequences of particular actions.

E. Role in COVID-19 Public Health Communications

236. I did not play any public facing role in communications or behaviour management during the pandemic, and the role of the Department is set out in my third witness statement in paragraphs 232 to 248, my fifth witness statement in paragraphs 413 to 415 and my eighth witness statement in paragraphs 312 to 313.

237. I consider that the alleged breaches of rules by ministers, officials and others were unhelpful and did dent public confidence in the UK Government and in the response by the public to COVID-19. Trust and confidence are essential when you are asking people to take drastic steps to change their lives. However, I have not seen any evidence that directly links these issues with public compliance with COVID-19 rules and guidelines at the time. My overall view is that the public responded with considerable altruism and resilience to both the letter and the spirt of the COVID rules and guidelines.

F. Role in Public Health and Coronavirus Legislation

238. The Department has submitted a corporate witness statement for this module on the impacts of legislation (CW9/162 - **INQ000273634),** the fourth witness statement of Clara Swinson. As noted above at paragraph 88, the CCA was not used as there was time to pass bespoke legislation. It had been recognised that the Public Health Act 1984 would not be sufficient to cover the eventualities required in a future pandemic. This necessitated the preparation of a draft pandemic flu bill, which was used as the starting point for what became the Coronavirus Act. Greater detail is provided in the relevant statements.

239. The CCA was widely misunderstood within government, particularly that it could only be used when bespoke legislation could not be passed. As discussed above, the Department, and the Government, did not exercise its powers under the CCA.

240. Additionally, I would make three further observations about implementing legislation which compulsorily deprives people of their right of free movement and to set out what people can or cannot do (and how organisations should or should not behave or do or not do).

241. First, once a legislative approach to NPIs had been taken it was very difficult to go back to more voluntary measures, as the public – completely reasonably – saw the

imposition of legal restrictions as a benchmark of how serious the situation was. So, when new variants emerged it became difficult to convince the public that they were sufficiently serious if shops and schools remained open. This was not something we had appreciated when the first lockdown was introduced on 23 March.

242. Second, legislative routes meant it was necessary to spell out with increasing levels of complication exactly what was legal and what was not. Again, when we first imposed a lockdown on 23 March, we did not imagine we would be taking decisions for example, on what constituted a substantial meal for the purpose of eating out.

243. Thirdly, as noted in paragraphs 130 to 131 above, the legislative approach to tiering was too complex.

244. Notwithstanding my comments, there are evidently clear reasons to adopt a legally-enforced approach for NPIs. However, these were issues which were not fully anticipated when the original decisions were taken and should be considered in the future. With hindsight, greater attention should be paid as to which matters require legislation and which are better left to guidance or common sense.

Evidence given to select committees

245. The Department has already submitted a "lessons learnt" statement to this Inquiry, my second witness statement (CW9/163 - INQ000185190), which sets out the

internal reviews carried out as well as external reviews. This references the relevant Select Committees to whom I gave evidence relating to COVID-19.

246. In addition, Clara Swinson's second witness statement (CW9/140 - INQ000212314) provides evidence that was separately provided to the House of Commons Science, Innovation and Technology Select Committee's Inquiry into 'Emerging diseases and learnings from covid-19'.

G. Key Challenges and Lessons Learned

247. In our closing statement for Module 1, we set out five key lessons learnt. I repeat them again here, as five lessons that remain important for future pandemic preparedness:

a. Creation of a "toolkit" of capabilities which can adapt to deal with whatever public health risk emerges, rather than a fixed plan against specific threats or viruses. The evidence from module one has been clear that, given the unpredictability and range of possible future pandemics, it is unrealistic to try to create a specific plan for each possible new threat. Instead, the Department recognises the need for future pandemic preparations to focus upon developing a "toolkit" of capabilities which can flexibly pivot to address different emerging threats and are backed up by sufficient resources so that they can be "scaled up" quickly.

b. Resilience matters. The Department recognises that central to pandemic preparedness is the underlying resilience of the health and social care system. As a society, there is a need to consider how levels of core capacity for day-to-day

health and care services can remain resilient and be expanded to meet demand when faced with a health emergency. The Department accepts that at the time the pandemic struck, the adult social care sector had structural challenges which damaged its resilience. It also notes that the NHS is run at capacity, and therefore has little spare flexibility in the system when shocks occur.

c. There must be the ability to "scale up" quickly. The Department has reflected that a key lesson learnt from the pandemic is the need for plans and the ability to scale up staffing and equipment necessary to address and mitigate the spread of a disease quickly assuming that it will impact all of society.

d. Use diagnostics and data. The Department recognises that data is central to providing good public health advice and services to all parts of society. The paucity of data at the start of the COVID-19 pandemic meant, as Sir Patrick Vallance put it, the UK was "flying blind" more than we would wish to. The Department accepts that the scale up of diagnostics to enable comprehensive data on the spread and extent of the disease was limited in the first phase of the pandemic.

e. Prepare for future threats, not just for COVID-19. Pandemic preparedness should not seek to prepare for the pandemic which has just happened; instead, pandemic plans need to take account of and be responsive to all the modes of transmission of communicable disease pandemics or major epidemics which could in the future occur, namely respiratory, touch, oral, blood and vector. The epidemiological experts have made clear that while pandemics have always

happened and will inevitably continue to happen, their precise nature cannot be predicted in advance.

248. In light of what has been discussed, I would set out the following additional lessons learned during the pandemic:

a. One of the key learning points of the pandemic is that we need standing structures that go beyond COBR for managing ongoing as opposed to incident related crisis. It would be beneficial to have a standing escalation function to be used when a national emergency is so large that it goes beyond the capacity of a LGD.

b. From a health perspective, voluntary NPIs were introduced too late in March 2020 and the second lockdown was implemented too late and lifted too early. However, these decisions are not taken solely on the basis of a health perspective, and must be balanced against economic, fiscal, and social consequences

c. When the decision was reached to introduce a legally-enforced (as opposed to voluntary) lockdown, it set a precedent that future lockdowns would likewise be legally-enforced. Having adopted that approach, it became difficult, in my view, to return to a voluntary framework as an expectation was set that future lockdowns would be underpinned by legal enforcement.

d. In practice, a nationally-led approach is needed to care homes and adult social care in any future pandemic. While the initial approach of a locally led response in line with Local Authorities' statutory duties was legally correct, but in practice

not effective. National consistency and additional national resourcing were needed to meet the challenges.

Disclosure of Whatapps and Text Messages

249. I have exhibited those portions of messages I consider to be relevant to this witness statement but this is not all the messages in the particular group or chain.

Statement of Truth

250. I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Personal Data

Signed: _____

Dated: 22/09/2023