

Thursday, 2 November 2023

1  
2 (10.00 am)  
3 **LADY HALLETT:** Mr O'Connor.  
4 **MR O'CONNOR:** My Lady, our first witness this morning is  
5 Lord Stevens.  
6 **LORD SIMON STEVENS (affirmed)**  
7 **Questions from COUNSEL TO THE INQUIRY**  
8 **MR O'CONNOR:** Could you give us your full name, please?  
9 **A.** Simon Laurence Stevens.  
10 **Q.** Lord Stevens, you have kindly prepared a witness  
11 statement for the Inquiry at our request, a copy of the  
12 front page of it is up on the screen now. I'm sure  
13 you're very familiar with the contents of that  
14 statement, and we don't need to go there, but on the  
15 last page you've signed that statement with a date of  
16 22 September of this year underneath the statement of  
17 truth saying that you believe the facts contained in  
18 the statement are true. Is that right?  
19 **A.** It is.  
20 **Q.** Thank you. Lord Stevens, you had a lengthy career in  
21 the NHS, latterly in NHS England, and of particular  
22 interest to the Inquiry, you were chief executive of  
23 NHS England for over seven years between April 2014 and  
24 July 2021; is that right?  
25 **A.** That is.

1

1 Health Education England had responsibility for  
2 education and training, NHS Digital for the data, Public  
3 Health England for obviously not just infectious  
4 diseases, but PPE stockpiles and so forth, and so over  
5 time, frankly, we attempted to try to ensure that,  
6 together, pieces of the jigsaw were coming together to  
7 form the full picture, but the consequence of that is  
8 that in legal terms at least, before a set of changes  
9 were made in 2022, NHS England was not actually directly  
10 responsible for the totality of what was happening in  
11 the NHS in England. Confusing as that sounds, but that  
12 is the legacy that Parliament bequeathed us.  
13 **Q.** Well, perhaps not responsible for the totality of the  
14 NHS in England, but what, in summary, was it responsible  
15 for?  
16 **A.** Well, **de facto**, particularly when Covid struck, our job  
17 was to lead the NHS response.  
18 **Q.** So that was the role of NHS England.  
19 **A.** Yeah.  
20 **Q.** Your role with it, as its chief executive, in summary?  
21 **A.** To be responsible for the work of NHS England itself and  
22 also to be directly accountable to Parliament as  
23 the accounting officer for the funding that flows to  
24 the NHS in England, which was about £150 billion a year.  
25 **Q.** Thank you. And that brings us to a point I wanted to

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1 **Q.** And it's clear, therefore, from the dates that the final  
2 year and a half of your tenure as chief executive was  
3 during the Covid pandemic?  
4 **A.** Yes.  
5 **Q.** We also know that you were made a life peer on stepping  
6 down as chief executive in 2021; is that right?  
7 **A.** Mm-hm.  
8 **Q.** Lord Stevens, help us a little bit, if you will, with  
9 the nature of your role as chief executive of  
10 NHS England. Is it right that you were, as it were, the  
11 operational head of that organisation?  
12 **A.** Yes.  
13 **Q.** It is, of course, an enormous organisation, enormous  
14 budgets, huge staff, buildings and so on. Just give us  
15 an idea, if you will, as to the scope of your role in  
16 that post.  
17 **A.** The NHS in England is not one and the same as  
18 NHS England, somewhat confusingly. So NHS England is  
19 the body that was created by Parliament in 2012, in  
20 the first instance to oversee the funding for different  
21 health services across the country, but as part of that  
22 2012 Act of Parliament, actually quite a number of  
23 the responsibilities for the health system overall were  
24 distributed, some might say fragmented, between  
25 different bodies, of which NHS England was one, but

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1 raise, which is that we need to be clear, don't we,  
2 about the relationship between NHS England but, in this  
3 case, you, and the Department of Health and Social Care  
4 and its Secretary of State, Mr Hancock. Putting it  
5 crudely, he was not your boss, was he?  
6 **A.** The chief executive of NHS England is accountable to  
7 the board of NHS England. I must say, frankly, it felt  
8 as if I had many bosses. So the board of NHS England  
9 was one. I obviously had an accountability to  
10 the Secretary of State and to the government, but also  
11 more widely to Parliament, as I've described, as  
12 the accounting officer for the organisation. And  
13 frankly I felt an obligation to patients, the public and  
14 the staff in the NHS as well.  
15 **Q.** All right.  
16 Moving on to the pandemic itself, Lord Stevens, it  
17 is obvious that the NHS was involved really at every  
18 level of the response to the pandemic, and that  
19 involvement will find its reflection in the involvement  
20 of NHS England with this Inquiry. There is to follow  
21 this module, as you know, a module that will focus on  
22 the NHS itself, there will be a vaccines module, there  
23 is a module to consider PPE, care homes, all of which  
24 the NHS will have a strong interest in.  
25 **A.** Absolutely.

4

1 **Q.** This module, as you know, is focusing on core political  
2 and administrative decision-making, essentially  
3 decisions about the pandemic made in Downing Street and  
4 the Cabinet Office, and so the scope of my questions  
5 today will be on the role that you and NHS England took,  
6 first of all, in that decision-making and also on issues  
7 that affected that decision-making. But we need to bear  
8 in mind that those operational matters, if you like,  
9 will be covered in subsequent modules.

10 So let me start, if I may, by asking you: what role  
11 do you think that you played, in general terms, in that  
12 core political decision-making in the period that you  
13 were in office during the pandemic?

14 **A.** Well, I think the main responsibilities that we had and  
15 I had were to do everything we could to ensure that  
16 the NHS was able to look after severely ill Covid  
17 patients and also all of the other non-Covid patients  
18 who needed our care during the course of the pandemic.

19 So, first and foremost, it was about the operation and  
20 the availability of the NHS.

21 We were not directly asked to contribute to debates  
22 that government was having about lockdowns and so-called  
23 non-pharmaceutical interventions or other ways of  
24 controlling the spread of the virus --

25 **Q.** Just pausing there a moment, Lord Stevens.

5

1 decided to take its decisions or review progress against  
2 the pandemic, so that abated as a forum for this type of  
3 discussion.

4 **Q.** Well, we've certainly heard that the COBR meetings  
5 stopped, but are you saying that you stopped going to  
6 them for that reason?

7 **A.** No, I think -- well, I went to every COBR meeting I was  
8 asked to go to, as far as I'm aware.

9 **Q.** Was it routine that either you or someone else from  
10 NHS England was invited to those meetings?

11 **A.** During February 2020 I think that's right, and probably  
12 March as well. I mean, I'd have to literally go back  
13 and look at all of the COBRs and the minutes and so  
14 forth, but that's my recollection, yes.

15 **Q.** You've mentioned just now, and you describe in your  
16 statement, a view that these meetings were not, in your  
17 words, optimally effective. Can you expand on that?

18 **A.** Yes. I -- my observation is that the COBR meetings were  
19 very large, so lots of people, which often makes it hard  
20 to have very substantial discussions, and sometimes  
21 the seniority of representation, ministerially, at  
22 the COBRs varied between departments. So it wasn't  
23 always the case that a minister necessarily had the full  
24 authority of their department when a discussion was  
25 taking place, was my observation. Now, you know, others

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1 **A.** Sure.

2 **Q.** If you can try to keep your answers relatively -- speak  
3 relatively slowly and relatively short, that would help  
4 us all.

5 **A.** I'll stop there then.

6 **Q.** All right. So you've described, in essence, most of  
7 your work, unsurprisingly, given what you've said, was  
8 on operational matters: helping the NHS deal with Covid,  
9 and of course dealing with all of the other things it  
10 would have been dealing with anyway?

11 **A.** Yeah, I think that's right.

12 **Q.** And you've said you were not routinely involved in those  
13 discussions about lockdowns and other NPIs.

14 We can see and you describe in your statement --  
15 perhaps we can look at paragraph 13 of your statement on  
16 page 5 -- you say that you did attend several of  
17 the COBR meetings, we've heard about these meetings,  
18 held in the early part of 2020.

19 **A.** Yes.

20 **Q.** Several, all, maybe you can't remember now?

21 **A.** Probably almost all. I know the Inquiry has the  
22 COBR minutes and whether I was there or not will be  
23 there. But certainly a number during February and then  
24 in March. But as I think I mention, in a sense COBR  
25 fell out of use as a mechanism by which the government

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1 in government may take a different view.

2 **Q.** There's a particular point you make, which we can see in  
3 this paragraph on the screen, Lord Stevens, which is  
4 that when, as we know they were, in the early stage,  
5 the COBR meetings were chaired by Matt Hancock, other  
6 secretaries of state sometimes avoided attending, and  
7 sent junior ministers instead. Was that a reflection  
8 you had at the time?

9 **A.** I'm not saying that was cause and effect, but that is  
10 the fact of the matter.

11 **Q.** Well, I'm sorry, the inference in your statement is that  
12 it was cause and effect, but you're not going that far?

13 **A.** Well, I just observed that those two coincided.

14 **Q.** Can you offer a view as to whether, in light of that,  
15 the phenomenon that you were observing, it would have  
16 been better for the Prime Minister to have chaired the  
17 COBRs at the early stage? Would that have, do you  
18 think, ensured that more senior people,  
19 secretaries of state, attended those meetings?

20 **A.** I think it's very likely that if the Prime Minister had  
21 chaired those COBRs then other secretaries of state  
22 would have chosen to go as well, but whether  
23 the substance of those COBR meetings was such that not  
24 having all of those folks there made a big difference,  
25 I defer to others.

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1 Q. Of course.  
2 Just following down the page, Lord Stevens, you  
3 indicate that you did attend some Cabinet committees,  
4 and I think we can see -- I'm not going to take you to  
5 the document -- you were an attender, were you not, of  
6 the MIG, the health -- there was a particular health MIG  
7 early in 2020, which I think you did attend; is that  
8 right?

9 A. Yeah, I think I went to several of them, but not all of  
10 them. And as I think I perhaps diplomatically say in my  
11 statement, I did not consider that they were the most  
12 effective forum for resolving operational questions,  
13 shall we say, and that's why, in fairly short order,  
14 they were abolished and replaced by a different system.

15 Q. They were replaced by what we, I think everyone,  
16 referred to as Covid-O, Covid-S, operational and  
17 strategy?

18 A. Yeah.

19 Q. I think you're saying that your MIG was replaced  
20 essentially by Covid-O; is that right?

21 A. I think all of the MIGs were, in a sense, replaced by  
22 Covid-O and Covid-S, the point being that I think having  
23 fragmented subject-specific ministerial groups didn't  
24 really deal with the cross-cutting issues which actually  
25 were the main purpose of having those kinds of forums.

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1 had happened I think earlier that week, and we can see  
2 from the start, the first line of the email, it was  
3 a meeting which included the Prime Minister, the  
4 Chancellor, Chris Whitty, Stuart, Vallance and you, and  
5 it may well be others as well.

6 A. Sure.

7 Q. We don't see your name on the copy list. This appears  
8 to have been an internal Number 10 document, but I know  
9 you've had a chance to look at this document, and  
10 obviously if there are any things in it which don't  
11 accord with your recollection, you'll tell us.

12 First of all, do you remember going to this meeting  
13 in the autumn of 2020? I say "going", it may have been  
14 a virtual meeting.

15 A. Yeah, I do -- I do remember it. I think this note is  
16 10 October, I think it relates to a meeting that  
17 Thursday, I think it was probably 8 October.

18 Q. Right. And we see again from the first line that the  
19 purpose of the meeting was to discuss Covid, perhaps in  
20 particular NHS preparedness.

21 A. Mm-hm.

22 Q. Preparedness for the winter to come?

23 A. Yeah, and in the light of rising Covid cases which were  
24 apparent by early October.

25 Q. We'll look at just a little bit of the detail in

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1 And when it came specifically to figuring out things  
2 that required political involvement, a ministerial  
3 decision on health, the MIG was probably not the best  
4 place to get that done.

5 Q. Did you attend either Covid-O or Covid-S and did you  
6 find that they were more effective forums for the --

7 A. Yes, I did from time to time, and that was my  
8 assessment. And as I think I say as well, I think when  
9 the Cabinet Office created with Number 10 this thing  
10 called the Covid Taskforce, that substantially improved  
11 the coherence of what the centre of government was doing  
12 relative to individual government departments, was my  
13 impression.

14 Q. You also say in your statement, Lord Stevens, that there  
15 were a few occasions at least where you had ad hoc  
16 meetings with the Prime Minister and other senior  
17 decision-makers.

18 A. Yeah.

19 Q. I'd like to take you to a document which records one of  
20 those meetings.

21 It's INQ000146616, please.

22 So this, Lord Stevens, is an email, is it not, dated  
23 10 October 2020, so we're in the autumn of that year.  
24 It's an email from Imran Shafi, who has given evidence  
25 to the Inquiry, essentially recording a meeting which

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1 a moment, but before we do, can you give us a sense of  
2 how frequent meetings like this were? Did you have  
3 meetings with the Prime Minister and the Chancellor  
4 weekly, monthly, less than that?

5 A. It ebbed and flowed. So during March 2020, and April,  
6 very frequently. Then as Covid numbers decreased and  
7 the pressures on the NHS likewise, then far fewer during  
8 May, June, July, August. But then from October they  
9 increased again, and certainly by the time we were in,  
10 say, late December, early January 2020, very frequently.  
11 In fact I think I had between New Year's Day and  
12 10 January something like six separate meetings with  
13 the Prime Minister and others on both winter,  
14 Covid pressures and the vaccine roll-out. So that was  
15 the sort of pattern of it over the course of the  
16 pandemic.

17 As I think I also say in my statement, Number 10 got  
18 into this sort of rhythm of having these so-called daily  
19 dashboard meetings at 9.15 that the Prime Minister would  
20 chair, and their frequency kind of changed a bit  
21 depending on what was happening with Covid. They could  
22 sometimes be every day, they could be three times  
23 a week, and I personally found those very useful  
24 sessions, because it was a chance to kind of tell it  
25 straight direct to the relevant senior politicians, and

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1 to the extent there were things that frankly I thought  
2 we could benefit from some support on, to sort of lodge  
3 that direct with the Prime Minister and others.

4 **Q.** Just helping us to imagine what you're describing,  
5 obviously, can you just give us an indication of whether  
6 those meetings were virtual or not? I mean, were you  
7 spending your life going back and forth to  
8 Downing Street when you were having these regular  
9 meetings or did you, for example, dial in to those  
10 9.15 meetings?

11 **A.** Yeah, some were virtual and some were face to face, so  
12 yeah, it was absolutely a mix of both.

13 **Q.** We will come to the detail, but since you've given us  
14 that overview of your interplay --

15 **A.** Yeah.

16 **Q.** -- the exchanges you had, the meetings you had with  
17 the Prime Minister and his team, you are of course aware  
18 that we have heard evidence in the last few days,  
19 the last week or so, of difficulties in  
20 the decision-making process, a certain level of  
21 dysfunction. There has been evidence of  
22 the Prime Minister finding it difficult to settle on  
23 a particular decision. "Oscillating" is one of the  
24 words, one of the words that's been used to describe  
25 that.

13

1 you've heard, as I understand it, over the last several  
2 days really relates to sessions that, frankly, I wasn't  
3 present at, so I can't give you good commentary on  
4 those.

5 **Q.** You would, though, have experienced the consequences of  
6 his decisions, and you would have found yourself at  
7 the next meeting hearing a decision you might have  
8 expected to have been taken either had or hadn't been  
9 taken, so is there really nothing that you can say about  
10 the way in which the decision-making process took place?

11 **A.** Well, I mean, obviously I can see some of the evidence  
12 that you can see now as well, not all of which obviously  
13 we were privy to at the time. What I would say is that  
14 in respect of decisions that we needed from Government  
15 on NHS capacity, I mean, sometimes decisions were taken  
16 which we didn't like but nevertheless, you know, those  
17 were the decisions.

18 I think the best example in a way of the sort of  
19 interface with Prime Ministerial decision-making that  
20 I can personally speak to was around the roll-out of  
21 the vaccine programme, where the Prime Minister was very  
22 personally involved in that, and for the most part that  
23 was actually a, you know, constructive engagement on  
24 what needed to get done. And we can obviously talk  
25 specifically about that, but ...

15

1 Can you give us an overview of your experience of  
2 those months that you spent discussing Covid, helping  
3 him make those decisions?

4 **A.** Well, in a sense, I don't think I did help him make  
5 those decisions, if by "those decisions" you mean  
6 lockdown restrictions, social restrictions and so forth.  
7 So I can't --

8 **Q.** Just pause there. What I meant, because you have just  
9 given evidence that you had frequent meetings with  
10 the Prime Minister --

11 **A.** Sure.

12 **Q.** -- at times very frequent --

13 **A.** Yeah.

14 **Q.** -- I'm not suggesting that you were making the decisions  
15 with him --

16 **A.** Sure.

17 **Q.** -- but one assumes that the purpose of him having those  
18 discussions with you was to help him make decisions.  
19 That's what I meant.

20 **A.** Yes, but actually the way the rhythm of it tended to  
21 work was we would have the session specifically on  
22 the NHS and then ministers would go off and have  
23 a separate session without the NHS present, where then  
24 the consequences of that for their wider decision-making  
25 would be taken account of. So I think a lot of what

14

1 **Q.** Yes. All right, we won't, because, as I said --

2 **A.** Right.

3 **Q.** -- there is another module to come, and I'm sure there  
4 will be an opportunity for you to talk about vaccines in  
5 the vaccines module.

6 Let's look, if we can, at this document, and it's  
7 perhaps the third paragraph where we see that:

8 "The PM asked about NHS capacity."

9 There is then a record of a relatively detailed  
10 review, if you like, that you conducted of the position  
11 as it stood regarding the NHS. We see reference to  
12 regional variation, and we also see in the first line  
13 that you stressed "the NHS was not overwhelmed".

14 **A.** On 8 October 2020, correct.

15 **Q.** Exactly. And so you are saying it wasn't overwhelmed at  
16 the time of the meeting, and then, reading on, you  
17 describe the regional position and give some view about  
18 the future. I'm going to come back to the question of  
19 NHS overwhelm shortly, but just looking a little bit  
20 further down the document, there's the next paragraph,  
21 we see that the discussion "turned to the question of  
22 NPIs". Simon Ridley, one of the Cabinet Office  
23 officials, gave a presentation about NPIs.

24 Then there is another paragraph where it appears  
25 that you contributed to the debate, perhaps about NPIs,

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1 it says:

2 "Simon Stevens argued that -- stepping back -- not  
3 everyone currently accepted there was a problem, people  
4 did not think measures were fair, they questioned  
5 whether they worked, and if they did work, they wanted  
6 financial support. Government response should take  
7 these factors into account."

8 So, first of all, slightly contrary to what you said  
9 a moment ago, this does appear to suggest that you were  
10 contributing to discussions beyond simply the NHS  
11 capacity matters?

12 **A.** Well, I think on this occasion I was asked: what are  
13 people in the health service in Liverpool, Merseyside,  
14 the northwest seeing about what's happening in their  
15 local situation? Because obviously part of my  
16 responsibilities were often to be out and about around  
17 the country, talking directly to people who were  
18 affected, and I think in that comment I was reflecting  
19 what I had been told directly from people in Merseyside,  
20 Manchester and elsewhere, that frankly the set of  
21 mechanisms that were then supposedly in place in those  
22 areas were not working, and their view was that part of  
23 the problem was that there wasn't sufficient financial  
24 support for people who were being asked to self-isolate.  
25 So when I was asked the question, I answered.

17

1 other people saying, but yes, that was also my personal  
2 view.

3 **Q.** Thank you.

4 I'm going to move away from this document, but stay,  
5 as it were, with that general issue of exchanges between  
6 you and the Prime Minister.

7 I'd like to go, if we can, please, to the written  
8 witness statement of Helen MacNamara, which is  
9 INQ000273841, paragraph 71, on page 39, I think. Yes.

10 Lord Stevens, I don't know if you have had a chance  
11 to look at this document before. I hope you have.

12 **A.** Sorry, which part are you looking at?

13 **Q.** Well, let me show you. One of the observations that  
14 Helen MacNamara makes in her witness statement, and in  
15 fact that she expanded on in evidence yesterday, is the  
16 last sort of five or six lines of this paragraph we're  
17 looking at. She, of course, is talking about her  
18 experience of dealing with officials and politicians in  
19 Number 10, but she said this:

20 "I do not remember anyone working in the centre or  
21 who was part of the conversations who had a detailed  
22 understanding of the way the NHS operated. This is not  
23 unusual or unique ..."

24 And she talks about the fact that social areas of  
25 policy are less well represented in Downing Street than

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1 **Q.** Yes. And in fact one of the themes of the evidence that  
2 we've heard is precisely on that issue, that there was  
3 a live question about whether sufficient financial  
4 support was being provided, including in fact to workers  
5 in the healthcare sector, and I think are you saying  
6 that perhaps it was workers in the healthcare sector  
7 that you were reporting back on, as it were, needing  
8 further financial support?

9 **A.** You know, I can't remember that specifically, because  
10 obviously there were different arrangements for NHS  
11 staff, furlough and so forth, so I can't say that  
12 directly. But what I can say is that I think this was  
13 a time, as I recall it, when it was a pretty variegated  
14 set of local restrictions that were in place around the  
15 country, and frankly a lot of people were struggling to  
16 understand the rationale and what they were supposed to  
17 be doing in one place or another, and I think it's  
18 the case that after this the government then moved to  
19 their more sort of clear-cut tiering system to try to  
20 respond to that.

21 **Q.** Quite. And on any view you were voicing support for  
22 the idea that further financial support needed to be  
23 given to people self-isolating?

24 **A.** That was my personal view. I think actually what these  
25 notes show was that I was describing what I'd heard

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1 military, national security type matters.

2 I'm interested in your views on that, with your  
3 experience of -- long experience of dealing with  
4 politicians, but perhaps particularly that period during  
5 the pandemic, did you feel there was, as it were,  
6 a deficit in their understanding of the granular way in  
7 which the NHS works?

8 **A.** I think Helen's description seems to me accurate,  
9 particularly as regards the Cabinet Office. The extent  
10 to which the Prime Minister's office, Number 10, has  
11 health expertise is to some extent a function of how  
12 the Prime Minister of the day chooses to staff their  
13 Number 10 policy unit.

14 During the pandemic itself, I think there is truth  
15 in what she says, but to some extent, as long as that  
16 doesn't lead to ill-informed second-guessing of  
17 the decisions that people in the NHS are actually trying  
18 to take, that need not in itself be a problem.

19 **Q.** One can certainly see how it would be a problem if there  
20 was that sort of second-guessing, but surely even if  
21 they leave the operational decisions to you, it would  
22 still be necessary for them to have that level of detail  
23 in making the higher level decisions, for example NPIs  
24 and so on?

25 **A.** Yeah, I think to some extent that is -- that is true.

20

1 I mean, I think there was a -- as I think Helen  
 2 described, and I agree with her, there was a sort of  
 3 disconnectedness between aspects of what  
 4 the Cabinet Office was doing early on in the pandemic  
 5 and what, sort of, we were seeing in terms of  
 6 the operational realities.

7 As I say, I think the Covid Taskforce really helped  
 8 with that because that brought together people who had  
 9 that more detailed set of expertise into one place with  
 10 a single voice where you could have a direct  
 11 conversation and know that the advice that would then go  
 12 to the Prime Minister and others would be properly  
 13 informed by what we were telling them.

14 **Q.** Just sticking with that, then, we will hear more about  
 15 the Covid Taskforce in evidence, in fact, next week.

16 **A.** Right.

17 **Q.** Help us with this: were there people, civil servants,  
 18 involved with the taskforce who had this sort of  
 19 granular understanding of the NHS in a way that perhaps  
 20 the earlier structures didn't have?

21 **A.** I think to a greater degree, yes, and there were some --  
 22 even if there were some generalists, they I think,  
 23 you know, pretty quickly understood the moving parts,  
 24 shall we say.

25 **Q.** I want to move to a slightly different topic,

21

1 or so later, 3 February, it's just at the top,  
 2 Dominic Cummings says:

3 "When SS off?"

4 Matt Hancock says:

5 "Wanted to talk to you about this in the margins of  
 6 meeting [tomorrow]. Short answer is his initial  
 7 proposal is to announce in Sept & go at Christmas.  
 8 I haven't yet engaged. How hard to push for sooner?"

9 Dominic Cummings says:

10 "We must get on with it now. Announce next week as  
 11 part of reshuffle frenzy and it will all get lost in  
 12 that."

13 Matt Hancock says:

14 "Let me see if I can square him for that? If  
 15 I can't, we can still go if we want."

16 So at least on the basis of these messages, first of  
 17 all, there certainly do seem to have been discussions  
 18 between Mr Hancock and Mr Cummings about you leaving.

19 **A.** Mm-hm.

20 **Q.** And it does appear that Mr Hancock had had some  
 21 discussions with you about that?

22 **A.** Well, take a step back. I, as I said at the start, was  
 23 appointed in 2014. When I took up post I envisaged  
 24 serving for around five years, which would have taken me  
 25 to 2019. As you may recall, there was a degree of

23

1 Lord Stevens, and it's still to do with your engagement  
 2 with the Prime Minister and Mr Hancock and others, but  
 3 it's a rather basic question, of whether Mr Hancock in  
 4 particular, but others, were encouraging you to resign  
 5 or otherwise remove you from office during the period of  
 6 the pandemic.

7 I'll take you to some documents, but were they, or  
 8 not?

9 **A.** No.

10 **Q.** Let's look --

11 **A.** Not to my face, anyway.

12 **Q.** Let's just look at a couple of WhatsApp messages, if we  
 13 may.

14 First of all, INQ000129176. Let me say these are  
 15 both -- these messages are from very early in the  
 16 pandemic, but you can see January 2020 Dominic Cummings  
 17 is texting to the owner of the cellphone, who is  
 18 Mr Hancock, saying:

19 "Where are we with SS?"

20 Simon Stevens.

21 He says:

22 "It's in train. I am first getting Ara Darzi to  
 23 persuade him it's in his best interests to go now. If  
 24 that doesn't work I'll move directly."

25 Then if we can go, please, to INQ000129185, ten days

22

1 political chaos in the United Kingdom during the course  
 2 of 2019, a change of Prime Minister, a general election,  
 3 and I therefore did not feel it was quite the right  
 4 moment to create a gap in the leadership of the NHS, so  
 5 I think it was known that that was something that had  
 6 been in my mind, but felt that I should stay through to  
 7 the New Year, and then sort of make a decision at some  
 8 point during the course of 2020.

9 Now, of course Covid then came along and it would  
 10 have been completely wrong to have left a vacuum during  
 11 the first wave of Covid. Come summer 2020, the thought  
 12 recurs, but I have a discussion with the Prime Minister  
 13 about that during summer 2020, but by the time that  
 14 possibility would crystallise, we were back into another  
 15 wave of Covid. So I therefore, again, felt duty bound  
 16 to see the winter period through and then the roll-out  
 17 of the vaccine, at which point, in July 2021, I was able  
 18 to -- I was able to leave.

19 **Q.** Well --

20 **A.** By the way, can I just say on some of these things,  
 21 I think there's a suggestion there, asking Lord Darzi to  
 22 persuade me. These emails I think have previously been  
 23 leaked to The Daily Telegraph and, in response to those,  
 24 Lord Darzi has said on the record that is not correct,  
 25 and I think his actual words were "that is

24

1 misinformation". So he did not seek to persuade me in  
 2 the way that's described here.

3 **Q.** Well, thank you for clarifying that and for the earlier  
 4 answer, Lord Stevens.

5 Let me be clear, the reason I'm asking these  
 6 questions is to understand whether there was  
 7 a relationship of confidence and trust between you doing  
 8 your very important job and Matt Hancock, Boris Johnson  
 9 and others during the period of the pandemic.

10 I think it follows --

11 **A.** Can I just say on that, I think it's relevant, as I saw  
 12 Dominic Cummings' statement earlier in the week, I think  
 13 he has said on the record that when the pandemic struck  
 14 he was then not seeking to do this, and I believe  
 15 Matt Hancock has said the same in his written statement.  
 16 So I have no insights other than what the two of them  
 17 have said on the record.

18 **Q.** And your evidence, putting those exchanges in context,  
 19 is that there was no sense in which you were somehow  
 20 defying them in staying in your role in  
 21 January/February 2020?

22 **A.** No.

23 **Q.** I do want to ask you about one more message, which is  
 24 from later in the year, August 2020. I'm not going to  
 25 bring it up on screen, but let me just read it out.

25

1 improve social care, that it needed to be not just about  
 2 ensuring that people didn't have to sell their homes but  
 3 also that the availability of social care increased and  
 4 that the social care workforce was addressed. I was  
 5 clear that I didn't think this could be done just as  
 6 a private Whitehall process, a sort of behind the bike  
 7 sheds agreement between ministers, it had to be a public  
 8 open process. And ideally, if it was going to create a  
 9 national consensus, so social care reform actually got  
 10 done, it needed to be on a cross-party basis. That was  
 11 the basis on which I suggested action was required.  
 12 Those points did not find favour and therefore I didn't  
 13 do it.

14 **Q.** Did you think that Boris Johnson, Dominic Cummings  
 15 trusted you to do your job during the summer and autumn  
 16 of 2020?

17 **A.** I can't speak for Dominic Cummings but there was  
 18 nothing -- because I had no conversations about Dominic  
 19 about this question, but my regular interactions in  
 20 the autumn with the Prime Minister did not give me  
 21 a different sense of that, no.

22 **Q.** What about Mr Hancock, Mr Stevens? It is important to  
 23 understand whether there was a fruitful relationship of  
 24 trust between the two of you. The Inquiry has heard  
 25 evidence that other people working with Mr Hancock found

27

1 Its primary focus is Mr Cummings coming back to  
 2 the question of whether Mr Hancock should leave his  
 3 role, but he does mention you as well. He says this:  
 4 "I also must stress I think leaving Hancock in post  
 5 is a big mistake -- he is a proven liar who nobody  
 6 believes or shd believe on anything, and we face going  
 7 into [an] autumn crisis with the cunt still in charge of  
 8 the NHS still -- therefore we'll be back around that  
 9 cabinet table with him and Stevens bullshitting again in  
 10 [September]. Hideous prospect."

11 So, leaving aside the question of Mr Hancock, did  
 12 you later on in 2020, in August, have the impression  
 13 that Dominic Cummings or Boris Johnson was dissatisfied  
 14 with the way that you were running the NHS or  
 15 "bullshitting" them?

16 **A.** Well, by the standard of Dominic Cummings' adjectives,  
 17 that's one of his gentler epithets. So, look, what  
 18 I would say is -- well, I just said it a moment ago  
 19 actually -- I did have a discussion with the  
 20 Prime Minister in the summer of 2020 about whether or  
 21 not I would be able to be released from active duty in  
 22 the NHS. We discussed specifically whether I might play  
 23 a role in helping improve social care in the country.  
 24 To be frank about it, I was pretty clear cut about what  
 25 I thought success would look like if we were going to

26

1 him someone who was untruthful. Was that your  
 2 experience or not?

3 **A.** There were occasional moments of tension and flash  
 4 points, which is probably inevitable during the course  
 5 of a 15-month plus pandemic, but, look, I was brought up  
 6 always to look for the best in people.

7 **Q.** I'm sorry, Mr Stevens, that's not an answer to my  
 8 question.

9 **A.** Which question? Which bit of it?

10 **Q.** Did you find Mr Hancock to be truthful or not?

11 **A.** Well, I know various people have made quite strong  
 12 accusations against -- against Matt Hancock. All  
 13 I would say is strong accusations need strong evidence  
 14 to back them up, and I don't think I've seen that  
 15 evidence.

16 **Q.** I'm still not sure you're quite engaging with my  
 17 questions, Lord Stevens, and it is important, because  
 18 you were at the head of the NHS, he was at the head of  
 19 the Department of Health and Social Care?

20 **A.** Sure.

21 **Q.** In your working relationship with him, during these most  
 22 extreme and important of times, was he someone you found  
 23 you personally could trust?

24 **A.** Yes, for the most part, yes.

25 **Q.** What do you mean by "for the most part", Lord Stevens?

28

1 **A.** Well, as I think I said right at the start, I'm not  
 2 denying that there were a small handful of occasions  
 3 during the course of the year, year and a half, when  
 4 there were tensions, but that I don't think is  
 5 particularly surprising given the circumstances under  
 6 which everybody was working.

7 **Q.** I'm going to move on to ask you some questions about  
 8 something called Operation Nimbus.

9 Let's look, first of all, at your statement, please,  
 10 paragraph 21, page 7.

11 I think it's right to say you attended this  
 12 operation --

13 **A.** Yeah.

14 **Q.** -- which was a tabletop training exercise?

15 **A.** Yes.

16 **Q.** I'm not going to call it up, but we can note that it was  
 17 an exercise that was implemented following a SAGE  
 18 meeting -- sorry, a COBR meeting on 29 January, we could  
 19 see it in the minutes, that there needed to be  
 20 an exercise, and, as I think we've said, it occurred  
 21 about two weeks later on 12 February 2020.

22 Can you just describe in a few sentences,  
 23 Lord Stevens, what that exercise was about and what you  
 24 took from it?

25 **A.** Yes, the purpose of the exercise was to look at

29

1 **A.** -- but I would have thought so, yes.

2 I mean, I might also say that, in a sense,  
 3 the effectiveness of this exercise was slightly  
 4 undermined by the fact that this took place on  
 5 12 February 2020, with a lot of ministers from a range  
 6 of departments other than Health around the table, and  
 7 then the very next day there was a Cabinet --  
 8 a ministerial reshuffle, and quite a number of them lost  
 9 their jobs. So it was an entirely new set of ministers  
 10 who had not been exposed to any of that 24 hours before.

11 **Q.** I was going to ask you, without wanting to stretch your  
 12 memory too much, in fact, who was there. Do you recall  
 13 whether the Prime Minister was there?

14 **A.** I don't think he was, no. I don't think so. But I'm  
 15 sure there will be records to that effect.

16 **Q.** Well, we haven't seen any, but we can carry on looking.

17 **A.** Right.

18 **Q.** I think it's implicit in what you say, then, that  
 19 certainly, I think, Mr Hancock was there --

20 **A.** Yeah.

21 **Q.** -- we'll come on to talk about that, and other junior  
 22 ministerial people, who, as you've said, some of whom  
 23 may have lost their jobs or changed their jobs the next  
 24 day.

25 **A.** Yeah.

31

1 the so-called reasonable worst-case scenario, which  
 2 I know the Inquiry has heard evidence about, which is  
 3 saying: if it's the case that Covid turns out to have  
 4 these features, maybe 81% of people are infected and  
 5 a proportion of them then die, that obviously is a huge  
 6 and devastating impact on the United Kingdom, what are  
 7 the responses the different government departments need  
 8 to make?

9 And so I think it was less specifically aimed at  
 10 the health response and more about having a broader  
 11 range of Whitehall departments who had not been so  
 12 involved in those conversations kind of getting their  
 13 head around: my goodness, this would be an absolutely  
 14 terrible thing, what would we need to do to make sure  
 15 our plans are prepared?

16 **Q.** We haven't actually seen any report or summary from this  
 17 exercise.

18 **A.** Right.

19 **Q.** Do you happen to know whether such a document existed or  
 20 would you have expected such a document to exist?

21 **A.** Yeah, I would have assumed that the Cabinet Office  
 22 relevant secretariat would have produced some sort of  
 23 notes from that, actions for departments. Whether they  
 24 have or not, I leave to you --

25 **Q.** Understood.

30

1 **Q.** Let's look at what we do have about Operation Nimbus,  
 2 Lord Stevens, which is -- if we can call up on screen,  
 3 please -- INQ00052022.

4 This is a set of, I think, slides, perhaps  
 5 a PowerPoint demonstration. It's perhaps what  
 6 the participants in the operation were shown or at least  
 7 part of what they were shown.

8 If we can go to page 7, please, we see the synopsis,  
 9 which is -- very much as you've already outlined, it is  
 10 to be imagined that the Covid pandemic has advanced, as  
 11 it were. We see that the participants are asked to  
 12 imagine that the date is 14 April, so two months further  
 13 on from 12 February, which was the date this took place.  
 14 Sustained transmission has been ongoing for a month and  
 15 a half, hypothetically, by that stage.

16 There are various facts and figures given, but  
 17 the most striking one is in the last bullet point, which  
 18 is that there might -- it is, as of the synopsis, to be  
 19 assumed that there may be around 840,000 excess deaths  
 20 over the 16-week wave of infection, which, as you say,  
 21 reflects the reasonable worst-case scenario at the time.  
 22 Is that fair?

23 **A.** Yes.

24 **Q.** Then if we look over the page, we see a wave, which was  
 25 the scenario that was being engaged with. The sort of

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1 solid line is the hypothetical line up to the date of  
2 the exercise and then there's a sort of projected dotted  
3 line after that. The wave lasts for 16 or so weeks, and  
4 the idea is that within that time there would have been  
5 that very large number, 840,000, excess deaths.

6 Just a couple of points I want to ask you about  
7 leading on from that. The first is that, as you  
8 describe in your witness statement, this exercise seems  
9 to have provoked a discussion about who should be  
10 responsible for making decisions about prioritisation,  
11 allocation of stretched NHS resources in a situation  
12 like this.

13 Perhaps we can take this down and look at  
14 paragraph 21 of your witness statement. It's on page 7.  
15 Sorry, perhaps I should have said that. So it's at the  
16 bottom of the page.

17 So we can see, Lord Stevens, you say:

18 "It ..."

19 That is the exercise:

20 "... did result in -- to my mind at least --  
21 an unresolved but fundamental ethical debate about  
22 a scenario in which a rising number of COVID-19 patients  
23 overwhelmed the ability of hospitals to look after them  
24 and other non-COVID patients. The  
25 Secretary of State ... [that's Mr Hancock] took

33

1 Social Care I think created an ethical, moral advisory  
2 panel to sort of ask the question, you know, if absolute  
3 disaster strikes then how would you ration care, limit  
4 it, in a way that would be fairest and have the --  
5 you know, be the most defensible under this, you know,  
6 horrible situation.

7 But I certainly wanted to discourage the idea that  
8 an individual Secretary of State, other than in the most  
9 exceptional circumstances, should be deciding how care  
10 would be provided. I felt that we are well served by  
11 the medical profession, in consultation with patients,  
12 to the greatest extent possible making those kinds of  
13 decisions.

14 **Q.** And this, I suppose, was Operation Nimbus doing its job,  
15 in the sense that it raised in advance an issue like  
16 this, while there was still time to think about how to  
17 deal with it. And did you then take steps to at least  
18 pursue that debate as to whether Mr Hancock should have  
19 that level of decision-making in a worst-case scenario?

20 **A.** Well, I think, and this is something that -- I think  
21 you're seeing Sir Christopher Wormald from  
22 the Department of Health and Social Care later, that was  
23 probably something that Chris Wormald may be able to  
24 give you information on as well. As I say, the  
25 department had this Moral and Ethical Advisory Group,

35

1 the position that in this situation he -- rather than,  
2 say, the medical profession or the public -- should  
3 ultimately decide who should live and who should die.  
4 Fortunately this horrible dilemma never crystallised."

5 Just before I ask you about this, to note that is it  
6 right that the previous Secretary of State or possibly  
7 a previous Secretary of State, but Jeremy Hunt had taken  
8 a different view of this matter, had he not? I think it  
9 was connected to Exercise Cygnus, which had happened  
10 some years before. He had taken the view, and this is  
11 in fact something that he spoke about in evidence in  
12 Module 1 of this Inquiry --

13 **A.** Right.

14 **Q.** -- that decisions of this type ought to be reserved to  
15 clinical staff. Is that something you're aware of?

16 **A.** Yes, I've heard Jeremy Hunt say that, yes.

17 **Q.** So there you are. I mean, he took one view and you're  
18 saying in your statement that on 12 February Mr Hancock  
19 took a very different view. Did you have a view as to  
20 whether that was an appropriate line for him to take,  
21 desirable or not?

22 **A.** I thought it would be highly undesirable other than in  
23 the most extreme circumstances, and you can argue that  
24 these are the most extreme circumstances, and that is  
25 one of the reasons why the Department of Health and

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1 and I think they continued in existence during this  
2 period. So I actually don't think this was a question  
3 that was resolved. There were specific instances that  
4 gave rise to this type of question. At one point during  
5 the first wave there was a group that had come up with  
6 essentially rationing criteria that might be used for  
7 critical care in the event that there were not enough  
8 critical care beds for severely ill patients.

9 Our view was -- my view was that -- actually by  
10 the time that was drawn up, it was clear it wasn't going  
11 to be needed, and in any event it was far too crude  
12 a tool, that would result in bad decisions being made  
13 around the country, so that was never promulgated.

14 **Q.** I want to move to a second issue sort of stemming from  
15 Operation Nimbus, Lord Stevens, which takes us back to  
16 this question of the NHS being overwhelmed.

17 We know that a month later than Operation Nimbus,  
18 12 February, we know that on 13 March or thereabouts  
19 there was a change of policy from the mitigation  
20 strategy towards a suppression strategy which, in the  
21 end, involved a lockdown. We also know that one of, if  
22 not the key rationale for that change of policy was  
23 a fear of the NHS being overwhelmed unless the policy  
24 was changed.

25 But we've also heard from a number of scientists who

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1 sat on SAGE who, in summary, have said that it, in fact,  
2 was obvious or fairly likely or very likely to them that  
3 the NHS would be overwhelmed some time before 13 March,  
4 and they -- I mean, for example, Professor Medley, who  
5 I'm sure you know, the chair of SPI-M, said that  
6 throughout February it became increasingly clear that  
7 NHS capacity in the UK would be overwhelmed.

8 Just looking at this Nimbus exercise, it's inherent  
9 in what we've been saying about decisions of life and  
10 death, and so on, that the exercise that was run there  
11 had, as part of its core, a situation in which clearly  
12 the NHS would have been overwhelmed.

13 So just drawing those strands together, from your  
14 perspective, was it as late as 13 March or thereabouts  
15 that it became obvious and only then did it become  
16 obvious that the mitigation strategy would involve the  
17 NHS being overwhelmed, or is it something, to your mind,  
18 that was apparent earlier or at least should have been  
19 considered earlier?

20 **A.** I think it was clear that, if the reasonable worst-case  
21 scenario were to come about in the UK, then the NHS  
22 would be overwhelmed, and we had a group of our  
23 clinicians and analysts working, for example, intensely  
24 with the SPI-M modellers on Sunday 1 March to refine  
25 what the parameters might be for thinking about how many

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1 and do I take it from what you've said then that, first  
2 of all 12 February, so Operation Nimbus, although the  
3 exercise involved a set of facts which included the NHS  
4 being overwhelmed, are you saying that, at that stage,  
5 because it was still then a worst-case scenario, it  
6 perhaps wouldn't be fair to say that, at that point, it  
7 was clear that, in reality, really the cards were on the  
8 table and the NHS was going to be overwhelmed at that  
9 stage?

10 **A.** Yeah, as you say, I want to be very careful of hindsight  
11 bias, but I think Nimbus was explicitly presented as  
12 a scenario, as a possibility, as an exercise. It was  
13 not being suggested by the epidemiologists or anybody  
14 else that "This is the course we're on, so now plan  
15 against it". And I think I've made the point in my  
16 written statement that one of my observations looking  
17 back is that there was too much ambiguity about what the  
18 status of this reasonable worst-case scenario was during  
19 the course of February and the first part of March and  
20 the probability that the reasonable worst case was  
21 actually going to become the case.

22 Obviously, that probability evolved during the  
23 course of February and early March, but I think,  
24 you know, for example, minutes of the COBR meeting on  
25 29 January say that, informally at least, it was thought

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1 intensive care beds each sick patient might need, and so  
2 forth, and that produced a set of scenarios that  
3 evening, Sunday/2 March, SAGE papers, as I see them now,  
4 on 3 March 2020, have two separate papers, one from  
5 Imperial, one from the London School of Hygiene and  
6 Tropical Medicine.

7 SAGE on 3 March says three things: it says it is  
8 highly likely there is sustained transmission of  
9 Covid-19 in the UK at present; secondly, they say, given  
10 current surveillance systems, it will not be possible to  
11 time the start of interventions optimally; and, third,  
12 they say, whatever the exact figure, NHS demand will  
13 greatly exceed supply in a reasonable worst-case  
14 scenario even with behavioural interventions and --  
15 behavioural and social interventions.

16 So I think it is -- it is apparent that, certainly  
17 by the beginning of March, it could be seen that, if  
18 action was not taken to reduce the growth of Covid, then  
19 the NHS would be overwhelmed.

20 **Q.** Thank you, and one of the issues that we are considering  
21 is whether advice from bodies like SAGE was clear  
22 enough. It may be that your reference there to the  
23 minutes slightly makes the point that sometimes these  
24 messages can be confused. But what I really want to get  
25 to is your own view, not with hindsight but at the time,

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1 there was a 90% probability that the reasonable  
2 worst-case scenario would not come to pass, and then,  
3 sort of, a few days later, early February, I think it  
4 was said there was a four-fifths probability that it  
5 wouldn't come to pass.

6 But I think one of the takeaways from this is that  
7 there needs to be much greater clarity about what is the  
8 probability that is being assigned to these different  
9 potentials, so that policymakers can understand what  
10 exactly they're being told.

11 **Q.** One way of looking at it, and this is -- I think it was  
12 Professor Woolhouse who said this, is that the point of  
13 having a reasonable worst-case scenario is that that's  
14 what you should be preparing for, and so, in a sense,  
15 you leave aside the probability of that situation  
16 eventuating, you just prepare for it. But I think,  
17 perhaps, your point is that that might be a slightly  
18 sort of -- it's too difficult to achieve that situation  
19 in real life, people are always going to want to know  
20 how likely it is that this sort of terrible event is  
21 going to happen.

22 **A.** You know, I make the point, I think, elsewhere in my  
23 statement that the government obviously has  
24 a pandemic -- sorry, has a National Risk Register and  
25 there are all sorts of reasonable worst-case scenarios

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1 in that. If we were actually to act on all of those,  
 2 ie give them a probability that, on the balance of  
 3 likelihood that they're going to come about, then,  
 4 you know, life would grind to a halt. So at some point  
 5 when these national risks begin to crystallise you have  
 6 to be clear as to whether you move from a purely  
 7 theoretical possibility to: this thing is happening, do  
 8 something.

9 **Q.** Let me move the conversation on, Lord Stevens, but  
 10 sticking with this question of NHS overwhelm just for  
 11 a few more minutes. We have been focusing on  
 12 March 2020, but it's right, isn't it, that the later  
 13 lockdowns, towards the end of 2020 and then into 2021  
 14 were also triggered, amongst other things, by a concern  
 15 that without it the NHS would again be overwhelmed.  
 16 Of course then much more water had flowed under more  
 17 bridges. Do you think that later in the pandemic there  
 18 was a clear sense amongst decision-makers of what NHS  
 19 overwhelm actually meant?

20 **A.** Yes, in the sense of -- look, I mean, if you're  
 21 confronted with the situation where you have, say,  
 22 100,000 hospital beds in England and you're being told  
 23 that, if the pandemic runs out of control, you might  
 24 need between 200,000 and 800,000 then, you know, that's  
 25 orders of magnitude above what can be created. You

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1 increase in the numbers infected, not just how do you  
 2 match the number of people who are going to be very,  
 3 very ill to the number of hospital beds?

4 **Q.** Thank you. As you say, that's a point which you develop  
 5 in your witness statement and it's what I wanted to ask  
 6 you about, which is: did you feel that taking the risk  
 7 of NHS being overwhelmed as, if you like, the switch,  
 8 the trigger for lockdowns was the right approach for the  
 9 government to take?

10 **A.** Well, it was clearly highly desirable to avoid  
 11 a situation where ill patients weren't able to get the  
 12 healthcare that they would benefit from, and we did,  
 13 I think, for the most part achieve that. But by itself  
 14 that, if you're interested in saving lives, is not the  
 15 only goal.

16 **Q.** Let me take you, please, to a different issue, and it is  
 17 the question of the discharge of patients from hospitals  
 18 into the community, into care homes, in March 2020.

19 Now, as you know, that's a set of issues which has  
 20 already been, amongst other things, the subject of  
 21 litigation, and it will also be addressed in a module of  
 22 this Inquiry, so I don't want to go into it in any  
 23 detail. But there is one issue that is raised in  
 24 Mr Johnson's witness statement for this module, and  
 25 which you touch on as well, and so I'd like to address

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1 cannot clone a new NHS in eight to 12 weeks and you were  
 2 certainly can't clone seven of them, and, by the way,  
 3 nor can any other country, and the same exact issues  
 4 were being confronted in France and Germany and Spain in  
 5 winter 2021 as well.

6 So that's, I think, the, sort of, first point to  
 7 make. The second point to make though is that, by the  
 8 time we got to autumn 2020, actually we obviously knew  
 9 a lot more about the virus, hospitals had done a lot of  
 10 work to create the ability to turn on so-called surge  
 11 capacity, extra critical care or other beds, as cases  
 12 rose, and we had new treatments for Covid, and so forth.

13 So taking, as it were, England as the unit of  
 14 analysis and saying just is the NHS overwhelmed or not  
 15 overwhelmed in a binary way kind of misses the point  
 16 because, actually, you have a graduated set of negative  
 17 impacts as Covid pressures increase on the NHS. But  
 18 I would make another point as well, which is that  
 19 I personally do not think solely viewing the amount of  
 20 Covid through the lens of whether or not there are NHS  
 21 beds to cope for severely ill patients is by itself the  
 22 right lens because, even with unlimited hospital  
 23 capacity, if you have large amounts of coronavirus for  
 24 vulnerable people, lots of people will still die.

25 So the right question is: how do you control the

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1 that, please.

2 Can we do it by going to Mr Johnson's witness  
 3 statement. Excellent, we have it on the screen. It's  
 4 paragraphs 330 to 331. So starting at the bottom of the  
 5 page, we see that Mr Johnson notes that, on 17 March  
 6 Cabinet meeting, there was a note that over  
 7 30,000 patients were imminently expected to be  
 8 discharged from hospital and into social care.

9 If we can go over the page --

10 **A.** Yeah, just to clarify, it wasn't that number -- I wasn't  
 11 at that meeting but I do see that the full Cabinet did  
 12 discuss that question before the policy was announced,  
 13 yes, on 17 March.

14 **Q.** This is really just setting up, Lord Stevens,  
 15 Mr Johnson's evidence and then I'm going to ask you  
 16 about it. So he describes, as we can see, on 22 March,  
 17 being provided with a copy of a DHSC document, Covid-19  
 18 response was discussed, there was an estimate in that  
 19 document that:

20 "... between 12,500 and 15,000 hospital beds could  
 21 be freed by postponing non-urgent elective operations,  
 22 and that potentially 15,000 further acute beds were  
 23 being occupied by patients awaiting discharge or with  
 24 lengths of stay over 21 days ..."

25 **A.** Can I just clarify one point, sorry. Although that may

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1 well have been in the Department of Health and Social  
2 Care's draft on 22 March, that information had already  
3 been presented to and discussed with the Prime Minister  
4 on 12 March.

5 **Q.** I'm not -- it's quite a high level point I want to take  
6 you, Lord Stevens, so don't worry too much about the  
7 chronology or the dates, sorry, or the numbers.

8 If we can go to the next paragraph, please, it's  
9 really this that is the core of it. Mr Johnson's  
10 position, he says:

11 "It was very frustrating to think that we were being  
12 forced to extreme measures to lock down the country and  
13 protect the NHS [as we've said, protect it from  
14 an overwhelm] -- because the NHS and social services had  
15 failed to grip the decades old problem of delayed  
16 discharges, [he says] commonly known as bed blocking."

17 And he says that before the pandemic began he was  
18 trying to address that. That's the point --

19 **A.** Right.

20 **Q.** -- whether, if you like, I think as Mr Johnson might  
21 say, he'd been painted into a corner of having to have  
22 a lockdown, in part because of the people he describes  
23 as bed blockers, and that's something that you address  
24 in your witness statement, and perhaps we can go to  
25 that, please, on page 12 and footnote 9.

45

1 I mean, another way of saying it is, even if all of  
2 those 30,000 beds were freed up, for every one  
3 coronavirus patient who was then admitted to that bed,  
4 there would be another five patients who needed that  
5 care but weren't able to get it. So, no, I don't think  
6 that is a fair statement describing the decision  
7 calculus for the first wave. And by the way, I think  
8 when you look at the second wave, when actually a lot of  
9 these problems have been addressed by the Treasury  
10 funding a lot more community health services and  
11 social care, getting rid of the means testing, so in  
12 a sense that problem had been significantly addressed,  
13 the Prime Minister still decided to have second and  
14 third lockdowns, with this problem having been  
15 substantially resolved. So for both reasons I think  
16 that is -- that suggestion doesn't stand up to scrutiny.

17 **Q.** Thank you.

18 Another issue, please, and this time it's a question  
19 about PPE.

20 **LADY HALLETT:** I think I'm getting that I'm being asked to  
21 take a break now.

22 **MR O'CONNOR:** My Lady, certainly.

23 **LADY HALLETT:** I hope you were warned, Lord Stevens, that we  
24 take regular breaks. I shall return at 11.25.

25 **(11.10 am)**

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1 We really will have to --

2 **A.** Reading spectacles at this point, yes.

3 **Q.** I mean, Lord Stevens, this is the part of your statement  
4 where you address that assertion.

5 **A.** Yeah.

6 **Q.** And, in summary, you don't accept it. Let's not read  
7 that out, but you tell us in your own words what your  
8 response to Mr Johnson's line is.

9 **A.** Well, I think Boris Johnson is right to point to the  
10 fact that there have been long-standing problems with  
11 the availability of social care that has often meant  
12 that patients end up stuck in hospital when they could  
13 be being looked after at home. That is without a doubt  
14 correct. However, if you think about his suggestion  
15 just a moment, even if you accept that there were 30,000  
16 hospital beds full in that way, which I think is  
17 certainly at the high end of what most people would  
18 estimate, but even if you think it's 30,000, we, and  
19 indeed he, were being told that if action was not taken  
20 on reducing the spread of coronavirus, there wouldn't be  
21 30,000 hospital in-patients, there would be maybe  
22 200,000 or 800,000 hospital in-patients. So you can't  
23 say that you would be able to deal with 2 -- or 800,000  
24 in-patients by reference to 30,000 blocked beds. So  
25 I don't think the maths works.

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**(A short break)**

2 **(11.25 am)**

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

4 **MR O'CONNOR:** Lord Stevens, I want finally to ask you a set  
5 of questions about PPE. I think I may have said that  
6 before the break. With the same caveat as the questions  
7 about the discharge of patients in March in the sense  
8 that, of course, detailed issues about PPE will be  
9 covered in another module. But this just picks up on  
10 some evidence that Helen MacNamara gave yesterday.

11 So if we could go to Helen MacNamara's statement,  
12 please, INQ000273841, page 53, paragraph 104.

13 When it comes up on screen, Lord Stevens, we will  
14 see that this is a part of Ms MacNamara's statement  
15 where she is describing various initiatives she took in  
16 the early months of the pandemic to try to effect  
17 certain changes, encourage issues to be addressed.

18 We will see, about halfway down this paragraph, one  
19 of those issues that she became concerned about related  
20 to what she describes as "the inadequacies of PPE for  
21 women". She says she tried to make sure this was taken  
22 into account in any new supply.

23 **A.** Mm-hm.

24 **Q.** She gave evidence about that orally yesterday, and we  
25 looked at an internal email in which she raised this

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1 issue in March -- sorry, in mid-April, with Simon Ridley  
 2 and Mary Jones within the Cabinet Office, and that she  
 3 was then told by another official within Downing Street,  
 4 Cleo Watson, on 30 April that the matter had been  
 5 raised, and her evidence, as you can see, is that it was  
 6 the Prime Minister who raised this issue with you on  
 7 April 30, 2020, and that you reassured  
 8 the Prime Minister and ministers that the issues  
 9 with PPE fitting women's bodies were misreported and  
 10 that there wasn't a problem.

11 Do you recall that?

12 **A.** Well, first of all, Helen was absolutely right to raise  
 13 this issue, because there were real concerns and we were  
 14 very concerned about it, and we were taking action. So  
 15 she raised it within the Cabinet Office, as you say.

16 As it happens, we were already acting and in fact  
 17 a week before this meeting the Chief Nursing Officer,  
 18 the National Medical Director for the NHS, had written  
 19 to every head of nursing, every medical director, every  
 20 chief executive in the country on this very issue of  
 21 fit testing to make sure that it was being done properly  
 22 and that the issues that Helen describes were taken into  
 23 account.

24 So it certainly wasn't something that took  
 25 the Prime Minister on 30 April to raise, it was already

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1 backgrounds, and those with different face shapes or  
 2 facial hair."

3 So I think the Cabinet Office's own records show  
 4 that what is attributed to me second-hand is not  
 5 actually what I said at the meeting.

6 **Q.** Well, that's very helpful, and -- so the answer that you  
 7 gave to the Prime Minister was perhaps a holding  
 8 response, saying that there was a problem but that you  
 9 were looking into it?

10 **A.** Yes, and the minutes of the meeting as well from  
 11 the Cabinet Office set a specific action, which was that  
 12 the Department of Health and Social Care should confirm  
 13 that PPE had been procured and was fit for purpose for  
 14 staff in response to reports that gowns did not fasten  
 15 as they were too small and that certain items did not  
 16 fit women. So this was specifically being addressed.

17 **Q.** What we know, and we can see in other evidence, is that  
 18 in fact this issue of misfitting PPE continued to be  
 19 a problem for weeks, months, even years afterwards,  
 20 didn't it, Lord Stevens?

21 **A.** I don't know about years, but it definitely was  
 22 a problem as a result of the short supply of PPE  
 23 overall, with the result that it was often very  
 24 difficult for DHSC to get sufficient range of masks in  
 25 different locations at the right time. There's no doubt

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1 being specifically addressed and we were very concerned  
 2 about it.

3 As to the specific -- as to my remarks in  
 4 the meeting, I think I take it from what Helen said that  
 5 she wasn't at the session itself, so that's not what  
 6 I actually said, and if we could pull up the minutes of  
 7 the meeting then I think that will be -- will show  
 8 itself. So it's actually INQ000088643 on page 7.

9 **Q.** Sorry to interrupt you.

10 **A.** Right.

11 **Q.** But as far as I'm aware, we haven't --

12 **A.** It's on your system. Can I just at least read it, then,  
 13 even if you're not going to pull it up?

14 **Q.** Yes, that's what I was going to suggest.

15 **A.** So actually the Cabinet Office's own minutes of that  
 16 meeting say, first of all, that the permanent secretary  
 17 at the Department of Health and Social Care responded on  
 18 the availability of PPE, given that the Department of  
 19 Health and Social Care has responsibility for securing  
 20 PPE for the NHS, and then it goes on to say:

21 "The chief executive for the National Health Service  
 22 said there was ongoing work to investigate  
 23 the suitability of PPE for all those using it, and  
 24 testing to make sure it was suitable for women, for  
 25 those who are black, Asian and from minority ethnic

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1 about that.

2 **Q.** Well, just finally let's look at one last document,  
 3 which is INQ000097875.

4 A letter written by the BMA to the chief executive  
 5 of Public Health England, so to be clear not either you  
 6 or your organisation, but dated January 2021, not quite  
 7 a year after that meeting.

8 If we can go to the second page, please, we see the  
 9 last substantive paragraph:

10 "We have written separately to DHSC to raise  
 11 concerns about PPE failing to meet the diverse needs of  
 12 the medical workforce -- in particular, that many female  
 13 doctors have reported struggling to find respiratory  
 14 masks that pass fit testing."

15 So the message that you had given to  
 16 the Prime Minister that this was being looked at,  
 17 I think that's a fair summary of the minutes?

18 **A.** Well, not just looked at, that action was being taken to  
 19 try to resolve the problem, given the pressures on  
 20 the supply of PPE, yes.

21 **Q.** And was action still being taken to try to resolve  
 22 the problem all those months later in January 2021,  
 23 Lord Stevens?

24 **A.** Well, as you say, that was not -- a letter I don't think  
 25 I saw, because it was sent to Public Health England.

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1 And I think the specific point that Dr Nagpul is raising  
2 in that letter is whether or not there should be  
3 a change in the rules or the recommendations for what  
4 type of PPE should be being worn. I think he  
5 specifically says that in the letter. And I'm sure the  
6 reason this was addressed to Public Health England is  
7 they set those rules and then everybody else sought to  
8 follow them.

9 **MR O'CONNOR:** Yes. Thank you very much, Lord Stevens.  
10 Thank you, my Lady. There are some questions to be  
11 asked by core participants.

12 **LADY HALLETT:** Thank you.  
13 Mr Weatherby.

14 **Questions from MR WEATHERBY KC**

15 **MR WEATHERBY:** Thank you very much.  
16 Lord Stevens, I am going to ask you questions about  
17 that final topic on behalf of the Covid Bereaved  
18 Families for Justice UK.

19 **A.** Yeah.

20 **Q.** Just picking up on that, your answer to Mr O'Connor,  
21 regarding the lack of appropriate fitting PPE for women  
22 but also for people from black and ethnic minority  
23 workforce, is that, by the time it's raised with you,  
24 there's ongoing work; is that right?

25 **A.** Well, I think -- yes, essentially, yeah.

53

1 **A.** It is, although the two points are somewhat related, in  
2 that if you can't be certain of getting the same type of  
3 face mask or PPE with each delivery, because there's  
4 a shortage, then that is probably one of the root causes  
5 of the problems that I think you're describing.

6 **Q.** Yes, so if you know about the problem in advance, then  
7 the sufficiency of different types of PPE should be  
8 catered for?

9 **A.** Absolutely.

10 **Q.** Yes.

11 **A.** Now, of course, as you know, what was actually happening  
12 at this time was there was a worldwide scramble for PPE,  
13 given that the --

14 **Q.** Yes.

15 **A.** -- UK stockpile was not sufficient --

16 **Q.** Yes.

17 **A.** -- and the Department of Health and Social Care, the  
18 Cabinet Office, the Department for International Trade  
19 went on a huge buying spree to try and secure us the PPE  
20 we needed.

21 **Q.** Yes. So at this point, the stable door was open and the  
22 position was trying to be recovered --

23 **A.** Yes.

24 **Q.** -- and it was difficult because there wasn't PPE  
25 available, even if you knew what you needed?

55

1 **Q.** Okay. So there's two issues here. First of all, in  
2 January and February 2020 NHS England did a stocktake,  
3 I think, of PPE; is that right?

4 **A.** No, I think that was Public Health England and the  
5 Department of Health and Social Care because Public  
6 Health England was responsible for creating and  
7 overseeing the PPE stockpile that supposedly would be  
8 sufficient if a pandemic struck and we all now know it  
9 wasn't.

10 **Q.** It wasn't sufficient?

11 **A.** Correct.

12 **Q.** Yes, and as the chief executive of NHS England that  
13 would be a major concern to you --

14 **A.** Yes.

15 **Q.** -- and of great relevance, whoever did the stocktaking?

16 **A.** Absolutely.

17 **Q.** So that's sufficiency, first of all, it's insufficient,  
18 but this point about fitting face masks, and also  
19 training to use PPE, is a further important point, isn't  
20 it?

21 **A.** Yes.

22 **Q.** So it's sufficiency on the one hand but also, even if  
23 you have lots of it, if it doesn't fit or if your staff  
24 don't know how to use it, then that's an additional  
25 problem?

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1 **A.** Yes, I mean, I think the national position and the  
2 National Audit Office had looked at this and I think  
3 their conclusion was that no individual item had  
4 a national stock-out --

5 **Q.** Yes.

6 **A.** -- but I think that's only part of the story, because  
7 obviously, if you're really up against it, then the  
8 ability to get PPE to where it's needed at the right  
9 time for the right person is much harder.

10 **Q.** Yes, and the management of it is something that no doubt  
11 the Inquiry will be going into, as Mr O'Connor  
12 indicated, in a future module, but an important point.

13 It's right, I think, that in 2016 NERV TAG had made  
14 a formal recommendation to the Department of Health that  
15 there should be a rolling NHS programme for the fit  
16 testing of respirators, FFP3 masks, effectively as  
17 an important part of infection control. That's right,  
18 isn't it?

19 **A.** I'd need to see the NERV TAG papers.

20 **Q.** Okay.

21 **A.** I'm not disputing that but I would need to see them,  
22 yes.

23 **Q.** As the chief executive NHS, this is something directly  
24 relevant to you, let me put it up on the screen --

25 **A.** Thank you, yeah.

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1 Q. -- and hopefully that will jog your memory.  
 2 INQ000022737, please.  
 3 And, as you can see, the heading of it "NERVTAG  
 4 Sub-committee on the pandemic influenza", so directly  
 5 related to pandemics and face masks and respirators  
 6 stockpile, and then formal recommendations to the  
 7 Department of Health, and I'll try to deal with this  
 8 quickly but, if we can go to page 2 -- I'm so sorry,  
 9 it's the bottom of page 1 and then 2. Have you got  
 10 that?  
 11 So under "Discussion points" and "Stockpile":  
 12 "Fit testing in the face of an emerging pandemic is  
 13 a major challenge ..."  
 14 Then, going over the page, the point I'm trying to  
 15 get to is the first bullet point:  
 16 "Just in time fit testing was proposed -- however,  
 17 there may not be sufficient time to put this in place,  
 18 between pandemic virus emergence and the first  
 19 UK impact. It was agreed that there is no substitute  
 20 for a rolling programme of fit-testing in NHS trusts  
 21 during inter-pandemic periods. There should be a caveat  
 22 about fit testing in any recommendations."  
 23 Okay? Does that help you in terms of the knowledge  
 24 about this?  
 25 A. Well, I mean, this is the first time I'm seeing this

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1 that Covid brought about.  
 2 Q. Yes, Lord Stevens, this is a document related to  
 3 pandemic flu, it's related to PPE, it's related to  
 4 a recommendation for a rolling programme across the  
 5 NHS --  
 6 A. Sure, but the point --  
 7 Q. -- did you know about that recommendation or the  
 8 issue --  
 9 A. I didn't about that specific recommendation --  
 10 Q. Yes.  
 11 A. -- but, just to be clear, the recommendation in respect  
 12 of pandemic flu, it was a completely different set of  
 13 PPE requirements, well not completely but substantially  
 14 different, and the type of staff who would be involved  
 15 in this type of fit testing, as I think this document  
 16 itself suggests, were different than what we ended up  
 17 with. So, look, there's no doubt --  
 18 Q. Yes, we're talking about respirators for a respiratory  
 19 virus.  
 20 A. Yeah, I mean, I'm talking about the aerosol generating  
 21 procedures but also the use of these PPE in far wider  
 22 settings than frankly was envisaged for the flu  
 23 stockpile and that's one of the great misjudgements,  
 24 essentially, that was made and resulted in the fact  
 25 that, when Covid struck, we did not, as a country, have

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1 document, but yes, I can read what you have put up  
 2 there.  
 3 Q. But you were chief executive from 2014 --  
 4 A. Sure, but this was a document I think to Public Health  
 5 England and the Department of Health and Social Care,  
 6 wasn't it?  
 7 Q. I fully take that point.  
 8 A. Sure.  
 9 Q. It directly relates to the NHS. It's a recommendation  
 10 that the fit testing rolling programme should take place  
 11 across the NHS and you're the chief executive.  
 12 A. Yeah, it may well be, but I do not want to give you  
 13 an answer that is not fact based. I can certainly ask  
 14 that question and make sure you get that answer --  
 15 Q. Okay --  
 16 A. But clearly, just really skimming this document now and  
 17 seeing it for the first time --  
 18 Q. Yes.  
 19 A. -- it appears to be suggesting that fit testing was  
 20 obviously specifically confined to intensive care units.  
 21 The issue with Covid was obviously that it was a much  
 22 wider set of requirements --  
 23 Q. Yes, but it's?  
 24 A. -- and, frankly, the pandemic planning for influenza flu  
 25 was wide of the mark for the sort of PPE requirements

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1 the PPE that we needed.  
 2 Q. Okay, let me just focus my question then. You told us  
 3 that, by the time it's raised with you in April 2020,  
 4 there was ongoing consideration about fit testing and  
 5 the propriety of the types of PPE that you had. Was  
 6 there a rolling programme of respiratory fit testing  
 7 during the period from 2016 to 2020?  
 8 A. Well, I think it's likely there would have been in those  
 9 parts of hospitals and health services that were using  
 10 that PPE but, as I say, I don't want to speculate, let's  
 11 find out the facts and get those to you.  
 12 Q. Yes, okay, well, that's very helpful, it's just that,  
 13 when you said there was ongoing work, you obviously did  
 14 look into this in April 2020 so --  
 15 A. Yeah, that was ongoing work as had been recommended for  
 16 Covid.  
 17 Q. Yes, I understand that but did you understand when that  
 18 ongoing work had started?  
 19 A. Well, this was specifically in response to Covid where  
 20 a far wider group of health service staff were needing  
 21 PPE.  
 22 Q. Yes.  
 23 A. So I think that's what the Chief Nursing Officer and the  
 24 National Medical Director were focusing on.  
 25 Q. Of course the context is Covid, that's what you were

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1 dealing with --

2 **A.** Yeah.

3 **Q.** -- but it was about respiratory -- respirators and

4 other PPE, which went rather beyond Covid, didn't it?

5 **A.** Well, as you know, there was a live and indeed ongoing

6 debate, which I was not directly involved with, but

7 a scientific debate as to the circumstances under which

8 it was appropriate to use the type 2R mask as against

9 the FFP3 --

10 **Q.** Yes, okay --

11 **A.** Masks and I think it's the FFP3 masks that you're

12 referring to specifically here.

13 **Q.** Well, I think that's something that possibly we'll leave

14 to a different module, the granular detail of it.

15 But finally this, had there been a rolling programme

16 of fit testing across the NHS, do you agree with me that

17 these problems with non-fitting PPE for women healthcare

18 workers or black and minority ethnic healthcare workers

19 would have been flagged up much earlier and would have

20 been dealt with or should have been dealt with prior to

21 the pandemic --

22 **A.** No, I think almost the reverse, because if you were

23 doing -- if you were doing it in a situation where there

24 was ample PPE supply because there wasn't a pandemic on,

25 you wouldn't actually have detected the problem. It was

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1 You have -- to introduce my question, I would just

2 like to ask you to recall that in your witness statement

3 at paragraphs 31 to 36 you have referred to a series of

4 fora where there were discussions of the matter of

5 measures to free up hospital capacity.

6 **A.** Mm-hm.

7 **Q.** And you have referred -- and that includes a discussion

8 in Cabinet on 17 March. I think you said earlier that

9 you didn't attend that particular meeting. You've also

10 referred to a meeting on 18 March 2020 with

11 the Prime Minister. I don't know whether you

12 immediately recall that meeting. It might be helpful if

13 you do recall whether you attended that particular

14 meeting on 18 March.

15 Your reference to it, I think, is that it was

16 specifically in relation to the matter of NHS resilience

17 and a meeting on NHS resilience with the Prime Minister

18 on 18 March 2020.

19 **A.** Yeah, I mean, there had been meetings with

20 the Prime Minister before that as well, so this question

21 was, for example, also discussed with him and others on

22 12 March. I know it was discussed in the Department of

23 Health and Social Care with Matt Hancock, with

24 DHSC officials, some of the senior doctors in the

25 department, social care advisers and so on.

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1 only when the shortage arose that it was so evident that

2 there was a problem.

3 **MR WEATHERBY:** Those are my questions.

4 **LADY HALLETT:** Thank you, Mr Weatherby.

5 Ms Harris.

6 **Questions from MS HARRIS**

7 **MS HARRIS:** Good morning, my Lady.

8 **LADY HALLETT:** Good morning.

9 **MS HARRIS:** Good morning, Lord Stevens.

10 **A.** Good morning.

11 **Q.** I appear on behalf of Covid-19 Bereaved Families for

12 Justice Cymru --

13 **A.** Right.

14 **Q.** -- representing bereaved families in Wales, and I would

15 like to ask you some questions relating to just two

16 areas, if I may.

17 First of all, in relation to hospital discharge, and

18 this is said, as Mr O'Connor has already highlighted

19 this morning, that the details in relation to discharge

20 into care homes are going to be dealt with in another

21 module, but they are to some extent dealt with in this

22 module, and I wish to ask you about one particular

23 aspect to do with the discussions that preceded the

24 policy or the guidance in March 2020 with regards to

25 discharge and the impact on social care settings.

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1 **Q.** Thank you.

2 **A.** But I was not at that 11 March meeting, I don't believe.

3 **Q.** Thank you for that. And the guidance itself was

4 published on 19 March, and that is referred to in your

5 witness statement as the hospital discharge, the

6 multi-agency hospital discharge guidance, and is it

7 correct that the purpose was to secure swift discharge

8 of hospital patients who were considered to be no longer

9 in need of -- to be in hospital, to secure their swift

10 discharge, and this included envisaging that there would

11 be a considerable number of individuals who would be

12 discharged into social care, including, here,

13 care homes?

14 **A.** Not that more people would be discharged than would

15 normally be the case, but just that the discharge would

16 not be delayed in the way that, as we've discussed

17 earlier this morning, was often the case.

18 **Q.** Thank you.

19 In terms of the impact of that guidance, I'm noting

20 that in paragraph 32 you have quoted specifically:

21 "... 'to free up hospital beds over 30,000 patients

22 were expected to leave hospital into social care

23 imminently' ..."

24 **A.** I don't think I've quoted that, because I think actually

25 it was -- the original modelling was that 15,000 of the

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1 bed capacity would be as a result of postponing routine  
2 surgery, and then, if it was possible to get better  
3 support for people at home and social care, which the  
4 government funded and changed the regulations on, then  
5 that would mean people who would have gone to  
6 social care and back home or care homes would be able to  
7 do so faster rather than slower, as had been happening  
8 up until then. So about half of that I think was  
9 attributed to the length of stay reduction, half of the  
10 30,000.

11 **Q.** Thank you.

12 But in any event, it was part of the picture that  
13 was envisaged resulting from the guidance that there  
14 were going to be individuals discharged from hospital  
15 into care home settings?

16 **A.** Well, people are obviously all -- if people have been  
17 living in a care home then, when they're ready to go  
18 home from hospital, they would return to their  
19 care homes. So it wasn't a new group of people who  
20 would be going to care homes who would not otherwise  
21 have done so, it was just trying to take out some of  
22 the delays in the system. And indeed, of course,  
23 the actual number of people who returned from hospitals  
24 to care homes went down in this period, not up.

25 **Q.** If I could just pick up on one point there, there would  
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1 number of tests? And I think the Secretary of State had  
2 said that he made that decision on 11 March as to who  
3 would be prioritised, and that did not include people  
4 being discharged into care homes. He did so on clinical  
5 advice, but that was the decision that he took.

6 **Q.** In the context of there not being testing, was there  
7 a discussion that you were aware of or were party to of  
8 the issue of possible asymptomatic cases of  
9 infectiousness going into care homes and the impact that  
10 that could have? Was that specific discussion had,  
11 about that specific type of risk?

12 **A.** I understand, looking back on it, I -- based on some of  
13 the materials that I've subsequently seen is that there  
14 was a discussion involving some of the senior clinicians  
15 and there was a balance of risk argument. I think they  
16 also contend that although the possibility of  
17 asymptomatic infection had been identified, it was not  
18 known how substantial a risk that was at that point in  
19 time. That is obviously something that there are  
20 conflicting views on and I'm sure, rightly, the Inquiry  
21 will want to look at that in very great detail when  
22 the Inquiry comes to care homes.

23 **Q.** So just to clarify, are you saying it was recognised  
24 that there was such a risk from asymptomatic discharges,  
25 even though there was uncertainty around the extent of

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1 be some new admissions to care homes as a result of this  
2 policy, would you not agree?

3 **A.** I don't agree, no, that there would be a higher number  
4 of people, newly or returning, going back to care homes,  
5 it's just that the delays of being stuck in hospital  
6 would be reduced.

7 **Q.** But we've agreed in any event that there would be people  
8 who would be discharged from hospital into care homes?

9 **A.** As always, yes.

10 **Q.** And the question arising out of this is: what  
11 discussions were you aware of or party to with regards  
12 to the risks for residents in care homes arising from  
13 discharge plans in terms of infection?

14 **A.** Well, I think -- as I say, I know there was a discussion  
15 at the Department of Health and Social Care with  
16 ministers and senior doctors on 11 March. I also know  
17 that over the following days there was a discussion  
18 about whether the risk was greatest if people were about  
19 to need hundreds of thousands of hospital beds and  
20 instead were going to, as we'd seen in northern Italy at  
21 that time, be left in hospital car parks dying -- so  
22 there was a risk the hospital beds weren't available.  
23 I think there was a related but separate decision that  
24 the Secretary of State took, which is: if you're going  
25 to have testing, how should you allocate a limited

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1 asymptomatic infectiousness?

2 **A.** I think potentially different people had different  
3 understandings of that and I don't have a, you know,  
4 comprehensive overview as to who was saying what, but  
5 I think that was, in some senses, taken into account but  
6 whether it was appropriately taken into account that's  
7 obviously something that, again, the Inquiry will have  
8 to look at very carefully.

9 **Q.** Yes, thank you.

10 Just on that question of whether it was  
11 appropriately taken into account, as you view matters,  
12 whose responsibility was it primarily to initiate  
13 consideration of the taking into account of that matter?

14 **A.** Well, I think, as was referred to earlier, this is  
15 something that the High Court has independently looked  
16 at, and I can't second-guess their judgment, their  
17 assessment was that it was reasonable for ministers to  
18 free up hospital capacity and it was reasonable for  
19 ministers to make the prioritisation of testing  
20 decisions that they did, but that what should have  
21 happened was clearer guidance to care homes about  
22 isolating people who were coming back to the care home.  
23 That's what the court found.

24 I also defer to the medical evidence that is  
25 contained in the Chief Medical Officer's review of this

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1 matter, and their assessment is that the majority of the  
2 infections that tragically entered care homes came from  
3 the community rather than from patients returning to  
4 them.

5 **Q.** Thank you, and I note -- and I think I'm nearly at the  
6 end of my time, so I think I'll have to finish very  
7 quickly on this -- but it's correct, isn't it, that that  
8 report also does note -- that very report which I know  
9 you have referred to in your witness statement, it does  
10 also note that there -- some care home outbreaks were  
11 introduced or intensified by discharges from hospital?

12 **A.** Yes, the report does say that. The overarching  
13 evidence, I think, is that, unfortunately, in any  
14 country where Covid is out of control in the community,  
15 it found its way into care homes, and that was true in  
16 many countries around the world.

17 **MS HARRIS:** Thank you. I think I've come to the end of my  
18 time and many apologies if I went over. Thank you.

19 **LADY HALLETT:** Thank you, Ms Harris.  
20 Mr Metzger.

#### 21 Questions from MR METZER KC

22 **MR METZER:** Thank you, my Lady.

23 Lord Stevens, I ask questions on one topic only, on  
24 behalf of the Long Covid groups.

25 **A.** Right.

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1 Is that what your second -- is that --

2 **Q.** Yes, it's really about the assistance that would be  
3 given to the NHS by messaging coming from the  
4 government.

5 **A.** Well, I mean, the root cause of the problem obviously is  
6 the amount of Covid infection, so I think, you know,  
7 there was a clear understanding that less Covid is  
8 better.

9 **Q.** Yes, but Long Covid comes from Covid infection.

10 **A.** Indeed.

11 **Q.** So do you agree that the NHS therefore would have been  
12 assisted by such a messaging campaign?

13 **A.** Sort of reminding, telling people about the existence of  
14 Long Covid so people therefore were sort of  
15 appropriately cautious about their interactions? Is  
16 that the --

17 **Q.** Yes.

18 **A.** Is that the thought? Yeah, I mean, possibly, yes.  
19 I haven't -- I mean, possibly.

20 **Q.** In August 2020, NHS England published a detailed  
21 briefing note on managing the long-term effects of  
22 Covid-19. The paper estimated that a significant number  
23 of the UK population will need some form of  
24 rehabilitation support for ongoing conditions over the  
25 year, and Long Covid is described as a new healthcare

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1 **Q.** In your evidence, you said that solely viewing the  
2 amount of Covid through the lens of whether or not there  
3 were enough NHS beds was wrong and the right question,  
4 you said, was how you control the numbers of people  
5 infected. Linked to that, I wish to explore with you  
6 long-term morbidity from Covid-19 infection, which is  
7 another metric of harm in the pandemic.

8 NHS England announced the Your Covid Recovery  
9 platform on 5 July 2020, which was a platform to support  
10 patients suffering from prolonged symptoms after  
11 infection from Covid-19. Would it be right to say from  
12 this announcement that by July 2020 the NHS were  
13 concerned about the prevalence and risk of Long Covid?

14 **A.** Yes.

15 **Q.** Thank you. Would the NHS have been assisted by a public  
16 health messaging campaign on Long Covid at this time?

17 **A.** So I think I'd break that question into two parts, if  
18 I might. There would be public messaging for people who  
19 might be experiencing what came to be known as  
20 Long Covid, so that they were able to come forward and  
21 engage with services. But perhaps the second part of  
22 your question is a different one, which is: would it  
23 have made sense for the Government to talk about the  
24 risks of Long Covid as a way of trying to encourage  
25 people to take action to limit the spread of the virus.

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1 challenge requiring actions to strengthen NHS services  
2 to meet new demand.

3 Do you agree that by August 2020 the NHS were  
4 concerned that emerging evidence of longer term sequelae  
5 of Covid-19 would pose an additional cost to the NHS?

6 **A.** Absolutely.

7 **Q.** And was the new healthcare challenge and its associated  
8 cost communicated to Number 10 and the Cabinet Office?

9 **A.** Well, inasmuch as we were making public announcements  
10 and they would have known we were making  
11 the announcements about the NHS services that were being  
12 responded, yes, I'm sure they would have been aware.

13 **Q.** So assuming that your answer is you agree, how, if at  
14 all, did the decision-makers respond?

15 **A.** Well, I think the Department of Health and Social Care  
16 shared our concern, and I know that senior clinicians,  
17 ministers, over the summer and into the autumn, were  
18 also engaging with the question of Long Covid and how  
19 appropriately to support, and there was a sort of active  
20 dialogue between the Department of Health and Social  
21 Care and us in the NHS about what that should look like.  
22 I can't say what the discussion was between them and the  
23 centre of government though.

24 **Q.** So does that mean you're not able to say how the  
25 decision-makers, those in Number 10 and the

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1 Cabinet Office, responded?

2 **A.** That's right.

3 **MR METZER:** Thank you very much, Lord Stevens.

4 Thank you, my Lady.

5 **LADY HALLETT:** Mr Dayle.

6 **Questions from MR DAYLE**

7 **MR DAYLE:** Thank you, my Lady.

8 Lord Stevens, I ask questions on behalf of FEHMO,

9 the Federation of Ethnic Minority Healthcare

10 Organisations. One of FEHMO's main concerns is about

11 the UK's pandemic response, and what it perceives as

12 a seeming lack of urgent, centralised and coherent

13 programmatic response to the spectre of disproportionate

14 deaths of black, Asian and minority ethnic healthcare

15 workers and their wider communities, and certainly at

16 the early stages of the pandemic. As such, I have four

17 discrete sets of questions for you, and my first

18 question is: when did it become clear that black, Asian

19 and ethnic minority communities were disproportionately

20 being affected by Covid-19, specifically in terms of the

21 death rates?

22 **A.** I think -- sorry, I'm not quite sure what I -- I don't

23 want to turn my back to you.

24 **Q.** Certainly. It's not impolite. That's been established.

25 **LADY HALLETT:** I don't want you turn away because of the

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1 again probably around maybe 9 April, something like  
2 that, and also from Dr Chaand Nagpaul at the BMA, and so  
3 I pretty immediately convened a meeting to -- with them  
4 and other stakeholders to say what do we think's going  
5 on, what is the action that is needed, and we held that  
6 meeting on 15 April 2020.

7 **Q.** From your vantage point, was there an escalation of  
8 concerns around this issue, and in answer to  
9 Mr O'Connor's questions, you spoke about regular  
10 meetings with the Prime Minister, for example. Was  
11 there an escalation in terms of how this issue was  
12 addressed or what the response was?

13 **A.** Well, I think there are maybe -- there's an element that  
14 obviously relates to what we were seeing in the NHS and  
15 then there's an element that relates to the information  
16 that people like Public Health England and others were  
17 showing about in the community, the disproportionate  
18 impact on people who were getting Covid and dying. In  
19 terms of the first of those, what we were doing in the  
20 NHS -- obviously we were able to take action in respect  
21 of the second of those, the broader impact on the  
22 community -- I think that is a question that I can't  
23 answer, and that's probably a question for, you know,  
24 the Department of Health or Public Health England as to  
25 the extent to which the centre of government was having

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1 microphones, Lord Stevens.

2 So you won't consider it an insult, will you

3 Mr Dayle?

4 **A.** Right.

5 I think the answer to your question is sort of early  
6 spring, and to be precise, more precise about it, I know  
7 that, for example, on 9 April 2020 the NHS National  
8 Medical Director, Professor Stephen Powis, having seen  
9 some of those emerging figures, as you rightly describe,  
10 raised the concern about the disproportionate impact at  
11 the senior clinicians group, and on the strength of  
12 that, I believe that Chris Whitty, the Chief Medical  
13 Officer, commissioned Public Health England to  
14 investigate more fully.

15 **MR DAYLE:** And that speaks to sort of an investigatory  
16 response for perhaps a more reflective response to this  
17 phenomenon. I want to button down on that in particular  
18 and ask you: do you consider that there was a timely  
19 response to this phenomenon?

20 **A.** Well, in terms of what the health service was doing,  
21 I think this matter was raised with me at about the same  
22 time as Steve Powis discussed it with those other senior  
23 clinicians, and in fact I had a very important letter  
24 from a group that I respect immensely called BAPIO,  
25 the British Association of Physicians of Indian Origin,

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1 a policy discussion with them about that. I don't know.

2 **Q.** And finally, can you tell us about any specific targeted  
3 intervention that was put in place in those early months  
4 to address disproportionate death rates among black,  
5 Asian and minority ethnic communities?

6 **A.** So within the NHS, on 17 March, we asked every part of  
7 the NHS to make sure that staff at higher risk of Covid  
8 and having a bad outcome from it were identified and  
9 were able to work in lower risk areas. We followed that  
10 up on 29 April and 30 April with a request that specific  
11 risk assessments be done across the service, and then,  
12 at the same time, I think I commissioned  
13 Professor Kamlesh Khunti from  
14 the University of Leicester with colleagues to identify  
15 specific risk reduction frameworks that would take  
16 account of the extra risk that appeared to be in place  
17 for minority ethnic staff. And that was produced in  
18 combination, I think, with the Faculty of Occupational  
19 Medicine.

20 **MR DAYLE:** Thank you. Thank you, Lord Stevens.

21 Thank you, my Lady.

22 **LADY HALLETT:** Thank you, Mr Dayle.

23 **MR O'CONNOR:** My Lady, those are all the questions for  
24 Lord Stevens.

25 **LADY HALLETT:** Thank you very much indeed, Lord Stevens,

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1 thank you for your help.

2 **THE WITNESS:** Thank you.

3 **(The witness withdrew)**

4 **LADY HALLETT:** I'm not going to rise but I'm told that

5 the stenographer would like -- so we'll take our time in

6 the handover.

7 **(Pause)**

8 **MR KEITH:** My Lady, the next witness --

9 **LADY HALLETT:** No, you're not allowed to say anything. I'm

10 giving the stenographer a rest.

11 **(Pause)**

12 Right.

13 **SIR CHRISTOPHER WORMALD (affirmed)**

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

15 **MR KEITH:** Could you give the Inquiry your full name,

16 please.

17 **A.** I'm Sir Christopher Wormald, I'm the permanent secretary

18 of the Department of Health and Social Care.

19 **Q.** Sir Christopher, you are known to the Inquiry,

20 of course, because you gave evidence in Module 1,

21 an event you'll no doubt recall.

22 Thank you for your continued assistance. You've

23 provided a number of additional statements to

24 the Inquiry. We don't need to bring them up, but four

25 statements in particular relate to the subject matter of

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1 **Q.** Can I also make plain, because of some of the questions

2 which have been put to the previous witness, that

3 of course matters concerning the detail of test and

4 trace, the care sector and PPE will be addressed in

5 detail in later modules held by this Inquiry, and

6 therefore we won't be going into the granularity of any

7 of those areas, we'll only be looking at them insofar as

8 they reflect the core administrative or political

9 decision-making.

10 With that context, could I ask you, please, to start

11 by describing the role of the permanent secretary and,

12 in particular, your role as a permanent secretary in the

13 DHSC in January 2020.

14 **A.** Yeah, thank you. And if I may, I'd like to repeat what

15 I said in Module 1 about the department's regret for

16 everyone who suffered either directly or indirectly as

17 a result of Covid and also our enormous thanks to

18 the incredible staff in the NHS and the care sector and

19 everyone who helped them and got them through

20 the pandemic.

21 **LADY HALLETT:** Pause there, if you would. Could you go much

22 more slowly, please? I'm afraid our stenographer has

23 had a tough morning already and I think she might kill

24 me if I let you --

25 **A.** I'm very sorry.

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1 Module 2, and they run to many hundreds of pages, in

2 fact.

3 Sir Christopher, members of the public won't know,

4 but in preparation for your evidence today, the Inquiry

5 provides you with particular documents on which it

6 intends to focus. I know that you were sent those

7 documents over the last few weeks, but in particular you

8 were sent a number of documents up to and including late

9 last night. You may not, therefore, have had a full

10 chance to consider those documents. I apologise that

11 you received them so late. We're just going to go

12 through them and we'll just see where we go.

13 I also want to make plain that my questions of you

14 are directly focused on Module 2. The Department of

15 Health and Social Care was, of course, the lead

16 government department in this health emergency, but

17 Module 2 focuses on the core political and

18 administrative decision-making at the heart of

19 government throughout the currency of the pandemic and,

20 therefore, we'll be looking at those areas in which

21 the DHSC engaged with central government or gave advice

22 to central government or met with central government, as

23 opposed to looking at matters which were specific to

24 the DHSC alone. Do you follow?

25 **A.** Yes.

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1 **MR KEITH:** Sir Christopher, you know, of course, from this

2 process before the absolute need to go slowly.

3 **A.** So the role of the permanent secretary I see as always

4 in three chunks. You are the chief executive of

5 the DHSC itself, and you lead the staff and systems of

6 the department. You are the chief adviser to

7 the Secretary of State who holds all the actual legal

8 decision-making powers, which does not mean you provide

9 all the advice yourself, indeed you provide very little

10 of it yourself, but you're responsible for the system of

11 advice. And thirdly, you are the accounting officer for

12 the resources voted by Parliament to the department to

13 fulfil its functions, and it's basically those three

14 things.

15 **Q.** Just briefly focusing on some of the moving parts within

16 the department, the Inquiry is, of course, extremely

17 well aware of the vital role of the Chief Medical

18 Officer, the principal medical adviser to the

19 government. To what extent is the CMO part of the DHSC,

20 or an adviser to the DHSC?

21 **A.** He is a completely integral part of the department, but

22 also has a wider role across government, so he is one of

23 the most senior staff at the department, ranked at

24 permanent secretary level, part of the executive team

25 that leads and runs the department. He advises

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1 the Secretary of State on particularly public health but  
 2 actually any clinical matter relating to England, and  
 3 then he's adviser to both the Prime Minister and  
 4 the entire Cabinet on clinical matters relating to  
 5 the -- both England and the United Kingdom. So if  
 6 another Cabinet minister requires clinical advice, they  
 7 would go direct to the Chief Medical Officer, not via  
 8 the department, and likewise with the Prime Minister.

9 **Q.** The Inquiry understands that, as a result of the demands  
 10 of the pandemic, a second permanent secretary position  
 11 was created within the Department of Health and Social  
 12 Care, but did you remain primarily focused on Covid  
 13 whilst that other second permanent secretary dealt  
 14 predominantly with other aspects of finance and group  
 15 operation and the --

16 **A.** Yes.

17 **Q.** -- many areas?

18 **A.** Yes, though it evolved over the period, so the original  
 19 idea --

20 **Q.** Shortly, please, Sir Christopher. Did you remain  
 21 responsible for the Covid -- in general terms, Covid  
 22 issues?

23 **A.** Yes.

24 **Q.** An important part of the permanent secretary's role in  
 25 providing advice to ministers in the department,

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1 the care sector, or PPE, all of which the DHSC was  
 2 centrally concerned in, would the majority, if not all  
 3 of the information received from the Secretary of State,  
 4 come from the department?

5 **A.** Certainly, the vast majority, but to take an example,  
 6 were a Secretary of State to wish to supplement some  
 7 advice on social care by talking to a local authority  
 8 director of social services about what it felt like from  
 9 the local authority, and they're completely free to do  
 10 that, but it would normally be a supplement to advice  
 11 received by the department, and, as I say, the vast  
 12 majority would have come from departmental sources.

13 **Q.** And the Secretary of State wouldn't go off on his or her  
 14 own and speak to somebody else without the knowledge of  
 15 and possibly attendance of a member of the department or  
 16 that process of meeting and the receipt of information  
 17 being recorded by way of email or departmental note?

18 **A.** Yes, so the rules in force is if they, if  
 19 a Secretary of State or any minister feels they have had  
 20 a conversation which is relevant to public policy, they  
 21 either have a private secretary in attendance who  
 22 records that, or they feed back to their private office  
 23 who record the conversation. And the test is not who  
 24 was the conversation with, but is it relevant to the  
 25 public record.

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1 presumably that includes the Secretary of State?

2 **A.** Well, it's primarily the Secretary of State, supported  
 3 by the junior ministers. I would normally be most  
 4 involved in -- with the Secretary of State.

5 **Q.** How does it work? Does the Secretary of State, whoever  
 6 they may be, receive advice exclusively from the  
 7 department in the discharge of their function as  
 8 Secretary of State, or are there other sources of advice  
 9 or information or material which they may be privy to or  
 10 receive from elsewhere?

11 **A.** So secretaries of state are free to take their advice  
 12 from wherever they like, that might be other  
 13 Parliamentarians, it might be independent experts, and  
 14 it might be other Cabinet ministers. There would always  
 15 be official departmental advice, but  
 16 secretaries of state could choose to supplement that if  
 17 they wished to.

18 So as a department, a civil servant, you have  
 19 a right to be heard, you know, you have a right to put  
 20 your advice to a Secretary of State, but not either that  
 21 that advice is necessarily followed or that that is the  
 22 exclusive advice that a Secretary of State would  
 23 receive.

24 **Q.** On matters specific to the Department of Health and  
 25 Social Care, for example, relating to test and trace, or

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1 **Q.** Your statement makes plain, or one of your statements  
 2 makes plain, Sir Christopher, that the permanent  
 3 secretary is usually copied in on all advice to  
 4 ministers, and of course one of your primary  
 5 responsibilities is to ensure that they receive  
 6 the right advice at the right time.

7 **A.** Yes.

8 **Q.** So you are, of course, aware that a number of witnesses  
 9 in this Inquiry from the Cabinet Office and Number 10  
 10 have given evidence to the effect that the  
 11 Secretary of State for your department regularly said  
 12 things that were untrue. I want to ask you, firstly,  
 13 therefore, whether you were aware during the pandemic of  
 14 that view apparently held by other people in the heart  
 15 of government?

16 **A.** So, there were two -- two things that were raised.  
 17 There were a very small number of cases where people  
 18 said the Secretary of State had said something that was  
 19 untrue. I have to say I did not either witness or come  
 20 across things where I thought he said something that's  
 21 actually untrue. There were a lot of people who said  
 22 that the Secretary of State was overoptimistic about  
 23 what would happen, and overpromised on what could be  
 24 delivered. That was said really quite a lot. I think  
 25 it was a very small number of people who said that he

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1 was actually telling untruths.

2 **Q.** The proposition I put to you was that there were  
3 a number of witnesses who have said that the  
4 Secretary of State regularly said things that were  
5 untrue, and I asked you whether you were aware that that  
6 was their belief. Do we take it from that past last  
7 answer that you weren't aware that witnesses, civil  
8 servants, advisers in the heart of government, were  
9 saying that the Secretary of State regularly told things  
10 that were untrue?

11 **A.** Regularly, yes. I had instances, individual instances  
12 raised, and, as I said, I couldn't see any validity to  
13 the accusation on the individual things that were  
14 raised. I didn't have it reported regularly untruth,  
15 the other category I did hear about a lot.

16 **Q.** So in fact your answer is: regularly, no, that's not  
17 something -- you didn't hear that people were regularly  
18 saying he was speaking untruths?

19 **A.** No.

20 **Q.** All right.

21 **A.** Not untruths, you know, but as I say, my two  
22 categories --

23 **Q.** We understand.  
24 When you gathered that there were instances of  
25 untruths, as you've described, and more, perhaps

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1 **A.** Well, as I say, there weren't instances of untruths  
2 which I raised with him, there were things he corrected,  
3 but, as I say, when -- on individual cases when they  
4 were raised, I couldn't see what untruth had been told.

5 On the setting, you know, the -- on the other  
6 category, we spoke about that, and he was always clear  
7 that he was doing it for a positive reason. So setting  
8 a very aspirational target not necessarily expecting to  
9 hit it, but to galvanise the system to do more. So that  
10 was -- well, you will ask Mr Hancock, I'm sure, but my  
11 understanding that was a sort of conscious decision.  
12 And of course whether that's a good thing to do or not,  
13 that is a matter of perception, not a matter of right  
14 and wrong.

15 **Q.** Sir Christopher, I've asked you about instances in which  
16 you agree he may have exaggerated the position.  
17 I wasn't asking about the setting of targets. I'm  
18 asking about instances in which you became aware that  
19 the Secretary of State had said something which just  
20 wasn't accurate, whether it was in terms of numbers of  
21 tests or things being done or things being done by the  
22 DHSC which may thereafter have required correction.  
23 What did you do when you were confronted with those  
24 instances?

25 **A.** So for those, which are the first category, I tried to

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1 multiple, occasions of exaggeration or matters being not  
2 quite right, being said by the Secretary of State, what  
3 did you do in terms of speaking to him?

4 **A.** So when you come across something where you think either  
5 in public or to a Cabinet committee something that is  
6 not true has been passed on, I mean, in the vast  
7 majority of cases it's accidental, and in those cases  
8 the -- you have to put the record straight, as it were,  
9 and ministers do this quite a lot in Parliament and also  
10 in the Cabinet -- you know, misremembering a number,  
11 for example.

12 Sorry.

13 **Q.** Yes.

14 **A.** In terms of the second category, I mean, that is  
15 a matter of perception. So I'm sure Mr Hancock will say  
16 he believed that what he'd said was deliverable. And in  
17 particular, and he did make a big thing of this, his  
18 style of leadership was to set very hard challenges as  
19 a way of motivating the system. So this came up most,  
20 probably, around the 100,000 tests pledge.

21 **Q.** We will come back to that in detail, but my question to  
22 you was: what did you do in terms of speaking to  
23 Mr Hancock when you became aware that there were  
24 instances of untruths and, more often, examples of  
25 exaggeration?

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1 satisfy myself whether it had happened or not. And, as  
2 I say, when I looked at the individual incidents,  
3 I couldn't identify examples where he had said something  
4 that was untrue.

5 So, to take an example, he was accused of misleading  
6 the Prime Minister about whether people being discharged  
7 from hospital into care homes were going to be tested.  
8 When I looked at that, I couldn't find any evidence that  
9 he had done that, I didn't witness it, and it was -- had  
10 been stated in public that we were not undertaking such  
11 tests. So I couldn't see how there had been any  
12 misleading going on. And in that case there is  
13 therefore no further action to take.

14 So, as I say, I didn't find any instances where he  
15 told an untruth that you could identify that you then  
16 needed to put right.

17 **Q.** But there were instances, weren't there, to use  
18 the wonderful phrase of one of your professional former  
19 colleagues, I think it was Lord Armstrong, where he may  
20 have been economic with the actuality?

21 **A.** Erm, I'm trying to think of a specific example -- well,  
22 I couldn't point to a specific example. As I say,  
23 the things that were mainly raised with me were at the  
24 level of: your Secretary of State promised 100,000 tests  
25 by the end of April, we don't think he's going to get

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1 there. It was much more that sort of overpromising in  
 2 the future as opposed to something that is not true.  
 3 Now, in that case it's of course a matter of  
 4 opinion, and the Secretary of State is entitled to his  
 5 opinion that he will hit his target. So the things that  
 6 were raised with me, they were much more in those sorts  
 7 of category of overpromising as opposed to untruth.  
 8 **Q.** Did you say to him, "Mr Hancock, I'm now aware that  
 9 there are a significant number of people, senior civil  
 10 servants and advisers in the heart of the government,  
 11 seeking to respond to this appalling crisis, who believe  
 12 that you are saying things regularly that are untrue or  
 13 you are exaggerating or you are simply giving a wrongful  
 14 impression about the reality" --  
 15 **A.** Not in exact --  
 16 **Q.** If you just let me finish my question.  
 17 **A.** Sorry.  
 18 **Q.** -- and therefore say to him, "This is damaging to the  
 19 trust and the confidence which your colleagues must  
 20 necessarily repose in you, and this is doing us and the  
 21 department harm"?  
 22 **A.** So we had conversations, and I couldn't point you to,  
 23 you know, a specific day, but I remember having this  
 24 sort of conversation with him where I would say,  
 25 you know, "People believe you are overpromising", and,

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1 that from Helen before either, that it was so  
 2 widespread.  
 3 **Q.** And he would have been in no doubt, would he, about  
 4 the concern that you expressed as  
 5 the permanent secretary of his department at the fact  
 6 that this appeared to be an issue?  
 7 **A.** So --  
 8 **Q.** Did you express concern, Sir Christopher, to him, or did  
 9 you just debate objectively whether or not there was any  
 10 validity to these issues?  
 11 **A.** No, in those sorts of circumstances, where it's not  
 12 about wrongdoing, I see my role as making sure that  
 13 the Secretary of State is aware of the position, and it  
 14 is then his choice as Secretary of State how he wishes  
 15 to behave. It's very different if you think there has  
 16 been wrongdoing, therefore breach of the  
 17 Ministerial Code, where you have a professional  
 18 responsibility to raise a concern. So in those sorts of  
 19 situations my role is to make sure the  
 20 Secretary of State knows what is going on, to the best  
 21 of my knowledge, and that if he is behaving that way he  
 22 is doing so in the knowledge that it is raising  
 23 concerns.  
 24 **Q.** Sir Christopher, we're not concerned here with code of  
 25 conduct. I'm asking you whether you said to him,

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1 as I say, the Secretary of State was always very clear  
 2 that he was doing -- he was saying what he was saying,  
 3 (a) he believed it was possible and (b) he believed it  
 4 was very important to be both optimistic and  
 5 aspirational.  
 6 So -- and that is, of course, in that category,  
 7 you know, it's not untrue, but people believe you are  
 8 overpromising, that is then a decision for him about  
 9 whether that is the image he wishes to portray. I don't  
 10 think he was in any doubt that some people thought that  
 11 of him. I don't think there was ... I think -- well,  
 12 you'll find out when you question him. I suspect he  
 13 will be surprised by how widespread it was. I mean,  
 14 I think he was very well aware that Mr Cummings held  
 15 those views of him and expressed them. I think he  
 16 probably knew that the Cabinet Secretary occasionally  
 17 made the same point --  
 18 **Q.** The Deputy Cabinet Secretary?  
 19 **A.** I suspect -- as I say, I am now guessing about what  
 20 Mr Hancock will think, but my guess would be that he  
 21 will be quite surprised that Helen MacNamara had  
 22 the same views. And I think some of your other  
 23 witnesses have said the same thing, so I think he --  
 24 **Q.** All right.  
 25 **A.** -- will be surprised, as I was, in fact I hadn't heard

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1 "Secretary of State, these concerns, these views, these  
 2 expressions of opinion about your truthfulness or your  
 3 accuracy or a tendency to exaggerate or be overly  
 4 optimistic, however you call it, these concerns have  
 5 been raised. I, as your permanent secretary, am  
 6 concerned about this because of the impact upon the  
 7 working relationships between this department and the  
 8 rest of government, and on the trust and confidence  
 9 which your professional colleagues must necessarily  
 10 repose in you"?  
 11 **A.** No, I didn't have that conversation, but, as I say,  
 12 I was not aware of the widespread view that has been  
 13 expressed to this Inquiry by witnesses.  
 14 **Q.** How many times did this conversation, this matter, come  
 15 up for debate between you? You said you spoke to him.  
 16 Did it stop?  
 17 **A.** I can only -- I can only, and, as I say, I cannot  
 18 remember the date, I can only remember one conversation,  
 19 but, as I say, we were mainly talking about the views of  
 20 Mr Cummings, and what he was saying.  
 21 **Q.** So there was one time when you spoke to Mr Hancock about  
 22 the views of other professionals in government about  
 23 him?  
 24 **A.** I couldn't ... I couldn't promise there was more than  
 25 one, I can remember one conversation, but, as I say,

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1 what I was seeing at the time was a very small number of  
2 people who were not Mr Hancock's friends saying this, as  
3 opposed to a widespread thing around government. As  
4 I say, that has been presented to the Inquiry.

5 **Q.** You're not suggesting, are you, that because they  
6 weren't his friends that they should be treated any less  
7 seriously in the concerns that they expressed?

8 **A.** Erm --

9 **Q.** Helen MacNamara?

10 **A.** No, well, as I say, I didn't know that Helen held those  
11 views and she never said those views to me. It's  
12 obviously a very different conversation if you're saying  
13 "Mr Cummings is saying A, B, C, D and you need to be  
14 aware of that". That was very different from there were  
15 ten people, including lots of senior civil servants,  
16 saying.

17 Now, that second thing I was not aware of at  
18 the time, and therefore did not have that conversation.

19 **Q.** All right.

20 Do you accept that if these witnesses are right that  
21 Mr Hancock did regularly say things that they understood  
22 were untrue, that that would have been/was very damaging  
23 to the government's operations at this time, because of  
24 the lack of trust and confidence that his fellow  
25 ministers and his advisers and the advisers in other

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1 **LADY HALLETT:** Whilst that's coming up, Mr Keith, could we  
2 break at about 12.45, please?

3 **MR KEITH:** Yes, of course, my Lady.

4 Paragraph 148, Lord Sedwill refers to the NHS, and  
5 then about six or seven lines down:

6 "Despite the experience of its political and  
7 professional leadership, [so that's its ministers and  
8 the civil servants], dedicated and determined staff, and  
9 a surge of civilian and military personnel, DHSC was  
10 neither structured nor resourced for a public health  
11 crisis of this magnitude."

12 It "straddled" too many different areas,  
13 responsibilities scattered across too many areas.

14 "Admirably, people had pulled together and  
15 front-line staff and volunteers had performed heroics,  
16 but the programmes delivered despite not because of  
17 the legacy systems."

18 He says he called for major reform.

19 Just pause there, because there is a theme.

20 Mr Cummings in his statement, we won't put it up,  
21 but he says at paragraph 120:

22 "The DHSC was overwhelmed by the scale of the crisis  
23 in Feb-May. It didn't have anything like the people it  
24 needed. It couldn't quickly build capacity ... was bad  
25 at asking the Cabinet Office for help."

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1 departments and civil servants could(?) place in him?

2 **A.** Categorically, yes. So at the time, I knew that there  
3 was some toxic relations both within Cabinet Office and  
4 Number 10 and between Cabinet Office and Number 10 and  
5 the Secretary of State.

6 What has come out very clearly from your witnesses  
7 is it was much more widespread and much more toxic in  
8 both of those categories than I knew at the time, and  
9 had I known it at the time, your statement is absolutely  
10 correct, that would be a big worry, and one of ... one  
11 of my reflections so far on the evidence that  
12 the Inquiry has heard is that the amount of time and  
13 energy that appeared to be taken up very early in  
14 the pandemic on the blame game, that energy would  
15 clearly have been much better spent solving the problems  
16 that the pandemic was bringing.

17 **Q.** Indeed.

18 **A.** So I recognise exactly the point that you are making.

19 **Q.** That is -- those questions focus on Mr Hancock and his  
20 relations with other parts of the government.

21 I now want to ask you some questions about  
22 the general view taken of the DHSC.

23 **A.** Yeah.

24 **Q.** Could we have, please, the witness statement from  
25 Lord Sedwill on the screen, INQ000250229, page 39.

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1 It was:

2 "... (... hard for me to know how much of this was  
3 [Mr] Hancock and how much structural to the DHSC)."

4 Helen MacNamara, if we could have this up,  
5 INQ000273841, page 30, paragraph 56. Thank you:

6 "Further concerns were raised by Lee Cain on the  
7 communications effort, including further indications  
8 that DHSC were overwhelmed (or appeared to be). DHSC  
9 was not able (or, perhaps, not willing) to provide  
10 anyone into the Cabinet Office to support the team ...  
11 look[ing] at public sector preparedness, [to] develop  
12 the policy on the NPIs or support on the ...  
13 co-ordination effort."

14 Then further down the page:

15 "We also -- mistakenly -- [and it's the fourth to  
16 last line in that paragraph] did not appreciate that  
17 DHSC had focused and were focusing on DHSC and the  
18 impacts on the acute health system, rather than  
19 the wider and long-term health of the public. I do not  
20 think we fully understood this until too late to do  
21 anything to really remedy it."

22 At page 88, paragraph 181, at the bottom of  
23 the page:

24 "It was difficult to get the right kind of  
25 engagement from DHSC or the NHS. There was an inbuilt

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1 reluctance to accept that it was possible to get to  
2 a point where the NHS was overwhelmed and/or to  
3 acknowledge that this would be something that Number 10  
4 and the Prime Minister would need to be across and  
5 content with the handling of."

6 Then you know, I won't bring them up in light of  
7 the time, but perhaps one of them will suffice, you'll  
8 know that Sir Patrick Vallance, the government's own  
9 Chief Scientific Adviser, expressed on multiple  
10 occasions in his evening notes views about chaos,  
11 operational mess, inefficiency, lack of grip in  
12 the DHSC.

13 If we could have INQ000273901, page 594, he refers  
14 to an email from within the DHSC describing it as  
15 ungovernable and a web of competing parts. So that's  
16 594 of document INQ000273901.

17 It is obvious, Sir Christopher, that the individuals  
18 and the personnel did their very best. Much was asked  
19 of them, and a great deal was delivered. But  
20 structurally, systemically, there appears to be a view  
21 quite widely held that the DHSC, in the face of this  
22 admittedly unprecedented crisis, did fail to perform as  
23 it was expected to do?

24 **A.** Well, let's -- there were a lot of points, a lot of  
25 different points made in the evidence that you -- that

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1 dealing with something unprecedented, and it felt -- at  
2 the time it felt incredibly tough, and a huge, huge  
3 responsibility, and people were at times very down that  
4 we weren't able to get on top of some of the problems.

5 So I'm not going to say this was some sort of  
6 perfect, easy situation. But I don't recognise  
7 the sort of chaos and dysfunction. I recognise the  
8 people working incredibly hard in very difficult  
9 circumstances to get on top of huge challenges.

10 **Q.** So may it just be a question of degree? You would  
11 accept that, in significant ways, the DHSC did fail to  
12 get on top of problems. It was regarded as -- regarded  
13 from the viewpoint of the professional colleagues  
14 working with it day in and out at Number 10 and  
15 Cabinet Office level as being chaotic or unable to deal  
16 with the things that it was asked to --

17 **A.** Well, let's have -- so let's break down between  
18 the four. As I say, I thought Mark's paragraph, which  
19 is largely about the structure of the health and care  
20 system, I largely agree with. Helen and he had -- he  
21 and I had had conversations about -- that's why,  
22 you know, when I received that piece of paper  
23 I recognised the view as one that had been -- that I had  
24 discussed with him. Helen's views I hadn't heard  
25 before. I'm slightly surprised that I hadn't. I would

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1 you quote, and some of them I agree with and some of  
2 them I do not.

3 **Q.** Well, structurally, do you accept the proposition that  
4 the DHSC was, to a significant and important extent,  
5 chaotic or dysfunctional or ungovernable?

6 **A.** No, I don't think any of those things. Now, the points  
7 that were made particularly in Mark Sedwill's first  
8 comment, about the nature of the health and care system  
9 and DHSC's role within it, I completely agree with, and  
10 would recognise. And this was the picture that I was  
11 seeing, I mean, I'm obviously biased as I was very proud  
12 of the work of my department and how it stepped up to  
13 the mark.

14 I think the point about the structural questions  
15 about how health and care were organised, what levers we  
16 had, and in particular -- and we covered this in  
17 Module 1, and I'm of exactly the same view now -- our  
18 ability both in the health and care system and in  
19 the wider government to surge for a crisis of this size,  
20 I do think that was a big problem. So, as I say,  
21 I recognise all of those things, I don't recognise --

22 **Q.** The overall problems?

23 **A.** Yeah, I mean -- for completeness, I mean, we were  
24 obviously under a huge amount of strain. We had people  
25 working incredibly hard in very difficult circumstances,

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1 be -- if she had those views I would expect her to have  
2 raised them.

3 Likewise with Patrick, if he had issues at  
4 particular times, as his diary clearly shows that he  
5 did, I thought we had -- I have huge respect for  
6 Patrick, I thought we had a good working relationship,  
7 and I would have hoped that he would have raised them  
8 directly with me.

9 And then for Mr Cummings, well, I mean, his views of  
10 government civil servants are long held and very public,  
11 so I would -- I would put the four pieces of evidence  
12 that you've given me in different categories like that.

13 **MR KEITH:** My Lady, that may be a convenient moment.

14 **LADY HALLETT:** We will break for lunch. I'm sorry we've got  
15 to ask you to come back after lunch. You were warned,  
16 I hope?

17 **THE WITNESS:** I was warned, and there are obviously lots of  
18 important questions to be answered.

19 **LADY HALLETT:** Very well, I shall come back at 1.45, please.  
20 (12.45 pm)

(The short adjournment)

(1.45 pm)

23 **LADY HALLETT:** Mr Keith.

24 **MR KEITH:** Sir Christopher, I now want to turn to some of  
25 the most important COBR meetings, and so that we can all

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1 understand the importance of this topic, COBR was  
2 of course the crisis machinery in the heart of  
3 government that responded to and responds to crises,  
4 both acute, and as we will see, longer running. It was  
5 at those COBR meetings that some of the most important  
6 decisions and the most important realisations came to be  
7 understood.

8 **A.** Correct.

9 **Q.** Yes. The DHSC was obviously aware from an early stage  
10 of the novel virus, and the evidence shows that you  
11 chaired a number of meetings in January with your  
12 officials, you chaired regular meetings from January  
13 with the CMO, the Deputy Chief Medical Officer,  
14 strategic incident director, and other bodies with which  
15 the DHSC was associated, Public Health England,  
16 for example, NHS England.

17 And presumably the DHSC, through yourself and  
18 others, attended all the COBR meetings?

19 **A.** Yes. So I chaired meetings, I think, from January 20th,  
20 and I went on doing so until there were regular  
21 ministerial meetings.

22 The initial COBR meetings were chaired by, as  
23 I think is well known, the Secretary of State for  
24 Health, and I attended, I think, all the COBR meetings  
25 that he chaired, and then subsequent COBR meetings where

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1 China and is not limited to China, but is anywhere else,  
2 other than China, there would be a pandemic-like  
3 scenario with the UK impacted. That is to say, if it  
4 leaks from China, it's coming.

5 **A.** Yes, that's what -- that's certainly what it -- that's  
6 certainly what it says. The CMO's views at the time, as  
7 he expressed them, and he of course is the DHSC in this  
8 case, there wasn't a sort of -- there isn't  
9 a difference -- I think were a little more nuanced than  
10 is set out here. But those were the two broad  
11 scenarios.

12 **Q.** In that second scenario, therefore, on the basis that  
13 the virus leaks from China, to what extent did the  
14 attendees ask themselves: well, if we're being told  
15 that, if it leaks from China, there would be  
16 a pandemic-like scenario and the UK is impacted; what  
17 measures do we need to start thinking about now to stop  
18 the United Kingdom being impacted once the virus has  
19 spread from China?

20 **A.** Well, so that was the whole reason there was -- there  
21 were COBR meetings at this time at all, and -- because,  
22 as I'm sure you know, it's quite a high bar --

23 **Q.** Sir Christopher, I'm so sorry. What measures were in  
24 any or all of your minds as to -- what thoughts were in  
25 your minds as to what measures could be taken to stop

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1 it was alternate between the Prime Minister and the  
2 Secretary of State.

3 **Q.** Yes. The first one that I want to take you to, although  
4 it's not the first in order, is 29 January 2020, page 1  
5 of INQ000056226. With all these documents, and with all  
6 these minutes, Sir Christopher, I'm going to ask you to  
7 focus, please, on what your understanding on the part of  
8 the DHSC was when you received the information and the  
9 relevant facts --

10 **A.** Yeah.

11 **Q.** -- and so on and so forth, in the course of these  
12 meetings. We can see the attendance on the first page,  
13 the ministers. Second page, officials, including  
14 yourself in the middle of the page on the left.

15 If we go to page 5, we can see in paragraph 3 the  
16 CMO telling the attendees that:

17 "... the UK planning assumptions were based on the  
18 reasonable worst-case scenario. There were two  
19 scenarios to be considered. The first was that the  
20 spread was confined within China, the second was that  
21 the spread was not limited to China and there would be  
22 a pandemic like scenario, with the UK impacted."

23 It appears from this, Sir Christopher, that  
24 the DHSC, amongst all the other attendees, was being  
25 told that if the spread -- if the virus spreads from

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1 this second eventuality arising?

2 **A.** Oh, sorry. I'm terribly sorry, I slightly misunderstood  
3 your question. So the measures people were thinking at  
4 the time would have been all the measures up to the full  
5 implementation of the pandemic flu plan that we've  
6 discussed before. That's what would have been in  
7 people's heads.

8 **Q.** There is no debate, if you take it from me, on the face  
9 of this document, as to what those measures might be,  
10 what can be done to start putting them into place or  
11 thinking about them or arranging them. Why is that?

12 **A.** Well, I mean, there was definitely thinking and  
13 discussion of that going on. COBR -- and this is one of  
14 the things we need to reflect on about the process.  
15 COBR tends to deal and is set up to deal with incidents,  
16 and you see that from the agenda of this thing, it was  
17 dealing with like very specific things. So from my  
18 recollection, there was definitely discussion within  
19 DHSC and within SAGE about the kinds of measures that  
20 you would need to take, and discussion of the flu plan.  
21 It's not in this particular meeting, that is true.

22 **Q.** So the answer is: it wasn't debated in COBR, which is  
23 the primary body for crisis machinery in the  
24 United Kingdom?

25 **A.** I haven't checked when it began to be discussed in COBR,

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1 certainly not in this meeting.

2 **Q.** Could we look at page 6, please, paragraph 12.

3 The reasonable worst-case scenario planning: the

4 government "continuously plans for a pandemic", it's

5 an "international issue", local resilience forums had

6 planning assumptions for pandemic influenza.

7 There are then a number of bullet points about

8 repatriation, dealing with British nationals in Wuhan,

9 pandemic plans in place for prisons, border staff, PPE,

10 transmission possibly of the virus through food or

11 animals.

12 Then over the page, transport -- communications.

13 Summing-up, 16, there must be a clear communications

14 plan. The CMO should lead communications, more detail

15 on Wuhan returnees.

16 Are you surprised, looking at this now, that there

17 was no debate at all about whether or not anything could

18 be done to stop the virus coming once it had left China,

19 or secondly what measures in practice might have to be

20 contemplated?

21 **A.** I didn't think -- I have to say I didn't think so from

22 memory about this specific meeting, because I did know

23 all those discussions about the flu plan were -- well,

24 they were certainly going on in DHSC. Now, I mean, the

25 closest this meeting gets to it is the thing we went

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1 advise people to go to particular places, wash hands,

2 all those sorts of things, those are public health

3 interventions done via communications, and from my

4 mind -- and it's particularly why there's a reference to

5 the CMO leading communications here, it's about, from

6 memory, that sort of public health communication,

7 you know, not is the government going to issue a press

8 notice.

9 **Q.** You've referred twice to the flu plan.

10 **A.** Yeah.

11 **Q.** In summary, and is this a correct summation of the

12 position, Sir Christopher, the flu plan upon which the

13 government at this stage was still proceeding --

14 **A.** Yeah.

15 **Q.** -- dating back to 2011, the flu pandemic strategy,

16 envisaged measures such as providing for proper

17 legislative powers to be exercised --

18 **A.** Yeah.

19 **Q.** -- the Coronavirus -- or flu Bill, the possibility of

20 school closures, washing hands and managing excess

21 deaths. Were those the broad heads of --

22 **A.** Erm, plus the communications bit. So what the flu plan

23 envisages --

24 **Q.** Just yes or no, are those the correct --

25 **A.** No.

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1 past on the reasonable worst-case scenario assumptions,

2 and that was clearly the focus of the work at the

3 moment, was working out -- was working out those.

4 Now, and the only further thing I'll say is at this

5 stage what the communications were to the general public

6 about what they should do, that is the first stage of

7 preparing for a novel disease. I know it's not directly

8 relevant to your question, but it's more than just ...

9 sorry, something very odd happened on the screen. It's

10 more than just comms in the traditional sense.

11 So if I'm honest, I can't say at that meeting I was

12 surprised, because the meeting was discussing, as it

13 were, the business of the day.

14 **Q.** Communications appears to be at the forefront of matters

15 considered by this committee. It appears to be the

16 focus of the summing-up. Why was so much focus

17 relatively placed on communications as opposed to

18 considering the practical measures which might be taken

19 to stop the virus reaching the United Kingdom, assuming

20 it had left China?

21 **A.** For the reason that I just said, that the question --

22 and I'm sure you'll want to ask our public health

23 specialists who you're talking to later, the question of

24 what are you advising the public to do is the first

25 thing that you want to do -- you know, whether you

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1 **Q.** -- heads? You say plus?

2 **A.** Yes, so -- and in some ways the heart of the flu plan is

3 voluntary -- I must remember not to use the acronyms --

4 non-pharmaceutical interventions, voluntary

5 non-pharmaceutical interventions, which are dialled up

6 and down to control, so that is the other thing in the

7 flu plan that we were expecting to do. So the work

8 going on in the department at this point is: can we

9 update the flu plan for this different disease but, as

10 you say, the presumption was that we would be following,

11 basically, the flu plan.

12 **Q.** Forgive me. What non-pharmaceutical interventions was

13 the DHSC actively considering other than those measures

14 which I have already mentioned which were part of

15 the existing flu plan, the possibility of school

16 closures, dealing with the physical problems associated

17 with excess deaths, arranging for legislative proposals

18 to be advanced, and washing hands?

19 **A.** It's what advice you give to the public on how they

20 should be behaving --

21 **Q.** Those are not non-pharmaceutical interventions. What

22 other non-pharmaceutical interventions?

23 **A.** Sorry, those are non-pharmaceutical interventions.

24 **Q.** The ones I have mentioned are non-pharmaceutical

25 interventions, I am asking you what else was under

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1 consideration by way of other non-pharmaceutical  
 2 interventions, not communications to the public, I'm  
 3 talking about practical measures to stop the spread of  
 4 the virus?

5 **A.** Sorry, this is where we're slightly misunderstanding  
 6 ourselves. Advice to the public on how to behave are  
 7 non-pharmaceutical interventions designed to stop the  
 8 spread of the virus, is my point.

9 **Q.** INQ000146557, pages 1 and 2.  
 10 This is an email enclosing minutes from a SAGE  
 11 meeting. It is an email which goes to  
 12 the permanent secretary at the dhsc.gov.uk. We can see  
 13 that in the top right-hand corner. Would that have been  
 14 you?

15 **A.** Yes.

16 **Q.** If we look down at the bottom of the page, we can see  
 17 that Professor Sir Chris Whitty says, of the four  
 18 scenarios, only two in practice are worth considering.  
 19 "The other is the opposite end of the risk scale and  
 20 is our reasonable worst case scenario for which plans  
 21 are also being developed. With R [the reproduction  
 22 rate] of 2-3 ..."  
 23 That's one person infecting two to three other  
 24 people in an unimmunised population.  
 25 "... mortality of maybe 2% (wide confidence  
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1 that might happen at this pace, not that it will, but it  
 2 might, was the basis on which DHSC was working.

3 **Q.** Once it leaves China, it will happen?

4 **A.** Yeah, and the "once" is very important here, so Chris --  
 5 and I've talked to him on a number of occasions about  
 6 this -- was clear that the conditional bit of that is  
 7 very important. So he is not saying there will be  
 8 a pandemic, he is saying, if it's not controlled in  
 9 China, then it's very likely to become a pandemic and  
 10 then, as becomes clear a few days later, he is saying  
 11 "And in the UK that might lead to 100 to 300,000  
 12 deaths", so I don't think there's any sort of dispute  
 13 about what we thought at the time.

14 **Q.** And by the beginning of February you discovered that it  
 15 had indeed left China?

16 **A.** Well, in -- at that point, in extremely small numbers.  
 17 Now, this is why I say that the CMO's view is rather,  
 18 slightly more nuanced, or certainly how he described it  
 19 to me, than is set out here.  
 20 So, I mean, as I say, I'm sure you will ask him  
 21 yourself, but his view was if you have, as it were, very  
 22 small outbreaks elsewhere that can be contained, in  
 23 exactly the same way as our strategy started with  
 24 contain, then of course it doesn't become a pandemic,  
 25 it's when you get sustainable human-to-human  
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1 intervals around both of these and all other numbers),  
 2 a doubling time currently of maybe 3-5 days and  
 3 an incubation period of mean 5 [days] this could within  
 4 the next few weeks ..."

5 Emphasise that, please, Sir Christopher.  
 6 "... become widespread and turn into a significant  
 7 pandemic relatively quickly."  
 8 The Chief Medical Officer was saying, in essence,  
 9 was he not, "We have a basic understanding of the  
 10 reproduction rate, we've got a basic understanding of  
 11 the mortality rate and, therefore, we can work out how  
 12 many people might die, a doubling time, and therefore  
 13 that this could spread within the next few weeks and  
 14 become widespread".  
 15 With that information available, and with  
 16 the knowledge from the COBR meeting that once the virus  
 17 has left China, if it leaves China, it's coming, why  
 18 were those two pieces of information not put together to  
 19 reach the realisation, with those characteristics and  
 20 with no practical means of stopping it once it's left  
 21 China, we are in real trouble?

22 **A.** No, and that was the view of the department. I mean,  
 23 a few days after this, the Chief Medical Officer is  
 24 saying that we might be looking at 100,000 to 300,000  
 25 deaths in that scenario, and that was the basis -- that  
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1 transmission across a wide range of countries. At that  
 2 point his view was it was very, very difficult to stop  
 3 and would become a pandemic.

4 **Q.** So you're saying that the assertion in the COBR minute  
 5 that the virus would become widespread -- the second  
 6 contingency, it would become widespread once it leaked  
 7 from China, is wrong?

8 **A.** No, it's not wrong, it's a -- certainly, as I understood  
 9 the CMO's views, but of course you'll ask him yourself,  
 10 that it's a -- it's about what you mean by leaked from.  
 11 So a case, one case appearing in another country that is  
 12 identified, contained and doesn't lead to human  
 13 transmission, he would not say that is -- has leaked  
 14 from China. Once you've got sustained human-to-human  
 15 transmission outside China, I think that's what he would  
 16 describe as -- I mean, I'm slightly -- why I'm um-ing  
 17 and ah-ing --

18 **Q.** I'm not asking for the Chief --

19 **A.** That was my understanding.

20 **Q.** That's right. I'm asking for your understanding.

21 **A.** Yeah.

22 **Q.** INQ000146558 is a letter from the private secretary in  
 23 Downing Street to the DHSC, because it says:  
 24 "The Prime Minister met your Secretary of State, the  
 25 CST and colleagues from the centre today for his first  
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1 DHSC Departmental Performance meeting."  
 2 Much of this statement or this letter deals with  
 3 matters concerning the NHS objectives for manifesto  
 4 commitments, performance, and so on.  
 5 There was, however, in the meeting a short update on  
 6 coronavirus, which appears to relate to the need to  
 7 explain the plan, whatever that plan was, and dealing  
 8 with travel restrictions.  
 9 Why was so little time, relatively speaking, devoted  
 10 in that meeting to coronavirus, in light of the  
 11 information from the COBR and that email from the Chief  
 12 Medical Officer saying the plausible scenario is once  
 13 the virus leaks from China it is coming?  
 14 **A.** So I've covered this meeting in quite some detail in my  
 15 statements, but -- so the meeting was set up at  
 16 the request of the Prime Minister to cover --  
 17 **Q.** Sir Christopher, I don't wish to be impolite. Please  
 18 would you answer the question: why was so little time,  
 19 relatively speaking, spent on the issue of coronavirus  
 20 during this meeting?  
 21 **A.** Well, what time was devoted to what was the choice of  
 22 the chair of the meeting, which was the Prime Minister.  
 23 **Q.** All right. So your answer is the Prime Minister --  
 24 **A.** We had -- we had asked for coronavirus to be added to  
 25 the agenda, and the CMO came specially, was not  
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1 of the novel coronavirus had spent between seven to  
 2 ten days in hospital ...  
 3 "- The two most high-risk groups appeared to be the  
 4 elderly and those with pre-existing illnesses.  
 5 "...  
 6 "- The fatality rate estimate remained at 2-3%."  
 7 Scrolling back out, please, paragraph 4 deals with  
 8 the issue of returnees.  
 9 Paragraph 6 notes that screening controls would be  
 10 unlikely to delay the arrival of the virus by very much.  
 11 Paragraph 7 deals with communications -- I'm sorry,  
 12 it deals with repatriation of those persons coming back  
 13 from China. I think maybe item 3 deals with -- item 4  
 14 deals with communication strategy, and item 3 reasonable  
 15 worst-case scenario:  
 16 "The DIRECTOR OF THE CIVIL CONTINGENCIES SECRETARIAT  
 17 set out the planning priorities ...  
 18 "... the following points were made:  
 19 "- The committee agreed the need for a clear  
 20 communications strategy ...  
 21 "... an emergency bill for support the UK's  
 22 response."  
 23 And the link between the devolved administrations  
 24 and local resilience forums.  
 25 Where was the debate about whether or not borders or  
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1 an original invite to the meeting, because we believed  
 2 that we should update on the status of Covid, which was  
 3 done. How the meeting was then run in practice was, as  
 4 I say, a matter for the chair.  
 5 I came out of the meeting thinking that the messages  
 6 about how serious this was and what the likely death  
 7 toll would be had been delivered, so I wasn't thinking  
 8 that our objectives for that bit of the meeting had not  
 9 been achieved, even though it covers lots of other  
 10 things. In my mind, we were there to tell  
 11 the Prime Minister this is very serious and the likely  
 12 death toll and to hear from the CMO, and that had all  
 13 been achieved.  
 14 **Q.** Do you agree that the letter from Downing Street  
 15 reflecting upon the meeting on behalf of  
 16 the Prime Minister makes absolutely no reference to  
 17 the death rates?  
 18 **A.** No, it doesn't, which -- now, my --  
 19 **Q.** Just yes or no, please.  
 20 **A.** No, it doesn't. Just as a matter of fact it does not.  
 21 **Q.** The COBR meeting on 5 February, INQ000056215.  
 22 Page 1, attendees. Page 2, officials, you're there  
 23 again. Page 5, paragraph 2:  
 24 "... the CMO said ...  
 25 "- On average individuals who had died as a result  
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1 a test and trace system or other practical form of NPI  
 2 could prevent the spread of the virus if it came to  
 3 the United Kingdom?  
 4 **A.** Well, I think, and this is from memory, if we look at  
 5 the slides mentioned in paragraph 9, that is the report  
 6 of the planning that is being done for the -- for  
 7 the reasonable worst-case scenario, which is that  
 8 the virus has escaped from China and become a pandemic.  
 9 So I think it is that bit of the discussion.  
 10 **Q.** The planning priorities there referred to were drawn,  
 11 were they not, from the 2011 pandemic flu strategy  
 12 document, which, as we've discussed, talked in terms of  
 13 washing hands, talked in terms of the possibility of  
 14 closing schools, talked in terms of how to manage large  
 15 numbers of dead people, and communication.  
 16 **A.** And the things I mentioned earlier.  
 17 Now, on the two things you raise specifically, so  
 18 the closing of borders, and I can't remember the exact  
 19 date, but our scientific and clinical advice at  
 20 the time, and certainly the WHO's advice, was that  
 21 closing borders would have not more than a marginal  
 22 timing effect. So I'm not surprised --  
 23 **Q.** We've read that --  
 24 **A.** Yeah.  
 25 **Q.** -- bit out.  
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1 **A.** So I'm not surprised that was not discussed. At this  
 2 point I don't think anyone in the UK was talking about  
 3 an extensive test and trace system as being  
 4 a possibility. Again, given that at this point I don't  
 5 think we ... I may get my timeline wrong, but this is  
 6 just -- this is the point when the first tests are being  
 7 invented, as it were. Certainly no one was talking  
 8 about an extensive test and trace system at this time.  
 9 So I'm not surprised it wasn't discussed.

10 **Q.** So is this the position: border measures by way of  
 11 screening for symptoms and the like was -- and in fact  
 12 your department advised on 21 February and the measures  
 13 and the advice were accepted on -- sorry, of January.  
 14 The advice was accepted by the Secretary of State on  
 15 22 January, to the effect that symptom screening at  
 16 borders was unlikely to be particularly effective --

17 **A.** Yes.

18 **Q.** -- and would only secure a few days' delay, if that?

19 **A.** Yeah.

20 **Q.** There was a recognition that there was no testing system  
 21 scaled up or in place. Other than the first few hundred  
 22 index cases, there was no real test and trace system,  
 23 was there?

24 **A.** No.

25 **Q.** That was because under the 2011 pan flu strategy it was

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1 was no scaling up of the test and trace system beyond  
 2 the first few hundred index cases until well after --

3 **A.** Yes, that's correct. And at this point, the scientific  
 4 advice we were receiving was -- I'm not quite sure what  
 5 the right words are, not definitive about how good even  
 6 the tests were at this point, so for quite a long  
 7 period, for example, it was believed that the test did  
 8 not reliably pick up either presymptomatic or  
 9 asymptomatic cases and it wasn't clear how reliable it  
 10 was for symptomatic cases till a bit later.

11 So at this point with the development of the testing  
 12 technology and the understanding of the testing, nobody,  
 13 as far as I know, was -- from either the policy side or  
 14 the clinical or scientific side, was saying that what  
 15 you're laying out was a practical proposition for  
 16 stopping the virus getting into the country in the first  
 17 place.

18 So the focus was, as is then set out in the plan on  
 19 March 3rd, on the contain -- the "contain" bit and then  
 20 the other stages of the plan.

21 **Q.** Do you accept that other countries turned it very much  
 22 into a practical proposition?

23 **A.** Oh, well, and -- and I've said, I've said before, that  
 24 some countries in South East Asia clearly did very, very  
 25 well.

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1 understood you don't need and you don't have to have  
 2 a test, trace system for dealing with flu; correct?

3 **A.** Well, basically, yes.

4 **Q.** Right.

5 **A.** As I say, at that point, there's no testing  
 6 infrastructure at all, so --

7 **Q.** Yes. Doctrinally, because of the latent period, the  
 8 incubation period, the characteristics of flu, there's  
 9 no point having a test, trace system. You take Tamiflu,  
 10 an antiviral, and you wait it out.

11 For this virus, which you knew was not a flu virus,  
 12 where was the understanding that you did need a test,  
 13 a massively scaled-up test, trace system if there was to  
 14 be any practical means of preventing the virus from  
 15 reaching the United Kingdom and spreading?

16 **A.** That came much later.

17 **Q.** Why didn't it come then?

18 **A.** Well, of course, at this point -- as I say, I can't  
 19 quite remember the timeline of the actual creation of --  
 20 creation of tests, but it's --

21 **Q.** The diagnostic -- forgive me -- the United Kingdom on  
 22 the same day as South Korea invented a diagnostic test  
 23 for coronavirus --

24 **A.** Yeah.

25 **Q.** -- it was, in fact, in the middle of January, but there

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1 **Q.** Yes.

2 **A.** Now the only thing I'd add on this, and again I think  
 3 I put it in my statement, that even the countries in  
 4 Europe which had a much bigger testing capacity,  
 5 particularly Germany, which had a very extensive  
 6 diagnostics industry, they didn't succeed in using  
 7 testing to stop the virus getting in either. So it  
 8 wasn't simply a question of how many tests you have --  
 9 and as the Chief Medical Officer gave in his witness  
 10 statement -- in his evidence to Module 1, when you look  
 11 at what South Korea had done, what they'd done was  
 12 a very big investment in public health in general, of  
 13 which testing was one part, as it were. So what  
 14 I wouldn't like to leave you the impression with was  
 15 that even -- even looking at South East Asia, but  
 16 the testing bit is a complete silver bullet. It was --  
 17 clearly they did it very well, they did it much better  
 18 than us, I think there's absolutely no doubt about that,  
 19 but at this point no one in the UK was thinking of  
 20 a test and trace system as being the answer.

21 **Q.** Regardless of Germany, with which we're not overly  
 22 concerned in this Inquiry, regardless of whether it was  
 23 a silver bullet, there was no practical or policy  
 24 consideration given at all, until very much later, to  
 25 the practical proposition of a test and trace system to

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1 prevent the spread of the virus?  
2 **A.** No, and the advice we were receiving from our clinicians  
3 and the scientists didn't include that measure, that is  
4 true.

5 **Q.** INQ00056227 is a COBR on 18 February.

6 At this stage, we can see there the attendees.  
7 Page 2, the officials, including yourself again.  
8 Page 5, a CMO update. A debate about the reasonable  
9 worst-case scenario. And I'm not going to deal with you  
10 with the point about whether or not focusing on the  
11 reasonable worst-case scenario and whether it would  
12 eventuate misdirected attention away from the reality of  
13 what was happening.

14 But this COBR minute makes plain that -- you will  
15 see from the CMO's description in paragraph 2 -- there  
16 was a risk of onward transmission, escalation to  
17 a global pandemic remained realistic possibilities.

18 Scrolling back out, please, repatriation,  
19 paragraph 4. Paragraph 5, the repatriation of nationals  
20 and the possibility of infection from persons entering  
21 the United Kingdom.

22 Scrolling back out, and then going to the next page,  
23 legislation, so again a debate about the legislative  
24 basis for anything that might need to be done.

25 Scrolling back out again, the following page:  
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1 they were good, with the Cabinet Office, and -- at  
2 political level, and we've discussed some of this  
3 already, they were rather more up and down. But we felt  
4 we had good communications, that we got a hearing, that  
5 we'd engaged with the Civil Contingencies Secretariat,  
6 that COBRs were happening, all those things we had asked  
7 for, we felt those relationships were good.

8 **Q.** You say in your statement that conflicts and tensions  
9 were time consuming and consequently affected  
10 the efficiency of the government's response, so it  
11 appears you accept that to some degree, but we mustn't  
12 overexaggerate it, the ability of the government to  
13 respond was adversely affected --

14 **A.** Yeah, I mean, so --

15 **Q.** -- clashes?

16 **A.** It wasn't surprise you I thought about my words here  
17 extremely carefully, so -- and it's exactly as I say in  
18 my witness statement. So I don't believe, and I've  
19 never believed, that the core decision-making of which  
20 NPI to implement when in this period, this March period,  
21 was affected by any of those issues. When I was -- my  
22 recollection at the time and when I've reviewed the  
23 evidence, you can see the golden thread from  
24 the scientific advice we were receiving to the decisions  
25 that the government made on NPIs. So I thought that

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1 "Planning for a Reasonable Worst Case Scenario":

2 "The DIRECTOR OF THE CIVIL CONTINGENCIES SECRETARIAT  
3 said that there was work to be done to create a clear  
4 plan of activity (across the UK Government) from the  
5 moment of sustained transmission to its estimated  
6 peak ..."

7 If you're right, Sir Christopher, that there was  
8 already thinking about NPIs and what measures reflective  
9 of the existing flu strategy or additional to the  
10 existing flu strategy could be contemplated and imposed,  
11 why was the COBR still at the stage of just talking  
12 about the need to create a clear plan of activity?

13 **A.** Well, I mean, what it says is there was still work to be  
14 done, which there was, the work had begun, but it had  
15 not finished. I think the situation is exactly as  
16 described on the page.

17 **Q.** You were obviously closely engaged with Number 10 and  
18 Downing Street and the Cabinet Office through these late  
19 days in February, were you not?

20 **A.** Yes.

21 **Q.** How effective was the working relationship at  
22 ministerial and at official level?

23 **A.** So, and again, I've done this in some detail in my  
24 witness statement, I believed that in terms of relations  
25 at official level, actually throughout the pandemic,

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1 core bit was following a proper process of advice  
2 et cetera.

3 What was affected by the issues that you mention  
4 was, exactly as you said, it was the efficiency of  
5 the government machine to do a number of other things.

6 **Q.** Right.

7 **A.** We had two, and I think I raised -- and it's in  
8 the evidence, two very specific practical things that  
9 went wrong that made us less efficient. One was  
10 meetings being called by several different bits of  
11 Downing Street and Cabinet Office at the same time with  
12 the same people on the same subject. And the other,  
13 which I have some text exchanges with Tom Shinner and  
14 with Mark Sedwill on, is multiple commissions on the  
15 same issue, and in one case I think there were two or  
16 three commissions on a procurement issue which turned  
17 out none of them were what the Prime Minister wanted and  
18 we wasted an entire day.

19 So there were definite -- I'm not disputing at all,  
20 there were definitely those sorts of issues. I didn't  
21 think, and I didn't raise, therefore, that those core  
22 decisions on NPIs, I didn't see any of that being  
23 affected by those issues.

24 **Q.** But the efficiency of the government's response was  
25 affected, yes or no?

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1 A. And in the examples I have given, and I put it on record  
 2 at the time, and we dealt with them, yes.  
 3 Q. Right.  
 4 INQ000279915 is a record of a WhatsApp communication  
 5 between yourself and then Sir Mark Sedwill --  
 6 A. Yeah.  
 7 Q. -- where on 18 March you were worried about the fact  
 8 that Number 10 SPADs were attending SAGE?  
 9 A. Yes.  
 10 Q. By 18 March, deaths had started to occur in  
 11 the United Kingdom, had they not?  
 12 A. Yeah, and by --  
 13 Q. No, just please wait for the question.  
 14 A. Oh, sorry. Yes.  
 15 Q. Why were you concerned with a matter of process of this  
 16 type as to who was attending SAGE when presumably  
 17 the focus of every single minister and official should  
 18 have been on the delivery, the outcome of these  
 19 committee meetings and what was being done?  
 20 A. Because of the part at the top of the page. So 18 March  
 21 is between the decision on 16 March to go for much more  
 22 extensive voluntary restrictions and then the decision  
 23 on 23 March to go for full lockdown.  
 24 My concern about SAGE here, and, as I say, I was  
 25 normally a big fan of SAGE, my specific concern is in  
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1 Let's go back a few days to another COBR,  
 2 26 February, INQ000056216.  
 3 Pages 1 to 3 give us the attendees.  
 4 If we just scroll, please, through page 2, we can  
 5 see that again you're there.  
 6 Then if we look at page 5, paragraph 1, an update on  
 7 the current global situation.  
 8 There was particular concern at the 26 February --  
 9 COBR -- wasn't there, Sir Christopher, about the fact  
 10 that in Italy there had been an explosion of the virus?  
 11 There had of course been a quarantining or a lockdown of  
 12 a number of northern municipalities in Italy, and  
 13 concern was expressed there about sustained  
 14 human-to-human transmission in Italy, which receives  
 15 a high number of travellers to and from  
 16 the United Kingdom.  
 17 If we scroll back out again, and just cast our eyes  
 18 down the page, we have health advice for travellers and  
 19 schools; over the page, international response, that's  
 20 to say helping other countries and helping the WHO; and  
 21 then (d) on page 6, paragraph 11:  
 22 "... the reasonable worst case planning assumptions  
 23 looked close to becoming the reasonable planning  
 24 assumptions as cases in Italy demonstrated the need for  
 25 heightened alertness ..."  
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1 the second text here, which was, as far as I could see,  
 2 SAGE had changed its analysis particularly around,  
 3 I think it was, the effects on the NHS, without there  
 4 being an explanation of new data.  
 5 So that was what I was concerned about. And then  
 6 I was concerned about the purity of the SAGE advice  
 7 which was going to the Prime Minister and others because  
 8 SPADs were available. Those were my concerns, so  
 9 I raised them.  
 10 Q. Sir Christopher, a concern about the substance of  
 11 the advice coming from SAGE is one thing. Why were you  
 12 wasting time concerned with the process of the system?  
 13 A. Because whether the advice is pure, and this was the  
 14 reference to Chilcot you will see here, that one of  
 15 the key findings of the various reports around the  
 16 Iraq War, including the Chilcot one, was the mixing up  
 17 of the technical factual advice and the political  
 18 advice. That is the reference to Chilcot.  
 19 Now, as I say, this had been a key issue in that  
 20 Inquiry --  
 21 Q. I'm going to --  
 22 A. We therefore wanted to take it very seriously.  
 23 Q. Forgive me. You've made the point, you were concerned  
 24 about the recommendations of the Chilcot Inquiry. We  
 25 don't need to go into what they were.  
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1 Progress legislation, ensure good public  
 2 communications, and there are references then to massive  
 3 numbers of deaths under the reasonable worst-case  
 4 scenario, which was of course appearing increasingly to  
 5 be the reality, guidance on excess death management,  
 6 a reference to economic impact.  
 7 And then if we just go over and scroll, pages 8, 9  
 8 and 10, we will see references to travellers --  
 9 thank you -- excess death management, and actions for  
 10 the processing of the Bill, the Covid-19 Bill.  
 11 Where is the practical debate about measures to stop  
 12 or control the spread of the virus, which is now in  
 13 Italy and is envisaged to undoubtedly, if it had not  
 14 already come to the United Kingdom, to come here?  
 15 A. So I would say that would be in the HMG preparedness  
 16 section that you described. Now, of course the other  
 17 thing that was going on at the moment, which I think  
 18 every attendee at the meeting would have known is this  
 19 is when we were preparing the -- for publication  
 20 the Covid action plan that went out on 3 March, and that  
 21 was the big thing that was being done at that point,  
 22 which was to set out that strategy, and the -- and just  
 23 for completeness, we were of course still in the contain  
 24 phase in the UK at this time.  
 25 Q. Yes. On 28 February, before that action plan was  
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1 published, a paper was prepared by the Civil  
 2 Contingencies Secretariat with the assistance of the  
 3 Department of Health, correct?  
 4 **A.** Yes, I don't remember the paper at the time, but having  
 5 read it, that is clearly the case.  
 6 **Q.** INQ000146569. The UK's preparedness, written by  
 7 the Civil Contingencies Secretariat, paragraph 1:  
 8 "Covid-19 looks increasingly likely to become  
 9 a global pandemic although this is not yet certain."  
 10 **A.** Yeah.  
 11 **Q.** Did you agree with that sentence?  
 12 **A.** Erm, at that point, I thought -- I mean, as I say,  
 13 I don't remember the paper at the time, but, as I say,  
 14 WHO at this point had not declared a global pandemic, we  
 15 were still in the contain phase --  
 16 **Q.** I'm so sorry to interrupt, Sir Christopher, regardless  
 17 of whether the United Kingdom was in a contain or delay  
 18 or mitigate stage, a matter of process in a plan yet to  
 19 be published, did you think on 28 February that that  
 20 sentence was correct?  
 21 **A.** Well, as I say, I didn't see that sentence on  
 22 28 February --  
 23 **Q.** Were you --  
 24 **A.** I think -- and the danger of hindsight is very large,  
 25 I think that our and the CMO's view was that it was

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1 a moment -- is currently to contain the small number of  
 2 cases here and reassure the public.  
 3 When you, your department, your officers, your  
 4 officials, read this document, what answer did they come  
 5 up for the question: how is the United Kingdom to  
 6 currently contain the small number of cases here?  
 7 **A.** Well, so, at this point, when you've got a small number  
 8 of cases, you can contain via contact tracing, and that  
 9 was what was being -- happening at this time. You go  
 10 into the delay phase, as it became, as you say, in the  
 11 strategy, later, at the point when you can no longer do  
 12 that. So that sentence, I assume, is a reference to  
 13 that.  
 14 **Q.** The action plan, could we have, please, INQ000106107.  
 15 This was, the Inquiry has heard, an action plan which  
 16 was described by a number of -- or one particular  
 17 official in Downing Street as being a comms plan.  
 18 Mr Warner said in his statement: where was the real  
 19 plan?  
 20 This plan had its genesis, although it was dated  
 21 3 March, some time before in a request from  
 22 the Secretary of State in early February; correct?  
 23 **A.** I can't remember the exact date of that --  
 24 **Q.** INQ000106107.  
 25 **A.** -- that he commissioned, but ...

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1 very, very likely indeed at this point.  
 2 **Q.** So that crucial document, setting out for the first time  
 3 in this form the Civil Contingencies Secretariat's view,  
 4 the crisis machinery's view in government of the UK's  
 5 preparedness, starts with a sentence of vital importance  
 6 that is materially mistaken, in your view?  
 7 **A.** Not materially mistaken, the sentence is not  
 8 inconsistent with what I have said.  
 9 **Q.** All right.  
 10 **A.** I think, and, as I say, the danger of hindsight here is  
 11 very high, I think, at that point, I and the CMO would  
 12 have -- and particularly the CMO, would have made it  
 13 stronger than that. But, as I say, my danger of  
 14 hindsight, just to be completely honest, my danger of  
 15 hindsight is very --  
 16 **Q.** Where is the hindsight, Sir Christopher? You said  
 17 "I think that the CMO's view was that it was very, very  
 18 likely indeed at this point".  
 19 **A.** No, yeah --  
 20 **Q.** Where is the hindsight in that?  
 21 **A.** Well, it's very easy to say on a particular date a view  
 22 was X, which I can't evidence, but so I'm giving you  
 23 what I think is my honest view.  
 24 **Q.** The UK's approach, underpinned by science -- we'll come  
 25 back to the issue of following the science in

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1 **Q.** 10 February, from somebody in the exchange  
 2 administrative group:  
 3 "... we have discussed updating the 2011 pandemic  
 4 flu strategy."  
 5 So just noting there, Sir Christopher,  
 6 the prevailing impact of that 2011 strategy on documents  
 7 being brought together, drawn up in the face of  
 8 the coronavirus pandemic:  
 9 "I wanted to flag that SoS has commissioned for THIS  
 10 WEEK a coronavirus version of the strategy document ...  
 11 there are many pan flu supporting strategies ... which  
 12 are more recent ... [but] this is an additional ask",  
 13 and so on.  
 14 **A.** Yeah.  
 15 **Q.** So on 10 February, an action plan designed to deal with  
 16 the fast-moving new, novel viral pandemic was sought to  
 17 be introduced, to be drawn up?  
 18 **A.** Yeah.  
 19 **Q.** If you look, please, at the minutes of the meeting in  
 20 which that direction was made, INQ000279883, you will  
 21 see:  
 22 "... We are building a campaign site which will be  
 23 the public window for the plan. We'd like to get  
 24 the site launched next week ..."  
 25 Then over the page, please, page 2:

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1 "[The Secretary of State] wants an acronym ... for  
2 the plan."

3 There was a debate about how you describe  
4 the "mitigate" phase.

5 "On timings ... he'd would be happy to publish on  
6 the 24th February, however later that week or up to the  
7 2nd March would also be fine."

8 You were aware that the position was changing  
9 rapidly --

10 **A.** Yeah.

11 **Q.** -- hour by hour, day by day. What was the point on  
12 10 February of commissioning a report wouldn't be  
13 published until up to 2 March by which time no doubt  
14 events had moved on radically?

15 **A.** Well, and from memory this is why it was extremely  
16 difficult to finalise the plan, because you were  
17 updating it for events as you went. So I was confident,  
18 and indeed we had the Chief Medical Officer sign off the  
19 factual accuracy of the plan, that the plan as published  
20 was up-to-date at that point, obviously something that,  
21 if it had been written on 10 March and then published  
22 on -- sorry, 10 February, and published on 2 March, it  
23 wouldn't have been.

24 **Q.** When the report -- the action plan was published on  
25 3 March, it proposed that the United Kingdom

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1 **Q.** This was your department's action plan, or at least  
2 an action plan to which you contributed?

3 **A.** Yeah.

4 **Q.** Did you not ask yourself on 3 March: why are we  
5 publishing a plan that provides for containment and  
6 delay in the future when I am aware that SPI-M-O has as  
7 a committee formally acknowledged the existence of  
8 sustained community transmission, that is to say absence  
9 of control in the United Kingdom?

10 **A.** Because the formal scientific advice, which is consensus  
11 advice, drawing on a range of scientific sources, was  
12 given to us by, in this case, the CMO but normally the  
13 CMO and the Government Chief Scientific Adviser on  
14 advice of SAGE, and they were at that point not advising  
15 that we were out of the contain phase, that happened, as  
16 I say, I think on 12 March, the day after WHO had  
17 declared a pandemic.

18 **Q.** But the United Kingdom's position did not of course  
19 depend on whether or not the WHO had declared a pandemic  
20 or not?

21 **A.** No, but it depended upon what the, in this case, CMO's  
22 assessment was of the consensus of scientific opinion  
23 which -- and I'm sure you will ask me this question,  
24 you know, that is a judgement call and scientists had  
25 different -- had different views, and that is how our

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1 thereafter adopt a strategy comprising firstly control  
2 and secondly delay?

3 **A.** Contain.

4 **Q.** Contain, I apologise: contain and then delay.

5 SPI-M-O had by that date formally acknowledged  
6 sustained community transmission in the United Kingdom,  
7 had it not?

8 **A.** Yeah, there was a scientific debate going on at this  
9 point. I mean, the actual decision on when you move  
10 from contain to delay was taken by, I think, the Chief  
11 Medical Officer, and I don't have it here, but there  
12 were a series of scientific debates about whether we  
13 were still in the contain phase moving into the delay  
14 phase, and that decision was finally taken on,  
15 I believe, 12 March.

16 **Q.** So at the date of publication, a formal part of the  
17 government scientific advisory process, SPI-M-O, had  
18 already formally acknowledged that there was sustained  
19 community transmission within the United Kingdom --

20 **A.** Yes.

21 **Q.** -- ie --

22 **A.** Yes, but that was not the whole of the scientific advice  
23 that we received. As I say, there was a scientific  
24 debate going on at this point which was resolved, as  
25 I say, by the scientists.

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1 scientific advice worked.

2 **Q.** Strategy.

3 We are not going to re-debate, Sir Christopher, the  
4 proper meaning to be given to a one-peak strategy or  
5 mitigation versus suppression. You know very well what  
6 the debate is.

7 You say in your statement that you believe, with  
8 hindsight, that you did place too much store in  
9 shielding as being the key measure in reducing deaths  
10 from Covid --

11 **A.** Personally, yes. Now, and I hope I made --

12 **Q.** Just will you please just wait for the question.

13 **A.** Sorry.

14 **Q.** You say in your statement you believed you placed too  
15 much store on shielding. Shielding is of course  
16 a crucial part of the mitigation, the squashing the  
17 sombrero with added herd immunity strategy, because you  
18 allow the virus to spread through parts of the  
19 population while shielding the vulnerable, and you hope,  
20 you expect a majority or some or a proportion will  
21 become infected and that will then prevent reinfection  
22 or rather prevent novel infection later and a second  
23 wave.

24 **A.** Not quite, no. So as I've described in my statement,  
25 I didn't think of herd immunity as an objective --

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1 Q. I'm not saying it's objective, I said it was a byproduct  
2 of the one wave mitigation strategy?  
3 A. Yeah --  
4 Q. No, no, I'm so sorry, Sir Christopher, you just have to  
5 wait for the question.  
6 To what extent did you and the DHSC resist  
7 the change of strategy that took place from mitigation  
8 to suppression between 9 March and that weekend of  
9 14/15 March?  
10 A. That's not when the change occurred. So I'll say  
11 a couple of things. So I've been very surprised by the  
12 number of references to a one-peak strategy. I don't  
13 remember that being said at the time at all. And I know  
14 it's come up in a number of witness statements, and as  
15 I've read and listened that has surprised me. Almost  
16 all pandemics in the whole of human history have had  
17 more than one wave. It's very --  
18 Q. Please let us not worry about why doctrinally --  
19 A. As you --  
20 Q. Forgive me, Sir Christopher -- why doctrinally it came  
21 to be called by some people as the one wave strategy.  
22 It is what it is.  
23 Why, if you did, and maybe you did not, but did you  
24 resist the change in strategy that other parts of the  
25 government came to understand was required and then

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1 A. Yes, there were definitely scientists saying that, and  
2 the debate, and this is very important, was about the  
3 timings of restrictions, not that there would need to be  
4 so.  
5 So -- and the clearest description of this is at the  
6 COBR on 12 March, where SAGE sets out, Patrick Vallance  
7 describes this very clearly, the NPIs that were being  
8 considered and SAGE's recommendation of which ones  
9 should be done now and which ones should wait  
10 a few weeks.  
11 So on 12 March, the government accepts exactly what  
12 SAGE, via the government Chief Scientist has advised on  
13 which NPIs are needed at that precise moment in time.  
14 Q. When, Sir Christopher, did you realise, as was  
15 an inevitable part of any reasonable worst-case scenario  
16 involving 800,000 deaths, that it was that reasonable  
17 worst-case scenario that was coming to pass, and it  
18 would inevitably involve the swamping of the NHS?  
19 A. I can't -- I can't put a specific date on it. I agreed,  
20 and I think I've said this in my witness statement,  
21 I agreed with the SAGE advice that we received on that  
22 day. It made sense to me, given the data, and, as  
23 I say, and you'll see this very, very clearly in the  
24 minutes, that the debates were not about: would we have  
25 to take further restrictions; the debate was about: what

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1 began to pursue?  
2 A. I don't think I did resist. The change happens -- and  
3 I've set this out in my witness statement, my  
4 recollection -- between 16 March and 23 March, and as  
5 I understood it, you know, basically up until 16 March  
6 we are still following basically the flu plan of  
7 voluntary, at that point quite heavy restrictions, and  
8 then between the 16th and the 23rd the government  
9 switches to legal restrictions, which become known as  
10 lockdown. I've set out in my statement why I think that  
11 change occurred. I don't think I particularly -- in  
12 fact, I don't think I did resist that strategy, and  
13 I don't think DHSC did. I think there was a general  
14 move in government that the position we established on  
15 the 16th, in line with the scientific advice at the  
16 time, of heavy voluntary restrictions wasn't going to be  
17 enough and we switched to legal restrictions on the  
18 23rd.  
19 Q. Do you agree that from 1 March onwards there were  
20 scientists in Imperial College London, the London School  
21 of Hygiene and Tropical Medicine, beginning to realise  
22 and beginning to say openly: with this infection  
23 fatality rate, with this infection hospitalisation rate,  
24 with this number of people in the population, there is  
25 going to be a massive wave of deaths?

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1 is the best time to implement those restrictions, and  
2 that was a debate, as I say, I agreed with.  
3 Q. The debate about what measures could work and when they  
4 should best be employed was a different debate from the  
5 stark realisation that unless something radical was  
6 done, the NHS would be overwhelmed?  
7 A. And, as I say, the question that was being debated was:  
8 when is the right point in the upturn to implement which  
9 NPI, and that is what we received SAGE advice on, which  
10 was, in part, based on their assessment of what the  
11 effect on the NHS would be. And that changes radically  
12 between 12th and the 16th, when we get updated advice  
13 that basically says we're much further up the curve than  
14 we thought we were.  
15 Q. On 12 March -- forgive me, on 12 March you had  
16 a WhatsApp exchange with Lord Sedwill -- could we have  
17 INQ000279901 -- where, notwithstanding the emerging  
18 scientific view that there would be a wall of death that  
19 would swamp the NHS, notwithstanding the figures from  
20 the NHS beginning to emerge as to bed capacity, and  
21 therefore the need for a radical change in strategy to  
22 suppression, Lord Sedwill said to you:  
23 "I don't think [the Prime Minister] & Co have  
24 internalised yet the distinction between minimising  
25 mortality and not trying to stop most people getting

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1 it."

2 So a reference to the herd immunity debate. Do you

3 agree?

4 **A.** Well --

5 **Q.** Is that a reference to the herd immunity debate?

6 **A.** No, I don't think it is. So what Mark says here is

7 pretty much identical to what Patrick Vallance says at

8 the COBR meeting later that day that we've just been

9 discussing. So as far as I'm concerned, Mark was

10 reflecting the state of the scientific advice at that

11 point --

12 **Q.** "Indeed presumably like chicken pox we want people to

13 get it and develop herd immunity before the next

14 wave ..."

15 So obviously it was a reference to the herd immunity

16 debate, Sir Christopher?

17 **A.** Oh, yeah, he was -- he was talking about

18 the herd immunity.

19 **Q.** And your position was:

20 "Exactly right. We make the point every meeting,

21 they don't quite get it."

22 Why were you, Sir Christopher, still wedded to

23 the mitigation herd immunity approach in the face of

24 the emerging scientific evidence, the advisory evidence

25 commissioned by your own department?

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1 was leading the United Kingdom astray.

2 At that 5.00 pm meeting, there was debate, was there

3 not, about the need to accelerate and suppress --

4 accelerate measures and suppress the virus, and you were

5 there?

6 **A.** Yeah.

7 **Q.** Mr Cummings was there, Sir Patrick Vallance was there,

8 Mr Warner was there, correct?

9 **A.** Yes.

10 **Q.** In Sir Patrick Vallance's notes, and in Mr Cummings'

11 witness statement, there is a reference to you, when

12 Sir Patrick Vallance said, "We must change course, we

13 must accelerate practical measures, we must suppress

14 this virus, it's going to overwhelm us", that you were

15 incandescent, "I got a ticking off indirectly from

16 the permanent secretary of the DHSC".

17 **A.** Yeah, and I have to say, well -- and as I've said

18 before, I have huge respect for Patrick and he was

19 clearly referring to something. I do not have any

20 recollection of ticking off the Government

21 Chief Scientist. I clearly said something that caused

22 him to think that, and, as I say, Sir Patrick is one of

23 the most honest and straightforward people I know, so

24 I'm not denying his ... but I don't recall doing

25 anything as described there, it may have been

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1 **A.** I would refer you to the very clear scientific advice

2 from the body that was charged with drawing up the

3 consensus, which was SAGE, via the government's

4 Chief Scientist, given to COBR on this very day

5 endorsing that strategy.

6 Now, I was very, very loose in my reply, I was

7 answering the exact question at the end of Mark's text

8 that we should be focusing on protecting the most

9 vulnerable. But, as I say, what Mark sets out there is

10 pretty much exactly, as I say, what we were hearing from

11 SAGE and what the Government Chief Scientist presented

12 at the COBR meeting on that day, so it wasn't an unusual

13 position here, and I accepted, as I've said, I agreed

14 with the SAGE advice.

15 **Q.** On 15 March at 5.00 pm that weekend --

16 **A.** Yeah.

17 **Q.** -- when there were multiple meetings with

18 the Prime Minister, Mr Cummings and Mr Warner and

19 Ms MacNamara and others had raised their concerns about

20 the calamity, the catastrophe that was about to

21 overwhelm the United Kingdom. The Prime Minister had,

22 as I said, a number of meetings in which he asked his

23 advisers as to what should be done, and there was

24 repeated debate about the need to change strategy and

25 whether herd immunity approach or a mitigation approach

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1 a miscommunication, and I think it says, I haven't got

2 the thing on screen, but I think it does say indirectly,

3 so it may have been a miscommunication, and in terms of

4 that --

5 **Q.** Who says that?

6 **A.** Sorry, I don't have it on the screen, I thought you said

7 indirectly, I may --

8 **Q.** Saturday mid-March:

9 "I dropped a bombshell of needing to move fast,

10 I got a ticking off indirectly from the

11 permanent secretary of the DHSC."

12 **A.** Yeah.

13 **Q.** "He was incandescent."

14 **A.** "Got a ticking off indirectly", yeah, so it may be -- as

15 I say, I don't remember this at all, it may be when he

16 says "I got a ticking off indirectly" somebody said to

17 him that. I don't know who that person was and I don't

18 know what they're referring to. Now, in terms of the

19 meeting itself --

20 **Q.** No, no, just pause there, please, I haven't asked you

21 about the meeting generally.

22 It became apparent and more and more people signed

23 up to the change of strategy, that there had to be more

24 stringent measures --

25 **A.** Yeah.

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1 Q. -- imposed, and there were measures imposed on  
 2 16 March --  
 3 A. Yeah.  
 4 Q. -- and then, of course, firstly consideration had to be  
 5 given, time had to be allowed to seeing whether those  
 6 measures work, correct?  
 7 A. Yes.  
 8 Q. Secondly, the government had to be able to have time to  
 9 put into place the practical arrangements associated  
 10 with any further stringent measures, correct?  
 11 A. Yeah.  
 12 Q. And so no decision was taken to lock down over that  
 13 weekend of 14/15 March, was it?  
 14 A. No, and my recollection of the meeting was that, by the  
 15 end of the meeting, where there had been a, as you say,  
 16 a robust debate about what the right thing to do was, my  
 17 recollection was everyone had coalesced around the  
 18 actually rather extensive package that then went to COBR  
 19 the next day --  
 20 Q. The package put into place on the 16th?  
 21 A. Yes.  
 22 Q. Right.  
 23 A. And as far as I was concerned, the meeting and all the  
 24 participants in it had, by the end of the meeting,  
 25 agreed that that package was the right set of things to

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1 MR KEITH: Yes, my Lady, I am.  
 2 LADY HALLETT: I think probably we will take a ten-minute  
 3 break now because I suspect we are going to have to take  
 4 another break because it could be a long day.  
 5 MR KEITH: I'm sorry, yes, I'm afraid so.  
 6 LADY HALLETT: So I will return at 3.05. Sorry for another  
 7 interruption.  
 8 (2.55 pm)  
 9 (A short break)  
 10 (3.05 pm)  
 11 LADY HALLETT: Mr Keith.  
 12 MR KEITH: Sir Christopher, the lockdown, the mandatory  
 13 stay-at-home order of 23 March. Ultimately,  
 14 the national lockdown, if I may call it that, was  
 15 ordered when it became apparent that the NHS would be  
 16 overwhelmed and the existing measures of 16 March proved  
 17 not to be enough to ensure compliance.  
 18 In your statement, you recognised that  
 19 the voluntary NPIs, if I may call them that, of 16 March  
 20 proved not to be enough, which is why a lockdown had to  
 21 be in the end imposed.  
 22 A. Not quite.  
 23 Q. Will you just wait for my question, please.  
 24 You do accept that, had voluntary NPIs, as you  
 25 describe them, been introduced earlier, it is

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1 do.  
 2 Q. And the DHSC was tasked with the obligation of providing  
 3 a battle plan --  
 4 A. Yeah.  
 5 Q. -- an overarching plan for how these measures would  
 6 work, what needed to be done, and of course envisaging  
 7 any further possibility of further, more stringent --  
 8 A. Yeah, now --  
 9 Q. If you would just agree that --  
 10 A. No.  
 11 Q. -- your department took on the obligation of developing  
 12 and producing a battle plan?  
 13 A. Yeah, so we were formally commissioned on, I believe,  
 14 20 March.  
 15 Q. 20 March.  
 16 A. The actual work that went into the battle plan had begun  
 17 considerably before that, I think basically from the  
 18 point of the strategy, so we were able to deliver the  
 19 battle plan back on, I think, the 22nd. Now, we didn't  
 20 develop it from scratch over those two days, as you  
 21 would imagine, so it was the culmination of a large set  
 22 of work within the department.  
 23 Q. All right.  
 24 Now, the lockdown decision and the time --  
 25 LADY HALLETT: Are you moving to a --

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1 possible -- and I emphasise, only possible -- that they  
 2 might have worked and there may have been no need for  
 3 a lockdown in order to preserve the NHS?  
 4 A. I'm sorry, right. So, we don't know, and we will never  
 5 know, what the effect of the 16 March package would have  
 6 been, because there was not long enough between it and  
 7 the national lockdown to be able to tell. Which is why  
 8 I've phrased my statement in the way that I did,  
 9 I think. And there is -- from what I have seen, there  
 10 is some evidence that the wave was already beginning to  
 11 turn because of the 16 March package, but, as I say, we  
 12 will never know, because we introduced the 23 March.  
 13 And I set out in my witness statement the reasons  
 14 why I think the government changed course, which was  
 15 certainly a belief amongst a number of people that those  
 16 measures were not enough. It was seeing lockdowns all  
 17 over Europe and us being out of step, and it was  
 18 a sense, driven by a lot of the media reporting, that  
 19 people were not complying with the 16 March things --  
 20 Q. Stop --  
 21 A. -- so in my mind it was those three reasons, but just to  
 22 be clear, I'm not -- I don't know and we can't know what  
 23 the effect of that 16 March package would actually have  
 24 been.  
 25 Q. But you accept it is at least possible that had those

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1 16 March measures been thought of, conceived and imposed  
 2 earlier, and I emphasise, possibility --  
 3 **A.** Yeah.  
 4 **Q.** -- then there may have been no need for a lockdown; we  
 5 just don't know?  
 6 **A.** That is certainly a possibility. And as I've said in my  
 7 statement, with hindsight we were at least a week late  
 8 at all points of the NPI decisions. I agreed with the  
 9 decisions at the time and the timing but, looking back,  
 10 we should have done each of the things on the 12th, the  
 11 16th, the 23rd, if we had got to the 23rd, at least  
 12 a week earlier.  
 13 **Q.** Should the government have changed course earlier? If  
 14 it had, then of course whatever measures were imposed on  
 15 16 March might have been imposed earlier --  
 16 **A.** Yeah.  
 17 **Q.** And there may have been an earlier realisation that  
 18 there were no other practical measures open to it.  
 19 Should the government have understood the position and  
 20 changed course earlier?  
 21 **A.** So, and I hope I have been clear about this, I think  
 22 the decisions based on the scientific advice were  
 23 completely rational at the time and I agreed with them.  
 24 With hindsight, I would agree with you that we should  
 25 have imposed them earlier.

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1 As I say, this all seemed at the time to me  
 2 completely rational of the timings of what we did when.  
 3 As I say, looking back, I would take different  
 4 decisions. Obviously I wasn't the decision-maker, but  
 5 I would have supported earlier implementation, as you  
 6 say.  
 7 **Q.** By contrast, Sir Christopher, in relation to the second  
 8 lockdown, your view at the time was that that second  
 9 lockdown, the lockdown of November 2020, was implemented  
 10 too late?  
 11 **A.** Yes. Now, and I hope I've made this clear in my witness  
 12 statement, so the issues in March are lack of knowledge  
 13 and understanding about the virus and taking decisions  
 14 in, you know, considerable uncertainty. That is not  
 15 the case for the second lockdown. By this point we have  
 16 a lot of testing, we know a lot about the virus, we  
 17 know -- we're not modelling, we basically know how it  
 18 goes up and down. And the debates, which I was nothing  
 19 like so close to, so I'll give the caveat that I was, as  
 20 it were, watching from DHSC rather than in the room at  
 21 this point, but the debates in November are not about  
 22 what is the situation, they're about what is the right  
 23 strategy. And that -- that's certainly how it looked to  
 24 us. It was much more: are lockdowns a good idea or not?  
 25 Not, what is the timing of a lockdown and what do we

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1 **Q.** We should have what, sorry?  
 2 **A.** Sorry, so with hindsight, I agree with the proposition  
 3 you put to me that we should have imposed them earlier.  
 4 **Q.** It is obvious that it took a number of weeks for  
 5 the government to understand the predicament it was in,  
 6 it took a number of weeks for the whole of government to  
 7 understand that, regardless of the modelling,  
 8 the infection fatality rate and the lack of practical  
 9 means of controlling the virus gave it very little room  
 10 for manoeuvre. Should not that awareness have taken  
 11 place, come to the government earlier?  
 12 **A.** As I say, I thought the decisions were rational at  
 13 the time, and they are -- and having looked back at  
 14 the record, they are fully in line with the scientific  
 15 advice that was received. Now, the debate at the time,  
 16 as I say, there was -- I think everyone agreed we were  
 17 going to have to have more and more restrictions,  
 18 the debate was about what the right timing was. And the  
 19 clear view of the Chief Medical Officer and others that  
 20 there were big downsides, as was proved to be absolutely  
 21 correct, to our NPI regimes, and therefore going into  
 22 them at the right time and coming out of them as quickly  
 23 as possible to minimise, as I say, what is been  
 24 correctly identified as the sort of collateral damage of  
 25 NPIs and lockdowns was very, very important.

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1 know.  
 2 Now, my point -- and I do understand the argument,  
 3 I don't agree with them, but I understand the arguments  
 4 from people that lockdowns are more damage than they do,  
 5 and that case is made, I understand it, I don't agree  
 6 with it, but if you're going to have a lockdown, which  
 7 we did, it would have been much better to do it earlier,  
 8 in my view, I wasn't the decision-taker, but in my view,  
 9 than when we did in November.

10 So I see the decision-making very, very differently  
 11 in that March first lockdown, which I say was based on  
 12 uncertainty, and the second and third ones which were  
 13 based on certainty but disagreements about the right  
 14 strategy.

15 Sorry, that was a long answer, but does that make  
 16 sense?

17 **MR KEITH:** Well, that's not for me to answer. I have no  
 18 more questions.

19 My Lady, there are a number of Rule 10 questions.

20 **LADY HALLETT:** There are.

21 Ms Campbell.

**Questions from MS CAMPBELL KC**

23 **MS CAMPBELL:** Thank you, my Lady.

24 Sir Christopher, I ask questions on behalf of the  
 25 Northern Ireland Covid Bereaved Families. I want to

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1 take you back, please, to that period in January and  
2 February 2020, and in your witness statement, I think  
3 it's perhaps your ninth one, you exhibit a document that  
4 is ultimately dated 25 February 2020, and we're going to  
5 have a look at it, if we may. It's INQ000051209.

6 Whilst it's coming up, Sir Christopher, and because  
7 we're limited for time, this is a Public Health England  
8 document that is endorsed by your department, and it is  
9 entitled, as you can see, "Guidance for Social/Community  
10 Care and Residential Settings".

11 If you just look at the very bottom of the first  
12 page, you can see it's endorsed and accredited by the  
13 Department of Health and Social Care, and indeed the  
14 Chief Medical Officer. Do you see that?

15 **A.** Yes.

16 **Q.** And, as I say, although this version is 24 February,  
17 it's ultimately published the next day.

18 Could we go over the page, please, to page 2. We  
19 can see on page 2 the list of community organisations to  
20 which this is to apply, and the bottom three bullet  
21 points: care homes, which are nursing care homes;  
22 care home services without nursing; support to people in  
23 their own homes. And of course there are other  
24 children's homes, homes for people with learning  
25 disability and so on.

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1 COVID-19 in the United Kingdom. There is no need to do  
2 anything differently in any care setting at present."

3 Okay?

4 Now, I'm not going to put it on screen, but your  
5 department at the same time on 25 February 2020 had  
6 published a situation report, a daily situation report,  
7 and you'll be familiar with those. Isn't that right?

8 **A.** I suspect so, yes.

9 **Q.** That report indicated that, as at 25 February, fewer  
10 than 6,800 people in the UK had in fact been tested, but  
11 of those tested there were 13 confirmed cases  
12 domestically. Okay? It also indicated that the  
13 situation internationally was that China was  
14 experiencing widespread infection, causing by that stage  
15 some 2,700 deaths. The situation in Italy was rapidly  
16 deteriorating and deaths had started and doubled  
17 overnight. And of course the situation in the Diamond  
18 Princess was that short of 700 people had become  
19 infected. Okay?

20 You've told us in your evidence today that as at the  
21 end of January of 2020, your department was working on  
22 the basis that once the virus leaves China we're in real  
23 trouble, isn't that right?

24 **A.** As we covered earlier, yes.

25 **Q.** Yes. Why is it, then, that as at 25 February 2020, when

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1 At the very bottom of page 2, the advice on  
2 25 February, that very bottom paragraph, please:

3 "This guidance is intended for the current position  
4 in the UK where there is currently no transmission of  
5 COVID-19 in the community. It is therefore very  
6 unlikely that anyone receiving care in a care home or in  
7 the community will become infected."

8 Okay? So it's very clearly stating right at the end  
9 of February that it is very unlikely that those who  
10 reside in care homes are going to be infected, much  
11 less, of course, seriously ill or die.

12 Before I ask you a question, let's look at a few  
13 other pieces of advice that are in this document.

14 Can we go to page 6, please.

15 It is reiterated in the top paragraph of page 6,  
16 last sentence:

17 "It remains very unlikely that people receiving care  
18 in a care home or the community will become infected."

19 Page 12, just give me one second to make sure I have  
20 the right reference.

21 **(Pause)**

22 I'm so sorry, I'll read it out to you, I just can't  
23 see it as it appears on the screen here, but on page 12  
24 it's repeated:

25 "Currently there is no evidence of transmission of

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1 the situation internationally was grim, and that the  
2 virus had arrived domestically, you were telling the  
3 care home sector or at least endorsing the advice that  
4 risks of infection were very unlikely and that there was  
5 no need to do anything at the moment?

6 **A.** Because that was the clinical advice at the time, so at  
7 this moment actual infection numbers in England, as this  
8 was, were believed to be very low indeed. So, as  
9 I understand it, this is a description of what the  
10 situation was at that time, it was not a prediction of  
11 the future. So I think everything you've read out --  
12 I mean, obviously this was signed off by a number of  
13 clinicians, not by me, but I think everything that you  
14 have read out is entirely consistent with the actual  
15 number, believed number of cases in the UK on that date.

16 **Q.** But of course, Sir Christopher, once the virus arrived  
17 in the UK, once the virus arrived, you knew and your  
18 department knew that we needed to be acting on the  
19 reasonable worst-case scenario basis; isn't that right?

20 **A.** Well, at this point, the --

21 **Q.** Sir Christopher, I'm quoting your evidence from this  
22 morning to you.

23 **A.** In terms -- so the distinction that I think is important  
24 here is between what were our predictions of the future  
25 and what was our advice to people to do at that moment

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1 in time. So it is completely consistent that there may  
2 be, as there were at this point, very small numbers in  
3 the UK that could be contained, and that our prediction  
4 of the future, the reasonable worst-case scenario of  
5 what might happen, might be very high. Those -- I don't  
6 see those two things as in contradiction at all.

7 **Q.** Let's look at it in this way: the Diamond Princess had  
8 many features that are consistent with care home or  
9 residential home features: high occupation, high  
10 occupancy, a lot of people sharing facilities, staff  
11 going from room to room and, perhaps even  
12 demographically, an older age group. We know that by  
13 that stage the Diamond Princess had suffered such  
14 an infection that 700 people on that ship had been  
15 infected. Okay?

16 Now, if we put it in context, was any consideration  
17 given at that point as to whether or not you should be  
18 advising care homes that your department was acting on  
19 a reasonable worst-case scenario and that they may well  
20 have to at least prepare to take plans to protect their  
21 residents?

22 **A.** Well, you've displayed how this document was put  
23 together, and who signed it off, and what you've just  
24 described was not the clinical advice that we were  
25 receiving at the time.

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1 **A.** Now, at the point that that guidance was put out, there  
2 was not evidence of community transmission occurring.  
3 As you say, there were, I think, from your numbers --

4 **Q.** 13 cases in the UK.

5 **A.** -- 13 cases, and from memory they were at that point  
6 largely imported cases and we didn't have evidence of  
7 community transmission. So I think the guidance is  
8 completely in line with what Professor Van-Tam has  
9 written, which is not surprising given that, as you  
10 showed at the beginning, the guidance was signed off by  
11 the Office of the Chief Medical Officer of which  
12 Jonathan Van-Tam was a part. So I don't see any  
13 inconsistency here.

14 **Q.** You say you didn't have evidence of community  
15 transmission at that point in time. There had been  
16 fewer than 7,000 tests. We had 13 confirmed cases. You  
17 knew what had happened internationally. You knew what  
18 had happened on the Diamond Princess. Would it not have  
19 been safer to operate on the basis that there was, at  
20 the very least, a risk of widespread community  
21 transmission starting from around the end of February  
22 and continuing well beyond?

23 **A.** Well, I can only repeat, we were acting on the clinical  
24 advice that we received at the moment, and -- at that  
25 time, and I'm sure we will cover this in great detail in

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1 **Q.** Well, can we put up, please, document INQ00047541.

2 And to put it in context, this is a document that  
3 comes from Professor Jonathan Van-Tam. It is advice  
4 that he provide, as he says, to his DHSC colleagues on  
5 24 January 2020.

6 Can we please in that document scroll down to  
7 page 3. The heading is "Significant spread and  
8 transmission in the UK", and the second paragraph,  
9 please. These are his corrections to a DHSC document:  
10 "If community transmission occurs in the UK, it [is]  
11 most likely that widespread community transmission would  
12 follow on rapidly; this would be a tipping point at  
13 which we would cease contact tracing, as it would be no  
14 longer be possible or a plausible route to stop the  
15 virus."

16 So as of 24 January your department was receiving  
17 advice that if community transmission occurs in the UK,  
18 it is most likely that widespread community transmission  
19 would follow. Were you aware of that advice at the  
20 time?

21 **A.** Yes, and it's completely consistent with what I've said  
22 in the rest of this hearing, and with what I've just  
23 said. So the key words in that paragraph are "if  
24 community transmission occurs".

25 **Q.** Yes.

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1 future modules, but in essence there were no  
2 non-damaging options here. So it's been widely reported  
3 the damage to individuals that isolation,  
4 non-pharmaceutical interventions, lockdowns have --

5 **Q.** Sir Christopher, I'm going to --

6 **A.** -- so we were exactly with the clinical advice that you  
7 were quoting.

8 **Q.** I want to move on and ask you whether you were aware of  
9 an article, again authored by Professor Van-Tam, at this  
10 stage in 2017, in relation to the possibility of  
11 an influenza pandemic, in which he said that long-term  
12 care facility environments and the vulnerability of  
13 their residents provides a setting conducive to  
14 the rapid spread of the influenza virus and other  
15 respiratory pathogens. And later in the article he  
16 talks about the risk in care homes potentially being  
17 explosive.

18 **A.** I'm not aware of that article --

19 **Q.** Does it follow that insofar as the department endorsed  
20 this advice, it did not put together the risk to  
21 residents in long-term care facilities, the global  
22 picture and the likelihood of transmission at least  
23 moving towards being widespread in the UK?

24 **A.** Well, I can only say the same thing that I have said in  
25 response to previous questions. This was advice clearly

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1 signed off by the clinicians and scientific advisers at  
 2 the time about what the best thing to do was in the very  
 3 specific circumstances that you've described where we  
 4 did not have evidence of community transmission and  
 5 therefore the kinds of things that you're describing  
 6 were not triggered. I mean, I get the point you're  
 7 making, but my answer is, as it were, the same, that  
 8 that was the scientific and clinical advice we were  
 9 receiving at that time.

10 **Q.** So the advice to those who manage care homes is: do  
 11 nothing, don't worry, any risk is very small?

12 **A.** And I think at that particular moment in time that has  
 13 proved to be correct. Now, obviously later in  
 14 the pandemic, and as I'm sure I will be giving evidence  
 15 on this in a future module, that position changes  
 16 completely, but at this particular moment in time  
 17 I haven't seen anything to suggest that that advice was  
 18 incorrect or out of line with our scientific advice at  
 19 that time.

20 **Q.** Sir Christopher, one more topic, if I may, because I'm  
 21 sure I've overrun my time.  
 22 Can we please put up INQ000106319.  
 23 This is a paper produced again by your department.  
 24 We understand on 31 March 2020. You can see it's  
 25 PPE guideline comparison. Can we go quickly, please, to  
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1 circumstances are to be wearing a single pair of gloves  
 2 per two hours.  
 3 In relation to surgical theatre gowns, one per  
 4 patient interaction is to be changed to one per  
 5 four hours. Do you see that?

6 **A.** Yes.

7 **Q.** Were, so far as you know, ministers told that PPE, in  
 8 order to prevent a crisis in availability, was going to  
 9 have to be worn for longer and worn for multiple patient  
 10 and colleague interactions in order to extend its usage?

11 **A.** Sorry, were ministers --

12 **Q.** Yes. Yes. They were aware of that, is that right?

13 **A.** Yeah, I mean, this was -- this was being widely debated,  
 14 it was very high up our issues list, we were very  
 15 worried about it, and I think ... I'll have to go away  
 16 and check and give you the answer afterwards, but  
 17 I think at this point ministers are holding several  
 18 meetings a week on PPE, possibly daily. So I think they  
 19 were very well sighted on these issues.

20 **Q.** Were you aware whether the proposals made in this  
 21 document were the result of any UK trials having been  
 22 undertaken to test whether they were safe, both for  
 23 patients and staff?

24 **A.** I couldn't tell you. Now --

25 **MS CAMPBELL:** Well, those are all my questions. Thank you.  
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1 page 2. There will be a great deal of other evidence in  
 2 this module and indeed in future modules about  
 3 procurement of PPE, but on 31 March your department was  
 4 proposing, under the intensive care column on the  
 5 right-hand side, that to deal with the problem of a lack  
 6 of PPE or a risk of lack of PPE, FFP3 respirators which  
 7 had been recommended to be one per patient interaction  
 8 was to be changed, and those who work in intensive care  
 9 were to wear one over the course of two hours. Do you  
 10 see that?

11 **A.** Yes.

12 **Q.** And you would accept no doubt that that would mean many  
 13 patient interactions and indeed colleague interactions  
 14 potentially within that two hours?

15 **A.** I should say I am not an expert in infection control at  
 16 all, so --

17 **Q.** I'm not asking you for your expertise in infection  
 18 control, but you do know that those who work within  
 19 intensive care facilities may well encounter several  
 20 patients and several colleagues over a two-hour period?

21 **A.** Yes.

22 **Q.** If we go down, please, to gloves, one per patient  
 23 interaction is to be proposed to be changed to one per  
 24 two hours.  
 25 So, again, those who work in those intensive care  
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1 **LADY HALLETT:** It's not your fault, Ms Campbell, but we have  
 2 another witness to get through this afternoon, so I'm  
 3 sorry to interrupt you.  
 4 Mr Metzger.

5 **Questions from MR METZER KC**

6 **MR METZER:** My Lady, I have been asked and I have agreed to  
 7 limit my questions further in light of the position  
 8 today.  
 9 Sir Christopher, I ask some questions on behalf of  
 10 the Long Covid groups.  
 11 On 7 July 2020, it was confirmed by email that the  
 12 DHSC had planned to raise public awareness about the  
 13 long-term effects of the Covid-19 but it was only on  
 14 21 October 2020 that the DHSC finally launched its one  
 15 and only video on indiscriminate risk of Long Covid,  
 16 which was directed at young people. Why was there  
 17 a delay of over three months in publishing the single  
 18 awareness-raising video on Long Covid?

19 **A.** I don't know about the video, I can go and check, but  
 20 there had been a lot of activity on Long Covid before  
 21 that, going back to 5 June, when the NHS issued its  
 22 first guidance on the aftercare needs of inpatients  
 23 recovering from Covid-19 and then the Secretary of State  
 24 holds a roundtable on Long Covid on 1 July. So we were  
 25 well aware of the issue and I should say, as it hasn't  
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1 come up before, it's a very serious issue that we take  
 2 very seriously but, as I say, I don't know about the  
 3 video. I can find out but there was a lot of activity  
 4 on Long Covid before the dates you're describing.

5 **Q.** Okay. Leave this video aside, there was no reason, was  
 6 there, to delay the accompanying press release?

7 **A.** Again, I couldn't tell you. I can find out.

8 **Q.** Yes, please.

9 Do you agree that this one public health video over  
 10 three years was insufficient to warn people, including  
 11 parents, of both the symptoms of Long Covid and that  
 12 Long Covid is caused from infection of Covid-19?

13 **A.** I think if the video had been the one thing that had  
 14 happened, I would agree with you. But, as I've said,  
 15 there was an awful lot of other activity on Long Covid  
 16 from when it became apparent after the first wave that  
 17 this was going to be an important thing for the country  
 18 and for its sufferers. So, I mean, I'm terribly sorry,  
 19 I can't really focus on the video because I don't  
 20 actually --

21 **Q.** I'll ask you a more general question: do you agree  
 22 overall that the information provided was insufficient  
 23 to warn people, including parents, of two things: the  
 24 symptoms of Long Covid and the cause, the fact that  
 25 Long Covid is caused from infection by Covid-19?

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1 making here is about the cross-government nature of the  
 2 communications, as opposed to that done directly by the  
 3 NHS, I think that's the point. I mean, again, I'm  
 4 sorry, I don't know the story of this in the detail that  
 5 your questions require, so again, on some of these I'll  
 6 take your questions away and come back, if that's okay,  
 7 with a more detailed and more expert answer.

8 **Q.** You certainly agree that the DHSC hadn't implemented  
 9 a communications strategy by that point?

10 **A.** Well, as I say, I think what Ed is talking about, but  
 11 I need to go away and check, is about the  
 12 cross-government wider implications, I mean, my  
 13 understanding is there was a lot of communication being  
 14 done by the NHS, as it were, on the straight clinical  
 15 issues, in the way that we do for all conditions.  
 16 I think he's making a point about the wider government  
 17 but, as I say, I'll check and give you a better informed  
 18 answer than I can give today.

19 **Q.** Thank you.

20 Do you know whether the discussions of the  
 21 Long Covid oversight board fed into Cabinet Office  
 22 messaging on Long Covid?

23 **A.** I don't know, off the top of my head, I know that my  
 24 ministers, and particularly, at this point, I think it  
 25 was Lord Bethell, took a very keen interest in

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1 **A.** No, I don't. I mean, there are other witnesses from my  
 2 department and related who your questions will be better  
 3 answered than particularly the clinicians. My  
 4 impression is that, actually, we and our colleagues in  
 5 the NHS were very front footed about Long Covid, both in  
 6 terms of its research and what we put in place around  
 7 its treatment. I'm sure more is needed, as I say, this  
 8 is a very significant thing, but I don't, certainly from  
 9 what I have seen, I haven't seen either a lack of focus  
 10 or a lack of action on this important issue.

11 **Q.** Please can we put up INQ000061266, bottom of page 2, and  
 12 the top of page 3, under item 5.

13 Eight months later, after the video, the DHSC  
 14 convened the Long Covid oversight board with other  
 15 government departments to co-ordinate the whole of  
 16 government activity and policy development. We can see  
 17 from these minutes of the first meeting in June 2021  
 18 that ES, who I am assuming is Ed Scully, raised concern  
 19 that there was a gap on the broader government view of  
 20 Long Covid and how that was being communicated.

21 Why at this point had the DHSC still not implemented  
 22 a communications strategy for Long Covid?

23 **A.** I think, well, there was a lot of communication about  
 24 Long Covid, I think the point -- and I think you're  
 25 correct that it's Ed Scully -- I think the point he's

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1 Long Covid so I know it was a very important thing  
 2 within the department, with a lot of escalation, and  
 3 obviously the NHS, as I'm sure you know, have done  
 4 an awful lot in this area. I couldn't tell you what was  
 5 put to Cabinet Office.

6 **Q.** All right. Do you know whether there was  
 7 a Cabinet Office strategy on public messaging of the  
 8 risk of developing Long Covid from Covid-19 infections,  
 9 either in June 2021 or at any time since?

10 **A.** Again, I don't know, but I'll find out.

11 **Q.** Okay, thank you.

12 You've said in your evidence today that advice to  
 13 the public on how to behave are non-pharmaceutical  
 14 interventions designed to stop the spread of the virus.  
 15 Do you agree that the public had the right to know about  
 16 the risk of Long Covid so they could protect themselves  
 17 from it?

18 **A.** Yes, and I think whatever we knew and the NHS knew about  
 19 Long Covid was put into the public domain. I don't  
 20 think there's a point when we have information that we  
 21 don't share. Again, I'll have to go and check with my  
 22 experts on this, and confirm, but I'm not aware there  
 23 was ever a delay in, as it were, our scientists knowing  
 24 something about Long Covid and that being made public,  
 25 but, once again, I'll have to check.

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1 Q. Thank you. On 5 June 2020 --

2 LADY HALLETT: Sorry, Mr Metzger, but I'm afraid -- I think  
3 if you've got questions, it sounds as if this witness  
4 can't really answer them and that he could put them into  
5 writing.

6 A. Yes, if you would like to write I'd be absolutely  
7 delighted to get somebody much more expert than me  
8 to ...

9 MR METZER: My Lady, I --

10 LADY HALLETT: Make this the last one, Mr Metzger.

11 And anything else we'll put into writing, all right?

12 MR METZER: Thank you very much, my Lady.

13 On 5 June 2020 -- I'll say it as speedily as  
14 I can -- the DHSC identified longer term sequelae of  
15 Covid-19 as one of four major implications for the  
16 health and care system in a presentation. I'm not going  
17 to cite it, you probably know it. Despite the DHSC's  
18 concern about this, you say in your witness statements  
19 that you can't recall that the risk of Long Covid was  
20 taken into account for decisions taken in relation to  
21 the second and third lockdowns. Thank you.

22 A. Yes, that's factually true. I don't think those  
23 lockdown decisions -- I think they were taken on the  
24 basis of the hospitalisation rate, the spread of the  
25 disease and the likely death rate, I think those were  
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1 strict with you as well, and then Mr Menon, because we  
2 have another entire witness to go.

3 Mr Dayle.

4 Questions from MR DAYLE

5 MR DAYLE: Thank you, my Lady.

6 Sir Christopher, I ask questions on behalf of FEHMO,  
7 that's the Federation of Ethnic Minority Healthcare  
8 Organisations, and I have three hopefully very brief  
9 topics that I wish to deal with with you.

10 Firstly, were there specific considerations or  
11 actions targeted interventions, if you will, that were  
12 pursued to identify and address the additional support  
13 needs of black, Asian and minority ethnic healthcare  
14 workers during the pandemic?

15 A. Yes. Yes, there were. I do think this is an area where  
16 we learned a lot and ramped up our activity accordingly.  
17 The two biggest things I would point you to is the CMO  
18 and SAGE commissioned PHE study done by Professor Fenton  
19 and others in April 2020, specifically on these issues,  
20 and then the development of the QCovid tool,  
21 commissioned in May 2020, that was trying to take a much  
22 more individualised approach to assessing people's  
23 risks, including not just their clinical risks but their  
24 socioeconomic risks as well.

25 I think those were probably -- certainly in the

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1 the three big conversations. Now, I should emphasise  
2 that that doesn't mean that Long Covid was not being  
3 taken seriously. It's just in the context of, as it  
4 were, the very extreme measure that a national lockdown  
5 is. I don't think that Long Covid was one of the  
6 considerations. It was certainly important to the  
7 government but I don't, as far as I know, the  
8 decision-makers were not doing it on that basis.

9 Q. I'm going to reduce the question still further, and we  
10 will probably do a fuller request in writing, thank you.

11 Do you agree that there was a difference in approach  
12 to Long Covid between the DHSC and Cabinet Office?

13 A. I'll check, I'm not aware that there was. You would  
14 expect the Department of Health and the NHS to have  
15 a focus on a medical condition that was much greater  
16 than that of Cabinet Office with all its  
17 responsibilities. I don't think you would expect much  
18 more from us than them. I don't think -- I'm not aware  
19 that there was ever a disagreement between us and them  
20 on this subject.

21 MR METZER: All right. So final question --

22 LADY HALLETT: We'll leave it there, Mr Metzger, I'm sorry.

23 MR METZER: Thank you, my Lady.

24 LADY HALLETT: Anything else will have to be in writing.

25 Mr Dayle, I'm afraid I'm going to have to be very  
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1 early stages, those are probably the two biggest things  
2 I would point you to.

3 Q. Second topic, how did the DHSC respond to the concerns  
4 and experiences of black, Asian and minority ethnic  
5 healthcare workers regarding PPE and the recommendations  
6 issued by the Public Accounts Committee on February --  
7 in February 2021, which included "improving  
8 understanding of the experience of frontline staff,  
9 particularly focusing on those from different ethnic  
10 backgrounds"?

11 A. I'll have to check what exactly we did -- yes, I'm  
12 talking the wrong way, sorry. I'll have to check  
13 exactly what we did with that specific recommendation.  
14 We report to the PAC on their recommendations quite  
15 regularly so there will be a published report of what we  
16 did with that specific recommendation. On the general,  
17 and I think we've set this out in our witness  
18 statements, so I won't repeat, there was a basically  
19 escalating action to deal with the very important issues  
20 that you raise, and certainly my understanding is we  
21 moved from a position where we had not very much  
22 understanding of these important issues to having a much  
23 greater understanding and that significant action was  
24 taken.

25 Q. Thank you.

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1 My third and final topic, this question arises from  
2 WhatsApp messages between yourself and Lord Mark Sedwill  
3 on 25 March 2020 regarding PPE, and the reference -- and  
4 it's not necessary to bring it up -- is INQ000279918.

5 In that exchange, Lord Sedwill writes at 5.31:

6 "Stories like this in The Telegraph likely to come  
7 up. Nurses in near revolt as some used bin liners to  
8 protect themselves."

9 My question is: from your vantage point, what would  
10 you say was done to ensure that PPE provided was  
11 suitable to fit and properly protect all staff,  
12 including black, Asian and minority ethnic healthcare  
13 workers?

14 **A.** Well, that is a huge question that would require a very,  
15 very detailed answer. And I think, as we'd said  
16 earlier, there's an entire module on procurement,  
17 including PPE, and I think it would probably -- I think  
18 the substantialness of that question demands more than  
19 a sort of few seconds answer, so I think it would  
20 probably be better, if that's okay, to answer that  
21 question in the module that's devoted to it.

22 **LADY HALLETT:** We'll have to come back to it, Mr Dayle,  
23 sorry.

24 **MR DAYLE:** Very well.

25 **LADY HALLETT:** Thank you.

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1 **MR O'CONNOR:** Can you give us your full name, please.

2 **A.** My name is Yvonne Doyle.

3 **Q.** Thank you. Professor Doyle, you provided at our request  
4 a witness statement for the Inquiry. We can see the  
5 first page of it is on screen now. We don't need to  
6 look at the last page, but you have signed that last  
7 page of the document below a statement indicating that  
8 you believe the contents of the statement are true, with  
9 the date of 17 October this year. Are the contents of  
10 the statement true, Professor?

11 **A.** Yes.

12 **Q.** Thank you.

13 Professor, you set out some considerable detail  
14 about your career in that witness statement. In  
15 summary, it's right, isn't it, that you are by training  
16 a medical doctor?

17 **A.** Yes.

18 **Q.** You have acquired a range of qualifications over your  
19 career, and indeed you have held a series of  
20 appointments in the field of public health?

21 **A.** Yes.

22 **Q.** That includes a series of roles acting as a director of  
23 public health for various local and regional authorities  
24 in England?

25 **A.** Yes.

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1 Mr Menon?

2 **MR MENON:** Having listened to the evidence of  
3 Sir Christopher today and reflected further, we have no  
4 questions.

5 **LADY HALLETT:** Thank you, Mr Menon.

6 **MR MENON:** We aim to please, my Lady, we aim to please.

7 **LADY HALLETT:** I think you've just made yourself one of the  
8 most popular people in the room, Mr Menon!

9 I'm really sorry that we've had to cut people short  
10 and I know that Mr Metzger wanted to ask more questions  
11 but I'm sure we can get the answers that you seek, even  
12 if -- maybe if at another stage we could read them out,  
13 if we get them, if that helps, Mr Metzger.

14 So thank you very much, Sir Christopher, I feel, as  
15 you've envisaged, that this isn't the last time that we  
16 shall meet.

17 **THE WITNESS:** I suspect not.

18 **LADY HALLETT:** So thank you.

19 I'm now going to keep quiet, everybody else is going  
20 to keep quiet while we do the handover for the next  
21 witness, so the stenographer can rest her fingers.

22 (The witness withdrew)

23 **LADY HALLETT:** Yes.

24 **PROFESSOR YVONNE DOYLE (sworn)**

25 **Questions from COUNSEL TO THE INQUIRY**

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1 **Q.** In June 2019, you were appointed as the medical director  
2 and director of health protection for the organisation  
3 Public Health England, or PHE?

4 **A.** Yes.

5 **Q.** From February to July 2020, you were PHE's senior  
6 responsible officer for the input of your organisation  
7 into the response to the Covid pandemic?

8 **A.** Yes.

9 **Q.** And I think it's right that you remained in post at PHE  
10 until that organisation was dissolved in October 2021?

11 **A.** Yes.

12 **Q.** And you then became the director for public health at  
13 NHS England, and you stayed in that role until you  
14 retired earlier this year?

15 **A.** Yes.

16 **Q.** Professor, as with other witnesses today, we will be  
17 asking you questions relating to PHE's involvement with  
18 the pandemic, but we will do so conscious that many of  
19 those issues touch on much broader areas that will be  
20 the subject of further examination by the Inquiry at  
21 further modules, in particular issues relating to test  
22 and trace and also PPE.

23 So we will be endeavouring today to ask you  
24 questions around the interface, if you like, between the  
25 activity of PHE and core political and administrative

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1 decision-making during the pandemic.

2 Before we get into those issues, can you give us,  
3 Professor, a brief outline, first of all, of, in general  
4 terms, PHE and what it did back in the days when it  
5 existed, and more specifically its role in relation to  
6 combatting infectious disease?

7 **A.** Yes. PHE was remitted to undertake four main functions:  
8 the protection of the population, including the  
9 instigation and curation of specialist -- certain  
10 specialist infection services, particularly  
11 laboratories, the oversight and the implementation of  
12 programmes on wellbeing, and health improvement of the  
13 population; the surveillance of disease and the curation  
14 of various disease registers; the support to the NHS,  
15 particularly on the reduction of inequalities in the  
16 NHS, but also on value and support to clinicians; and  
17 finally, the development and ensuring of the development  
18 of the workforce in public health.

19 **Q.** So I think it's clear from what you've said that where  
20 there is a novel infectious disease that needs to be  
21 combatted in this country, that can engage several or  
22 perhaps even all of those areas that you just described?

23 **A.** Yes. And you asked about its particular role in  
24 infectious diseases, where there were several  
25 subfunctions. First being the oversight and management

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1 protection, but also specifically to manage  
2 the chemicals, radiation, environment and emergency  
3 planning services.

4 **Q.** I see.

5 Could we look briefly at paragraph 8 of your  
6 statement, please, Professor, it's on page 3.

7 **A.** Yes.

8 **Q.** You describe in this paragraph, in the six months or so  
9 after you joined PHE, having to deal with a series of  
10 outbreaks of other diseases, we're talking before 2020  
11 now, so not Covid, but as listed here, listeria, what  
12 was then called monkeypox but which we have now been  
13 told is Mpox, and also Lassa fever.

14 I don't want to spend a great deal of time talking  
15 about other disease outbreaks, Professor, but it may be  
16 that dealing with those outbreaks was more typical of  
17 the more that PHE regularly undertook in those days than  
18 Covid, which we'll come to talk about.

19 If that's right, can you just give us a sense of the  
20 work that PHE undertook on those issues in 2019?

21 **A.** That's correct. So these would be the more spectacular  
22 end of health protection outbreaks, or emergencies.  
23 There were 10,000 incidents a year that the health  
24 protection service looked after as well, which were much  
25 more local, many of them actually did relate to areas

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1 and running of the specialist laboratories, the  
2 development and the execution of field services for the  
3 control of outbreaks, the running of the emergency  
4 service, training and testing, training particularly,  
5 and exercising, and then specialist areas in radiation,  
6 chemicals and environmental health, which were based at  
7 Chiltern.

8 **Q.** Now, we've said, Professor, that your role that you were  
9 appointed to in 2019 at PHE was that of medical director  
10 and director of health protection. Give us a sense of  
11 the scope of your duties in that role.

12 **A.** Well, the organisation had changed somewhat, it's in my  
13 statement, that before 2018 the whole health protection  
14 service encompassed both the national infection service,  
15 the laboratories and the field services, and health  
16 protection teams, and then also the chemicals, radiation  
17 and environment services, and an important surveillance  
18 service which I should have mentioned actually as part  
19 of its core health protection function.

20 Now, in 2019 that changed, in the appointment of  
21 a national infection service director, and my role  
22 remained as the health protection director and medical  
23 director, but my responsibilities for health protection  
24 were mainly to oversee the whole -- that the whole  
25 system held together, we co-operated for health

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1 that were affected eventually by Covid.

2 These were very special outbreaks, they absorbed  
3 a lot of resource. The listeria outbreak, sadly  
4 patients died in the NHS, but the complexity of what we  
5 had to deal with there in terms of the food chains that  
6 we were dealing with was immense and took a lot of time.  
7 It took eight weeks, really, for that whole incident to  
8 work its way through, and there was still work  
9 afterwards.

10 Mpox, at the time monkeypox, was one case. Again,  
11 a very complex case, needed a lot of contact tracing.  
12 Dozens of people had to be contacted on a travel basis.  
13 And it also called up the elements of the  
14 high-consequence infectious disease work.

15 Then the repatriation, interestingly, again recurred  
16 during the pandemic, because we did have to get very  
17 involved with repatriations early in the pandemic.

18 So these -- in many ways, they were spectacular but  
19 not typical. What they showed me was that we were  
20 running very hot at the end of 2019, we were very busy,  
21 and this was just the thin end of a very large wedge of  
22 outbreaks.

23 **Q.** Right.

24 That takes us, then, to 2020. You describe in your  
25 statement PHE being first informed of a potentially

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1 serious threat of pandemic on 2 January 2020, and can we  
2 take it that that triggered early investigative work  
3 at PHE?

4 **A.** Yes. So in fact I was informed on New Year's Eve by our  
5 on-call incident director that he was concerned that  
6 there were problems in China and that this could have  
7 implications for our ports. But we -- certainly from  
8 our reports coming from the WHO and elsewhere, we  
9 alerted DH and CMO early in January on a precautionary  
10 basis, yes.

11 **Q.** A little further on in your statement you describe how  
12 in the following weeks, January and going into February  
13 I think, PHE developed a test for this new strain, what  
14 we know as Covid-19. That, we see referenced in other  
15 documents, has been recognised as one of the early  
16 successes of PHE in terms of combatting the virus.

17 Can you explain in a few sentences how that came  
18 about?

19 **A.** Yes. The test was developed in PHE based and using the  
20 learning from MERS in 2012 and indeed developed on  
21 a multiple platform of viruses, and was able to be stood  
22 up really for clinical use by the end of January, which  
23 was rapid by the scale of this, given how novel it was  
24 and that the actual genomic recipe for it really had  
25 only appeared in January.

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1 that it spreads -- particularly in healthcare settings,  
2 but it spreads rapidly; it's difficult to detect; and it  
3 needs a very complicated, enhanced response.

4 So it would be appropriate entirely for a novel  
5 virus of this nature to be designated in this way. The  
6 consequence -- and it was decided by the four countries,  
7 actually. There is a standing four-country infectious  
8 disease group of clinicians.

9 **Q.** Just pause there a second. Is that because, as early as  
10 10 January, you knew that Covid had all of those  
11 characteristics, or was it done on a precautionary  
12 basis?

13 **A.** It was done on a precautionary basis. We didn't know  
14 all of that. But on the other -- and there was very  
15 little information to go on at that time. However, on  
16 a precautionary basis the four countries decided this  
17 was the right thing to do.

18 **Q.** Did it become apparent over the weeks, maybe months,  
19 that followed that in fact Covid did not warrant that  
20 classification?

21 **A.** Yes. So here was the first balance decision, really.  
22 So we were still learning about the virus, but by  
23 28 February there were other consequences, as you've  
24 asked. For instance, high-consequence infectious  
25 diseases require a certain category of lab, a category 3

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1 That was because we had expert virology, which is  
2 part of our function, it's to meant an expert infection  
3 service.

4 **Q.** Was that work done by you alone or was it -- did it  
5 involve international co-operation of any sort?

6 **A.** It certainly involved international co-operation, but  
7 the UK, through PHE, was an important contributor to  
8 that. The recipe had come through China, WHO, and  
9 GISAID had been able to share that, and there was very  
10 quick co-operation with a number of countries, including  
11 the UK, Germany, the USA, to get this test functioning.

12 **Q.** You mentioned, I think it was in the context of Mpox,  
13 this HCID, as you put it, which stands, doesn't it, for  
14 high-consequence infectious disease?

15 **A.** Yes.

16 **Q.** In your statement you refer to the fact that Covid-19  
17 was designated as an HCID at a very early stage, on  
18 10 January 2020.

19 Can you explain to us, please, what that -- first of  
20 all, designation means, but also what consequences went  
21 with it?

22 **A.** Yes. So high-consequence infectious diseases are  
23 designated on the basis of a number of criteria: first  
24 and foremost, a high case fatality rate, so a lot of  
25 people who get this will die, that's the assumption;

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1 lab, which means they're very contained and very  
2 limited, and that's correct, and also only people --  
3 certain people who are trained to deal with them,  
4 because they may be very dangerous to staff. That  
5 dreadfully limits the number of laboratories that can  
6 actually engage in this.

7 So, given that we felt that it was more important to  
8 have, you know, a huge influx of other help into  
9 the laboratory system, we applied -- the four countries  
10 applied to de-escalate this to a category 2. And that  
11 had to go through a number of -- it had to go through  
12 a number of committees to escalate and it had to go  
13 through those committees to de-escalate.

14 **Q.** We don't need to get into the detail of that process,  
15 Professor, but I think you say, was it on 16 March that  
16 in fact that process was complete and Covid was  
17 de-escalated so that it was no longer had that  
18 classification?

19 **A.** Yes, that's correct.

20 **Q.** And as you say, the practical consequence of that was  
21 that whereas previously only a very small number of  
22 perhaps your high sort of security, if you like,  
23 laboratories were allowed to do Covid work, once  
24 the disease had been declassified, it became possible  
25 for a far larger number of more routine laboratories to

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1 work on the disease, including testing?  
 2 **A.** Correct.  
 3 **Q.** We're going to come to the question of testing in  
 4 a moment, but since we're on this subject, in the  
 5 dairies that we have that were written by the Government  
 6 Chief Scientific Adviser, Patrick Vallance, there is  
 7 an entry -- I'm not going to bring it up on screen, I'll  
 8 read it out -- there is an entry on 2 April 2020, so  
 9 within a couple of weeks of the disease being  
 10 declassified, where he refers to Crick, and I think  
 11 that's the Crick laboratories, having offered  
 12 300 scientists, and in his words "and got no response  
 13 from PHE. Crazy". That's his words.

14 Was there an offer from the Crick laboratories to  
 15 provide 300 of their scientists, or perhaps laboratory  
 16 space, to assist you dealing with Covid at that stage?

17 **A.** Yes, there was. Not to me personally, but there was to  
 18 senior executives in PHE. And as far as I'm aware, it  
 19 was welcome. However, there were issues about how  
 20 testing could proceed on an end-to-end basis. This by  
 21 the way is not a comment about the Crick at all. But in  
 22 general, every laboratory wanted to help, small  
 23 laboratories of every kind, and what they needed to be  
 24 able to offer was a system of accruing the tests, doing  
 25 the tests, which they were offering, and then getting

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1 **Q.** If we look over the page, in fact, on to the second page  
 2 of this document we can see that it was someone called  
 3 Nick Phin from Public Health England?

4 **A.** Yes.

5 **Q.** Can we take it that, routinely, there would have been  
 6 someone at COBR meetings from Public Health England?

7 **A.** Usually. It depended on the -- obviously what the  
 8 orientation of the meeting was, but in the period of the  
 9 pandemic usually there was somebody, but I have to say  
 10 possibly not at every COBR meeting.

11 **Q.** But you say on occasions it was you, but, as we can see,  
 12 not this time?

13 **A.** Not this time.

14 **Q.** We've looked at this set of minutes for a number of  
 15 different reasons. This time can we go, please, to  
 16 I think it's page 8. It's the last page. Yes.

17 So here is the set of actions from the meeting, and  
 18 if we look at point 7, we see:

19 "Public Health England to develop and run  
 20 a Ministerial table top exercise within the fortnight to  
 21 consider the range of decisions that may be required in  
 22 the event of a reasonable worst case scenario."

23 So there is a tasking to Public Health England to  
 24 conduct, as it is said, an exercise. Was that something  
 25 that, at least within this type of series of events, was

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1 the tests back out through usually the NHS but elsewhere  
 2 into the community or whatever, so that there was what  
 3 we called an end-to-end service, so that the test was  
 4 taken and the patient got the response they needed.

5 Now, as I understand it, not all laboratories could  
 6 do that either, and the first group of partners who  
 7 could were the NHS laboratories, and they were recruited  
 8 pretty quickly by our national infection service  
 9 directors.

10 But eventually, the whole testing arrangements  
 11 really expanded pretty quickly actually after a seminar  
 12 on 17 March.

13 **Q.** We'll come back to the question of testing shortly,  
 14 professor, but thank you for that.

15 I want to move on to a slightly different subject,  
 16 and it's one that we have -- the Inquiry at least --  
 17 considered already today, and that is Operation Nimbus,  
 18 which I know you have at least some familiarity with.

19 Could we look, please, at a document, it's a set of  
 20 COBR minutes, INQ000056226. Professor, I had intended  
 21 to ask you previously: were you someone who attended  
 22 either COBR meetings or SAGE meetings during this  
 23 period?

24 **A.** I did attend COBR meetings but not this one, to my  
 25 knowledge.

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1 unusual or exceptional?

2 **A.** No, it wasn't. COBR and government were at -- were  
 3 obviously at will to ask anything of PHE that was in its  
 4 remit, and exercising was, so in this case that inquiry,  
 5 that commission would have been taken through into  
 6 Public Health England.

7 **Q.** We know that what followed from this instruction was  
 8 indeed Operation Nimbus which took place on 12 February,  
 9 so just inside the fortnight. Were you involved in  
 10 organising Operation Nimbus yourself, Professor?

11 **A.** No, I wasn't.

12 **Q.** Perhaps we can take it then that you weren't there,  
 13 personally?

14 **A.** I wasn't there, but my team would have supported the  
 15 running of the exercise.

16 **Q.** I know that you have at least some familiarity with what  
 17 happened --

18 **A.** Yes.

19 **Q.** -- on that occasion. We've seen the slides that were  
 20 prepared for Operation Nimbus, the reasonable worst-case  
 21 scenario, the synopsis, the scenario being a wave in  
 22 which 800,000-odd people would die in a 16-week period,  
 23 I think it was.

24 Are you able to help us with who attended the  
 25 tabletop exercise, Professor?

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- 1 **A.** I'm not able to give you exact names, I'm afraid.  
 2 I know that the NHS, that the Department for Health and  
 3 senior public health members of PHE were involved,  
 4 possibly PHE on a basis of running the exercise, and the  
 5 Cabinet Office would have been, because the Cabinet  
 6 Office actually took the commission and required PHE to  
 7 run the exercise. That would not be unusual.  
 8 **Q.** When you say "commission" there, you simply mean they  
 9 were the ones who, as we've seen from these minutes, as  
 10 it were, instructed or asked PHE to undertake that  
 11 exercise?  
 12 **A.** Yes.  
 13 **Q.** Could we look at another document, please.  
 14 It's INQ000273915.  
 15 This is, in fact, a document which I think PHE have  
 16 helpfully provided possibly today, certainly very  
 17 recently.  
 18 **A.** Yes.  
 19 **Q.** Yes, thank you, and I know you're familiar with this  
 20 document, Professor. This is, as we see, a "Summary  
 21 Note on Exercise Nimbus", and it says "Novel Coronavirus  
 22 Preparation", but I think it's clear from the content of  
 23 the note that it was prepared after the exercise had  
 24 happened; is that right?  
 25 **A.** Correct.

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- 1 recommendations, describing what took place at the  
 2 exercise and everything that flowed from it.  
 3 Would you have expected something detailed by way of  
 4 report or recommendations to emerge from this exercise?  
 5 **A.** Yes, and that would be a normal outcome from -- well,  
 6 output, really, from something like this. The report  
 7 might be written by our emergency planning team, but the  
 8 recommendations would be agreed with the commissioner,  
 9 and the implementation would be assigned to the  
 10 responsible body, who in this case would have been the  
 11 commissioner as well.  
 12 **Q.** You've referred to the commissioner, but you mean?  
 13 **A.** I mean the Cabinet Office in this case. In other  
 14 exercises, if I could explain, just to be helpful,  
 15 recommendations can often be delegated to the most  
 16 appropriate body within government or the NHS to  
 17 implement.  
 18 **Q.** Can we take it at least that PHE has no further  
 19 material, no detailed summary of the exercise, no  
 20 detailed recommendations from it, and that, if we were  
 21 to look for such material, we would need to ask the  
 22 Cabinet Office and perhaps the contingencies  
 23 secretariat --  
 24 **A.** As I understand it, that's correct.  
 25 **Q.** All right. Well, I won't ask you any further questions

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- 1 **Q.** If we can look briefly at page 2, there is a very short  
 2 and high-level description of what the exercise was  
 3 about, its aims, objectives, a format.  
 4 Then, going on to page 3, please, there is  
 5 a description of a scenario, which really just reflects  
 6 what we've already seen in the slides.  
 7 There is a very brief reference to participants. We  
 8 see 55 people, including ten to 15 ministers. It  
 9 appears that people -- representatives from the devolved  
 10 administrations were there. Are you able to help us,  
 11 perhaps not from your knowledge, but who would you have  
 12 expected from the devolved administrations to have  
 13 attended an exercise like this?  
 14 **A.** I would expect very senior administrators and  
 15 ministerial presence as well. I cannot say who was at  
 16 this meeting, I'm afraid, and I understand that  
 17 the Cabinet Office retain that information, as we speak.  
 18 **Q.** Just then finally on this document, we see under  
 19 "Actions", it says:  
 20 "Cabinet Office circulated findings internally and  
 21 implemented the appropriate actions."  
 22 Professor, the Inquiry in Module 1 has seen the  
 23 documents relating to an exercise called Cygnus, which  
 24 took place some time before the pandemic, and there are  
 25 very detailed ex post documents prepared, learnings,

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- 1 about that, Professor, thank you.  
 2 Lastly on this early period January/February, can we  
 3 look at paragraph 98 of your statement. It's on  
 4 page 33.  
 5 Professor, you state here that your main concern in  
 6 late January/February 2020 was that your situational  
 7 awareness advice was not always welcome. You say that  
 8 this led to a distancing for a period from offering  
 9 direct advice, and you add that it was never clear which  
 10 parties were most offended and why, a situation you say  
 11 you encountered when professional information was  
 12 presented in good faith to inform the public, and you  
 13 also say there was general confusion and increasing  
 14 concern as to who was in charge in government and why  
 15 delays were occurring in getting, for example, key  
 16 guidance documents out to the public.  
 17 It's our fault, I'm sure, but that's all quite  
 18 vague. Can you put some detail onto exactly what these  
 19 concerns that you had in this period were?  
 20 **A.** Well, they encompass a number of issues which were  
 21 concerning to me. The first was what I'm relating to  
 22 here in terms of the distancing, and this is put on  
 23 paper really to explain that there was a distance  
 24 between the end of January and quite a bit of February  
 25 actually, between myself and ministers, particularly the

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1 Secretary of State, and --  
 2 **Q.** Just pause there for a minute. Which Secretary of  
 3 State?  
 4 **A.** The Secretary of State for Health, and it followed  
 5 a media interview I had done at the end of January where  
 6 I said straight that there could well be cases in the  
 7 country, which of course there were about ten days  
 8 later, and that we were unclear about -- but were  
 9 prepared to consider that asymptomatic infection could  
 10 occur, very unclear about transmission at that point,  
 11 and that it would take possibly six months for a vaccine  
 12 to be developed. I was rather, I think, optimistic  
 13 about that.

14 This did not go down well, I'm afraid. It may well  
 15 my presentation or the way I did that interview or the  
 16 set of interviews, but I felt it was the truth, I was  
 17 telling the truth.

18 The way that was handled was that I was advised not  
 19 to do any further media, and that the Secretary of State  
 20 would need to clear all media, which, of course, we  
 21 agreed to. But also that it was probably best if I just  
 22 kept a distance for a while until things settled down,  
 23 which I did.

24 **Q.** You describe the press interviews on a particular day.  
 25 Did you meet the Secretary of State on that day, or were

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1 with my work.

2 I did eventually stand on platforms in  
 3 Downing Street and did media in March, and right up to  
 4 April, and indeed one episode in May. So it did  
 5 resolve.

6 **Q.** But I think you've said that you were told, either by  
 7 Mr Hancock or others, that you shouldn't have any direct  
 8 contact with him for a period of time after this  
 9 incident?

10 **A.** Not quite. I was advised by colleagues in the civil  
 11 service that this would be the best way to calm things  
 12 down, and I understood that, and I complied.

13 **Q.** But this was at a time when, you tell us, but perhaps  
 14 you would have expected to have quite frequent contact  
 15 with the Secretary of State, given the developing  
 16 pandemic?

17 **A.** Yes, and had had, actually, very frequent contact up to  
 18 2020.

19 **Q.** Were there things that you would otherwise have wanted  
 20 to say to the Secretary of State that you felt that you  
 21 couldn't during that period?

22 **A.** No, because there were good colleagues who were able to  
 23 convey that, and deputies stepped in. So we managed to  
 24 continue the work, and I really felt that the public  
 25 population should not suffer in any way because of this,

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1 you simply told that he was not happy with what you had  
 2 done?

3 **A.** No, I did meet the Secretary of State on that day and he  
 4 did make his displeasure clear.

5 **Q.** In what way?

6 **A.** He asked me not to patronise him.

7 **Q.** What did you reply?

8 **A.** Well, I apologised, actually. I remember my words,  
 9 I said, "I really am sorry if you think the science has  
 10 let you down".

11 **Q.** Did you think that you had let him down, Professor?

12 **A.** I did, in that our ethos always is to support our  
 13 ministers, and this was not a good outcome. So I did  
 14 feel I had let him down in some way, but I still felt  
 15 I had spoken the truth.

16 **Q.** From what you've said, you weren't trying to do anything  
 17 that would either let the Secretary of State down or,  
 18 indeed, anything other than promote the objectives of  
 19 Public Health England and the Department of Health?

20 **A.** Absolutely.

21 **Q.** So what was then the aftermath of this incident?

22 **A.** I didn't make any fuss about it. I continued with my  
 23 job, as -- and I was asked to be SRO mid-February to do  
 24 various elements of the internal management of the  
 25 incident in Public Health England, and I just continued

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1 and therefore we found ways to continue the work.

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

3 My Lady, I'm about to move to another topic.

4 I think you had intended to take one more short break.

5 If you were, now would be a good time.

6 **LADY HALLETT:** Right. Very well, five minutes, no more.

7 (4.22 pm)

(A short break)

8  
 9 (4.27 pm)

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

11 **MR O'CONNOR:** Professor, I want to move back to the question  
 12 of test, trace and isolate, and it's right, of course,  
 13 that contact tracing is a fundamental weapon against the  
 14 spread of an infectious disease. I think it was the  
 15 Mpx disease in 2019 where you indicated that there had  
 16 been quite a significant degree of contact tracing on  
 17 that occasion.

18 **A.** Mm-hm.

19 **Q.** It's also right, isn't it, that viruses such as  
 20 Covid-19, where patients are infectious at  
 21 the presymptomatic stage, are viruses where contact  
 22 tracing can be particularly important?

23 **A.** Yes.

24 **Q.** Generally speaking, is there a point at the development  
 25 of a disease, of a virus, where contact tracing ceases

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1 to be effective?

2 **A.** Yes, it is actually difficult to identify people at  
3 presymptomatic stage, if they're the first case, of  
4 course. But contact tracing works best when there are  
5 low numbers of cases, particularly in community  
6 settings, because it's then quite reasonable to be able  
7 to follow each one and really put the fire out, that's  
8 what contain is about, is stop an outbreak from  
9 spreading.

10 When there are large numbers of cases, it becomes  
11 difficult logistically but it also becomes probably  
12 impossible to contain, and there are a number of reasons  
13 for that. But the first point is that, with small  
14 numbers of cases, the hope is that you can actually  
15 extinguish the virus at that point from contacting.

16 What we were looking for and what became very  
17 important is where it was clear that there were cases  
18 that were called second, third, fourth generation -- in  
19 other words contacts of contacts of contacts -- which  
20 were out there which didn't have a known link to what we  
21 understood were the sources of the virus in the  
22 community, and that happened predominantly at the end of  
23 February, first case was 28 February.

24 **Q.** Yes.

25 Now, you refer to February and Covid; we know that  
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1 hadn't, and, incidentally, the scale of that became  
2 clearer later in the pandemic when there were attempts  
3 to recruit 18,000 people to contact trace, so that was  
4 the scale of what we would have to deal with in  
5 a widespread infection within the population.

6 But to answer your question, at this point Public  
7 Health England was still committed to doing everything  
8 it could to find every case and contact that it could,  
9 within its capacity, and its capacity was still extant,  
10 it was still in existence in mid-March.

11 **Q.** Let's look at a set of SAGE minutes, Professor, if we  
12 can go to INQ000052098, please.

13 We can note, Professor, that this is a set of  
14 minutes for a meeting that took place in February 2020?

15 **A.** Yes.

16 **Q.** Just underneath, we see that these minutes were  
17 published some months later in May. Do you see that?

18 **A.** Yes.

19 **Q.** It's much smaller writing.

20 **A.** Yes.

21 **Q.** The Inquiry has heard that in February it was not  
22 practice, was it, to publish these minutes, but steps  
23 were taken --

24 **A.** Indeed.

25 **Q.** -- some time later to publish them, and that's why we  
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1 the World Health Organisation issued a very clear  
2 encouragement: test, test, test. There was a suggestion  
3 made by Jenny Harries, the Deputy Chief Medical Officer,  
4 in March 2020 that that guidance, the need for testing,  
5 was something that didn't necessarily apply to this  
6 country. The term she used was that it was guidance  
7 that was really for less-developed countries. Is there  
8 any force in that at all?

9 **A.** It wasn't a strategy that we pursued in Public Health  
10 England. Our view was that we would pursue the strategy  
11 that we had laid out quite clearly, which was to  
12 identify and contain as many cases as possible and all  
13 their contacts.

14 **Q.** As you say, at the very outset of the pandemic that's  
15 exactly what Public Health England sought to do. But,  
16 of course, we know that the pandemic became far, far  
17 larger as those early weeks and months progressed, and  
18 what we saw later in 2020 was a population level attempt  
19 at a programme of testing and contact tracing.

20 If we can look, please, at paragraph 26 of your  
21 statement, at page 9, do you make the point here,  
22 Professor, that that type of contact tracing exercise  
23 was something for which PHE simply hadn't been designed  
24 or funded?

25 **A.** That's correct, for large scale contact tracing it  
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1 see the difference there.

2 There has been some debate about an entry on --  
3 I think it's page 2 of the minutes, yes. Casting our  
4 eyes just briefly up the list, up that page, we see that  
5 there seem to have been two people there from PHE,  
6 Sharon Peacock and Maria Zambon, but not you?

7 **A.** Not me.

8 **Q.** At paragraph 7, as I say, there is an entry which  
9 states, we will recall this was mid-February:  
10 "Currently PHE can cope with five new cases a week  
11 (requiring isolation of 800 contacts). Modelling  
12 suggests this capacity could be increased to 50 new  
13 cases a week (8,000 contact isolations) but this  
14 assumption needs to be stress tested ..."

15 Was that correct, Professor?

16 **A.** It wasn't quite correct. I understand what it may have  
17 been trying to convey. So the five was five  
18 introductions, and these were introductions from abroad.  
19 They were not five cases in country, they were five  
20 introductions. The paper on which it was based was  
21 a modelling paper which looked at a pooled set of data  
22 from several European countries, and looked at the  
23 genetic variation and the likelihood of onward contacts  
24 in this group of people. And the -- so the paper was  
25 suggesting that five contacts -- sorry, I beg your  
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1 pardon, five introductions would lead to, in each case,  
 2 the -- each generation for each case, up to a fourth  
 3 generation, would lead to thousands of contacts. So it  
 4 was a proposition that this would rapidly get out of  
 5 control. It was basically saying multiple generations  
 6 will yield very rapid numbers of contacts, very quickly,  
 7 because of what is known about the transmissibility of  
 8 this virus.

9 Unfortunately, that got translated into popular  
 10 narrative as "Public Health England can only cope with  
 11 five cases a week", and this was not the case.

12 **Q.** Well, if that's right, why were the minutes drafted in  
 13 that way, but, perhaps more important apply because we  
 14 know that mistakes can be made, why weren't the  
 15 maintenance corrected either in February, shortly after  
 16 the meeting, or certainly before they were published in  
 17 May?

18 **A.** I don't know and, unfortunately, it was probably our  
 19 misstep not to have picked this up and corrected it  
 20 sooner.

21 **Q.** Would you routinely, not you necessarily personally, but  
 22 PHE as an attender at a SAGE meeting, have been asked to  
 23 approve the minutes in the way that perhaps is normal in  
 24 other committee meetings?

25 **A.** When I eventually attended SAGE the minutes were  
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1 worked, you mentioned disparities as being one of those  
 2 issues that you were tasked to addressing. And  
 3 of course that is something that applied particularly at  
 4 a time of emergency like the Covid pandemic?

5 **A.** Yes.

6 **Q.** We've heard much evidence now about the very early  
 7 indications of the disproportionate impact of Covid,  
 8 probably first of all disproportionate impact on elderly  
 9 people, but very shortly followed by evidence of  
 10 disproportionate impact on the black, Asian and minority  
 11 ethnic communities, particularly in the healthcare  
 12 sector.

13 **A.** Yes.

14 **Q.** It's right, isn't it, that Public Health England was  
 15 commissioned, I think by Chris Whitty, to conduct  
 16 research into those issues early in the pandemic,  
 17 I think it probably was April or May 2020; is that  
 18 right?

19 **A.** That's correct.

20 **Q.** And that resulted in a report, did it not -- thank you,  
 21 it's been brought up on screen -- called "Disparities in  
 22 the Risk and Outcomes of Covid-19".

23 **A.** Yes.

24 **Q.** Were you involved in any way in either researching or  
 25 writing this report?

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1 approved at the next meeting of SAGE, yes. But  
 2 generally they were written and agreed internally first  
 3 and then presented to SAGE. And very often the agendas  
 4 were very pressured and crowded and it simply may have  
 5 been missed.

6 **Q.** This is obviously important in its own terms, Professor,  
 7 but there is also a wider question about the accuracy,  
 8 the comprehensibility of SAGE minutes, because this is  
 9 not the first occasion where we have found that people  
 10 didn't understand what SAGE was trying to say in its  
 11 minutes.

12 Do you think it could have been done -- there could  
 13 have been a better process for your organisation but  
 14 also other organisations agreeing on the accurate and  
 15 clear content of SAGE minutes?

16 **A.** It was certainly a cogent lesson for Public Health  
 17 England that they really could have moved quicker to put  
 18 this to rights and help, actually, Professor Vallance,  
 19 you know, who was a very busy person, and his  
 20 secretariat. I don't think we picked this up fast  
 21 enough, and it became into popular narrative, which  
 22 became very difficult to deal with.

23 **Q.** I want to move on to another subject, Professor, and  
 24 when I asked you at the beginning of your evidence about  
 25 the different areas in which Public Health England  
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1 **A.** I was involved, first in identifying the signals,  
 2 I didn't do the epidemiology, but I asked my colleagues,  
 3 as SRO, to find those signals, and then to -- we stood  
 4 up a team to get involved in producing in report for the  
 5 CMO, yes.

6 **Q.** It was published on 2 June 2020 and if we look at the  
 7 third page of the report, please, we can see from its  
 8 contents that it had sections throughout the report on  
 9 different vulnerable sectors within the population.

10 **A.** Yes.

11 **Q.** We've also heard that, almost as soon as the report was  
 12 published, there was criticism of it, and we can see if  
 13 we go to another document, please, INQ000097872.

14 This is a letter, in fact, to Matt Hancock dated  
 15 12 June, so a week or so, ten days after the publication  
 16 of that report. In summary, Professor, there was  
 17 criticism that the report which we've just looked at,  
 18 first of all, didn't contain the input that had been  
 19 received from inequality and other groups, but more  
 20 importantly, perhaps, didn't include any  
 21 recommendations. One might have thought that  
 22 recommendations were at the heart of the purpose of  
 23 a report like this.

24 First of all, do you agree, and secondly, if so, why  
 25 didn't that report contain any recommendations?

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1 **A.** I do agree, and the criticisms were understood, and  
 2 I was very -- very concerned and sensitive about that,  
 3 as was my good colleague, Professor Kevin Fenton. We  
 4 did get those recommendations out into the public  
 5 domain, it took some time, there were six or seven of  
 6 them, they were challenging to us, and the  
 7 recommendations eventually went to the minister for  
 8 disparities and into the Cabinet Office -- sorry, to the  
 9 office for disparities within government, and there were  
 10 quarterly reports about how that -- those  
 11 recommendations or requests really were being dealt  
 12 with. So there was some follow-on.

13 **Q.** The short question, though, Professor, is: why were  
 14 those recommendations not published with the report  
 15 containing the research on which the recommendations  
 16 were based?

17 **A.** Well, initially there were a number of issues that led  
 18 to these delays. The first was that it wasn't entirely  
 19 accepted that the -- this kind of qualitative work had  
 20 the same value as the quantitative work, and therefore,  
 21 you know, we needed to make sure that everybody  
 22 understood this was a very balanced piece of work. It  
 23 was intended to show the epidemiology, but also get the  
 24 voices of people into this discussion, and also what  
 25 they were telling us that needed to happen, which was

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1 and the Cabinet Office were interested also, because we  
 2 gave talks across government on it. But I do agree with  
 3 Professor Khunti that it will take hard work to continue  
 4 to implement some of this. For instance, there's a lot  
 5 of recommendation around fair assessment at work, work  
 6 that is, you know, culturally well orientated towards  
 7 people from various communities and so on, and that  
 8 takes quite a lot of system change. And, therefore, one  
 9 of my recommendations is that we need to keep this very  
 10 much in sight, the findings of these reviews, and not  
 11 lose sight of this, which can be so easy to do.

12 **Q.** If we can just go back, Professor, to that report, so  
 13 it's INQ000101218, and look at page 3.

14 That, you'll recall, is the contents page, so we see  
 15 the different chapters of the report. As I indicated,  
 16 a range, if you like, of vulnerable groups.

17 We don't see there a section on disabled people,  
 18 Professor. Why were they not identified as a vulnerable  
 19 group who ought to be included in this work?

20 **A.** Well, people with disabilities certainly had been  
 21 identified as vulnerable groups throughout the pandemic.  
 22 We were requested and did undertake a further review of  
 23 people with learning disabilities and autism, and that  
 24 was published in the autumn of 2020, and its main  
 25 purpose was to raise awareness of the vulnerability

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1 going to be challenging.

2 That, I think, needed -- those recommendations,  
 3 those requests did need some discussion internally in  
 4 government as to who owned them, they were very much  
 5 about cross-government, they weren't simply about the  
 6 NHS. So it did take time, but it did emerge into the  
 7 public domain and there was a commitment which was  
 8 followed on. So in that sense, the work had some  
 9 impact.

10 **Q.** Professor, I'm not going to take you to the  
 11 recommendations themselves. I know you're familiar with  
 12 them. They were contained in a subsequent report, were  
 13 they not?

14 **A.** Yes.

15 **Q.** But you know that the Inquiry has heard evidence from  
 16 Professor Khunti criticising the recommendations, saying  
 17 that they were too general, they didn't contain a clear  
 18 programme of action, they didn't contain any timeframes  
 19 for delivery, or methods of implementation. In summary,  
 20 you've already in part defended the recommendations, but  
 21 what do you say to those criticisms?

22 **A.** I completely agree that, if recommendations don't have  
 23 named organisations or individuals preferably, they  
 24 don't go anywhere, and these recommendations were taken  
 25 through the Race Disparity Unit, which was appropriate,

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1 particularly of this group in terms of mortality, which  
 2 it did, and that was presented then to -- particularly  
 3 to the interested parties in the NHS and clinicians and  
 4 others in the care home sector who would benefit from  
 5 knowing this information.

6 **Q.** Learning disabilities and autism, but what about  
 7 physically disabled people?

8 **A.** Well, physical disabilities, they're -- I'm not sure  
 9 whether they're actually included in here, but they  
 10 certainly have come across various groups. It may well  
 11 have been that we should have concentrated on that  
 12 particular group as well.

13 **MR O'CONNOR:** Yes. Professor, thank you very much. Those  
 14 are all my questions for you.

15 My Lady, there are, as you know, some questions from  
 16 core participants.

17 **LADY HALLETT:** There are.

18 I think, Ms Mitchell, you're going first.

#### Questions from MS MITCHELL KC

20 **MS MITCHELL:** I'm obliged, my Lady.

21 Professor Doyle, I ask questions on behalf of  
 22 Scottish Covid Bereaved.

23 You say in your statement that Public Health England  
 24 has a specific remit from the Secretary of State and  
 25 that remit includes the UK's national focal point, and

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1 that deals with International Health Regulations, or you  
2 ensure that you comply with them.

3 Given this was a UK remit, what I would like to  
4 understand is what part Scotland, be it Public Health  
5 Scotland or what you've described in your evidence as  
6 the standing four countries infectious disease group,  
7 what input did Scotland have into that process?  
8 **A.** Well, before 2020, there was, and there continued to be,  
9 a four-country group of health protection directors,  
10 senior leaders, which my department supported, and the  
11 chair rotated. I think it was with Wales just before  
12 2020, but it had been with Scotland. So we were equal  
13 partners in that.

14 We had the four-country infectious disease  
15 consultants and the four-country infection prevention  
16 control experts who met regularly; we had the regular  
17 clinicians' meetings, which were four countries, during  
18 the pandemic; and I chaired, throughout 2021,  
19 a four-country genomics group. My purpose there was to  
20 ensure that the devolved countries got their fair share  
21 of funding for the development of their genomic  
22 services.

23 As well as that, we had regular -- every day we had  
24 situation awareness with the four countries and, when  
25 they wished to join, the Republic of Ireland, and we  
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1 procedures designated as aerosol generating. We are  
2 therefore calling on [Public Health England] to support  
3 the wider use of RPE in other high-risk settings across  
4 primary and secondary care."

5 Professor, so the first question I have for you is:  
6 appreciating that there was considerable uncertainty in  
7 the early stages of the pandemic, when did Public Health  
8 England first become aware that aerosol transmission was  
9 a significant transmission route of Covid-19, including  
10 through daily actions such as coughing, talking,  
11 et cetera?

12 **A.** Thank you. So there was always a recognition, well,  
13 from fairly early on, that aerosol transmission could  
14 occur. I think what changed over the months, and  
15 particularly after the summer of 2020, was the work that  
16 had been done particularly through SAGE and through its  
17 subgroup, and Professor Noakes, of course, and the  
18 importance of aerosol -- the balance of aerosol  
19 transmission versus droplet versus fomite, and,  
20 you know, surface transmission. And that balance  
21 changed.

22 Professor Noakes is part of a number of scientists  
23 who wrote to WHO and asked them to change their advice  
24 on this as well.

25 But in the early months, we had certainly provided  
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1 kept very close contact on an ad hoc basis with our  
2 colleagues in Public Health Scotland.

3 **MR WILCOCK:** My Lady, thank you, I don't have any other  
4 questions. My other questions were answered earlier.

5 **LADY HALLETT:** Thank you very much indeed.  
6 Mr Stanton.

#### 7 Questions from MR STANTON

8 **MR STANTON:** Thank you, my Lady.

9 Professor, I'll be asking you a small number of  
10 questions on behalf of the British Medical Association.  
11 I apologise for the slightly awkward positioning.  
12 Please don't feel any need to face me.

13 I'd like to bring to your attention a letter of the  
14 BMA as context for the questions I have. The letter is  
15 document INQ000097875.

16 At the fourth paragraph, I'll just read -- I beg  
17 your pardon, I should say the letter is addressed to  
18 Michael Brodie, who at the time was interim chief  
19 executive. You may not have seen this letter before,  
20 but it's possible you have, given your role.

21 The fourth paragraph reads:

22 "There are significant and growing concerns about  
23 the role of aerosol transmission of COVID-19 in  
24 healthcare settings, and the need for wider use of RPE  
25 (for example, FFP3 respirators) outside of those  
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1 guidance for those who were in the context of what were  
2 known to be aerosol-generating procedures, and certainly  
3 a precaution around the importance of social -- of  
4 distancing, and, where at all feasible, the use of face  
5 coverings.

6 Now, that came again to a discussion later in 2020,  
7 and I am aware of this letter in 2021 which Mr Brodie  
8 received. He did ask for -- the guidance that had been  
9 produced around this letter was a four-country guidance  
10 and it was also NHS and DHSC, so it was the infection  
11 prevention and control group who had produced the  
12 guidance on what protective equipment was needed and  
13 aerosol procedures.

14 The IPC cell, this infection prevention control  
15 cell, was asked to look at that guidance again at the  
16 end of 2020, which they did. This also did this in  
17 conjunction with the New and Emerging Virus Group,  
18 NERVTAG, and they had a good look also at the evidence,  
19 because there was a lot of testing going on in various  
20 healthcare settings, this was about healthcare, and  
21 the testing had shown that actually -- this was in the  
22 context of the Alpha variant -- that there hadn't been  
23 an increase in serious illness among healthcare workers,  
24 but that healthcare worker to healthcare worker  
25 transmission was important, and therefore a CAS alert  
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1 had been issued, which I think Mr Brodie was able to  
2 advise the BMA, which recommended the strengthening of  
3 infection control procedures.

4 There was obviously an interest in ensuring that  
5 those who needed to use the highest level of equipment  
6 had access and did so, and guidance was produced on  
7 donning and doffing so that they could do so in the most  
8 effective way. But I can accept that this remained  
9 an area of serious concern throughout the pandemic.

10 **Q.** Thank you, Professor.

11 Professor, could you help clarify how infection  
12 prevention control guidance is produced? Is it written  
13 or was it written at the time by Public Health England?

14 **A.** Well, it's not entirely just by Public Health England.  
15 There is a national infection prevention control manual,  
16 and there is the four-country infection prevention  
17 control expert group, and there are a number of  
18 subgroups like NERVTAG which also advise on this.

19 So the infection prevention control guidance takes  
20 account of the current evidence, which was very dynamic.  
21 It is put together by the infection control  
22 prevention -- it is agreed by the infection control  
23 prevention group. Public Health England will write the  
24 guidance, and will brand it with the NHS and with DHSC,  
25 but it's often called Public Health England guidance,

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1 most exposed to dangerous situations, and that's what  
2 a lot of the guidance and the donning and doffing was  
3 also put out there to support.

4 **MR STANTON:** Thank you very much, Professor.

5 **LADY HALLETT:** Thank you, Mr Stanton.

6 Ms Morris.

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

8 My questions are on Operation Nimbus so, at the risk  
9 of knocking Mr Menon off his perch, I have also  
10 reflected and Mr O'Connor has dealt with the matters  
11 that I was going to deal with with Professor Doyle, but  
12 we agree with the Inquiry for the need for further  
13 inquiry to be made of the Cabinet Office and the CCS in  
14 particular in that regard. So, thank you.

15 **LADY HALLETT:** Very well. Whenever you and Mr Metzger --

16 I can't remember who else was asking about Nimbus, but  
17 anyway, whenever we have the answers to the questions in  
18 an agreed form, please let me know and if you wish them  
19 to be read out, then I'll be very happy to.

20 **MS MORRIS:** It may be for another witness in fact, my Lady.

21 **LADY HALLETT:** Right, okay. Thank you.

22 Sorry, Mr O'Connor.

23 **MR KEITH:** No. My Lady, that concludes the questioning for  
24 this witness, and also for today.

25 **LADY HALLETT:** Thank you very much indeed, Professor.

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1 but it is more than that.

2 **Q.** Thank you, Professor.

3 Professor, did you, over the period of the pandemic,  
4 whilst contributing to infection prevention control  
5 guidance, detect any reluctance to impose measures that  
6 might otherwise have been required for reasons of  
7 resource or operational strain that they might place on  
8 the NHS?

9 **A.** The whole pandemic was characterised by no easy  
10 decisions and the need to balance the least bad option,  
11 and sometimes that related to supplies and sometimes it  
12 related to scientific opinion, which wasn't always in  
13 agreement, and sometimes it simply related to the right  
14 thing to do that some parties didn't agree with. But  
15 there was always tension in these decisions, there was  
16 no easy decision.

17 So it is perfectly plausible that decisions had to  
18 be made that were certainly not optimal in normal times.

19 **Q.** Might decisions around the provision of FFP3 masks be  
20 one of those decisions, do you think?

21 **A.** Well, I can't really comment on this in great detail  
22 just now, but we were very conscious of the need to  
23 ensure that FFP3 masks were used in the places where  
24 they were most needed by the people who were --  
25 you know, healthcare workers particularly -- who were

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1 **THE WITNESS:** Thank you, my Lady.

2 **(The witness withdrew)**

3 **LADY HALLETT:** That completes the evidence for today, as

4 Mr O'Connor says, so we return at 10.30 on Monday. Is  
5 that right?

6 **MR O'CONNOR:** My Lady, yes.

7 **LADY HALLETT:** Thank you all.

8 **(5.00 pm)**

9 **(The hearing adjourned until 10.30 am**

10 **on Monday, 6 November 2023)**

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<b>MR KEITH: [11]</b> 77/8 77/15 80/1 95/3 100/13 100/24 147/1 147/5 147/12 152/17 215/23	<b>13 March [3]</b> 64/2 66/16 67/2 <b>11.10 am [1]</b> 47/25 <b>11.25 [1]</b> 47/24 <b>11.25 am [1]</b> 48/2 <b>12 [4]</b> 45/25 105/2 154/19 154/23 <b>12 February [5]</b> 32/13 34/18 36/18 39/2 188/8 <b>12 February 2020 [2]</b> 29/21 31/5 <b>12 June [1]</b> 204/15 <b>12 March [8]</b> 45/4 63/22 134/15 135/16 139/6 139/11 140/15 140/15 <b>12 weeks [1]</b> 42/1 <b>12,500 [1]</b> 44/20 <b>12.45 [1]</b> 95/2 <b>12.45 pm [1]</b> 100/20 <b>120 [1]</b> 95/21 <b>12th [2]</b> 140/12 149/10 <b>13 [3]</b> 6/15 159/4 159/5 <b>13 confirmed [2]</b> 155/11 159/16 <b>13 March [3]</b> 36/18 37/3 37/14 <b>14 April [1]</b> 32/12 <b>14/15 March [2]</b> 137/9 145/13 <b>148 [1]</b> 95/4 <b>15 [1]</b> 190/8 <b>15 April 2020 [1]</b> 75/6	<b>2 April 2020 [1]</b> 185/8 <b>2 January 2020 [1]</b> 181/1 <b>2 June 2020 [1]</b> 204/6 <b>2 March [2]</b> 133/13 133/22 <b>2 November 2023 [1]</b> 1/1 <b>2,700 [1]</b> 155/15 <b>2-3 [2]</b> 109/22 115/6 <b>2.55 pm [1]</b> 147/8 <b>20 March [2]</b> 146/14 146/15 <b>200,000 [2]</b> 41/24 46/22 <b>2011 [5]</b> 107/15 116/11 117/25 132/3 132/6 <b>2012 [3]</b> 2/19 2/22 181/20 <b>2014 [3]</b> 1/23 23/23 58/3 <b>2016 [2]</b> 56/13 60/7 <b>2017 [1]</b> 160/10	<b>3 February [1]</b> 23/1 <b>3 March [5]</b> 38/7 128/20 131/21 133/25 135/4 <b>3 March 2020 [1]</b> 38/4 <b>3-5 days [1]</b> 110/2 <b>3.05 [1]</b> 147/6 <b>3.05 pm [1]</b> 147/10 <b>30 [2]</b> 49/7 96/5 <b>30 April [3]</b> 49/4 49/25 76/10 <b>30,000 [7]</b> 46/15 46/18 46/21 46/24 47/2 64/21 65/10 <b>30,000 patients [1]</b> 44/7 <b>300 [1]</b> 185/15 <b>300 scientists [1]</b> 185/12 <b>300,000 [2]</b> 110/24 111/11 <b>31 [1]</b> 63/3 <b>31 March [1]</b> 162/3 <b>31 March 2020 [1]</b> 161/24 <b>32 [1]</b> 64/20 <b>33 [1]</b> 192/4 <b>330 [1]</b> 44/4 <b>331 [1]</b> 44/4 <b>36 [1]</b> 63/3 <b>39 [2]</b> 19/9 94/25 <b>3rd [1]</b> 119/19	<b>3</b>
<b>MR MENON: [2]</b> 174/2 174/6	<b>13 confirmed [2]</b> 155/11 159/16 <b>13 March [3]</b> 36/18 37/3 37/14 <b>14 April [1]</b> 32/12 <b>14/15 March [2]</b> 137/9 145/13 <b>148 [1]</b> 95/4 <b>15 [1]</b> 190/8 <b>15 April 2020 [1]</b> 75/6	<b>2</b>	<b>4</b>	
<b>MR METZER: [7]</b> 69/22 73/3 164/6 169/9 169/12 170/21 170/23	<b>13 March [3]</b> 36/18 37/3 37/14 <b>14 April [1]</b> 32/12 <b>14/15 March [2]</b> 137/9 145/13 <b>148 [1]</b> 95/4 <b>15 [1]</b> 190/8 <b>15 April 2020 [1]</b> 75/6	<b>2</b>	<b>4.22 pm [1]</b> 196/7 <b>4.27 pm [1]</b> 196/9	
<b>MR O'CONNOR: [11]</b> 1/4 1/8 47/22 48/4 53/9 76/23 175/1 196/2 196/11 208/13 216/6	<b>13 March [3]</b> 36/18 37/3 37/14 <b>14 April [1]</b> 32/12 <b>14/15 March [2]</b> 137/9 145/13 <b>148 [1]</b> 95/4 <b>15 [1]</b> 190/8 <b>15 April 2020 [1]</b> 75/6	<b>2</b>	<b>5</b>	
<b>MR STANTON: [2]</b> 210/8 215/4	<b>13 March [3]</b> 36/18 37/3 37/14 <b>14 April [1]</b> 32/12 <b>14/15 March [2]</b> 137/9 145/13 <b>148 [1]</b> 95/4 <b>15 [1]</b> 190/8 <b>15 April 2020 [1]</b> 75/6	<b>2</b>	<b>5 February [1]</b> 114/21 <b>5 July 2020 [1]</b> 70/9 <b>5 June [1]</b> 164/21 <b>5 June 2020 [1]</b> 169/1	
<b>MR WEATHERBY: [2]</b> 53/15 62/3	<b>13 March [3]</b> 36/18 37/3 37/14 <b>14 April [1]</b> 32/12 <b>14/15 March [2]</b> 137/9 145/13 <b>148 [1]</b> 95/4 <b>15 [1]</b> 190/8 <b>15 April 2020 [1]</b> 75/6	<b>2</b>		
<b>MR WILCOCK: [1]</b> 210/3	<b>13 March [3]</b> 36/18 37/3 37/14 <b>14 April [1]</b> 32/12 <b>14/15 March [2]</b> 137/9 145/13 <b>148 [1]</b> 95/4 <b>15 [1]</b> 190/8 <b>15 April 2020 [1]</b> 75/6	<b>2</b>		
<b>MS CAMPBELL: [2]</b> 152/23 163/25	<b>13 March [3]</b> 36/18 37/3 37/14 <b>14 April [1]</b> 32/12 <b>14/15 March [2]</b> 137/9 145/13 <b>148 [1]</b> 95/4 <b>15 [1]</b> 190/8 <b>15 April 2020 [1]</b> 75/6	<b>2</b>		
<b>MS HARRIS: [3]</b> 62/7 62/9 69/17	<b>13 March [3]</b> 36/18 37/3 37/14 <b>14 April [1]</b> 32/12 <b>14/15 March [2]</b> 137/9 145/13 <b>148 [1]</b> 95/4 <b>15 [1]</b> 190/8 <b>15 April 2020 [1]</b> 75/6	<b>2</b>		
<b>MS MITCHELL: [1]</b> 208/20	<b>13 March [3]</b> 36/18 37/3 37/14 <b>14 April [1]</b> 32/12 <b>14/15 March [2]</b> 137/9 145/13 <b>148 [1]</b> 95/4 <b>15 [1]</b> 190/8 <b>15 April 2020 [1]</b> 75/6	<b>2</b>		
<b>MS MORRIS: [2]</b> 215/7 215/20	<b>13 March [3]</b> 36/18 37/3 37/14 <b>14 April [1]</b> 32/12 <b>14/15 March [2]</b> 137/9 145/13 <b>148 [1]</b> 95/4 <b>15 [1]</b> 190/8 <b>15 April 2020 [1]</b> 75/6	<b>2</b>		
<b>THE WITNESS: [4]</b> 77/2 100/17 174/17 216/1	<b>13 March [3]</b> 36/18 37/3 37/14 <b>14 April [1]</b> 32/12 <b>14/15 March [2]</b> 137/9 145/13 <b>148 [1]</b> 95/4 <b>15 [1]</b> 190/8 <b>15 April 2020 [1]</b> 75/6	<b>2</b>		
'	<b>13 March [3]</b> 36/18 37/3 37/14 <b>14 April [1]</b> 32/12 <b>14/15 March [2]</b> 137/9 145/13 <b>148 [1]</b> 95/4 <b>15 [1]</b> 190/8 <b>15 April 2020 [1]</b> 75/6	<b>2</b>		
'to [1] 64/21	<b>13 March [3]</b> 36/18 37/3 37/14 <b>14 April [1]</b> 32/12 <b>14/15 March [2]</b> 137/9 145/13 <b>148 [1]</b> 95/4 <b>15 [1]</b> 190/8 <b>15 April 2020 [1]</b> 75/6	<b>2</b>		
<b>1</b>	<b>13 March [3]</b> 36/18 37/3 37/14 <b>14 April [1]</b> 32/12 <b>14/15 March [2]</b> 137/9 145/13 <b>148 [1]</b> 95/4 <b>15 [1]</b> 190/8 <b>15 April 2020 [1]</b> 75/6	<b>2</b>		
<b>1 July [1]</b> 164/24 <b>1 March [1]</b> 138/19 <b>1.45 [1]</b> 100/19 <b>1.45 pm [1]</b> 100/22 <b>10 [17]</b> 10/9 11/8	<b>13 March [3]</b> 36/18 37/3 37/14 <b>14 April [1]</b> 32/12 <b>14/15 March [2]</b> 137/9 145/13 <b>148 [1]</b> 95/4 <b>15 [1]</b> 190/8 <b>15 April 2020 [1]</b> 75/6	<b>2</b>		

<b>5</b>	<b>above [1]</b> 41/25 <b>abroad [1]</b> 200/18 <b>absence [1]</b> 135/8 <b>absolute [2]</b> 35/2 80/2 <b>absolutely [13]</b> 4/25 13/12 30/13 49/12 54/16 55/9 72/6 94/9 114/16 120/18 150/20 169/6 194/20 <b>absorbed [1]</b> 180/2 <b>accelerate [3]</b> 143/3 143/4 143/13 <b>accept [12]</b> 46/6 46/15 93/20 97/1 98/3 99/11 119/21 123/11 147/24 148/25 162/12 213/8 <b>accepted [5]</b> 17/3 117/13 117/14 142/13 205/19 <b>accepts [1]</b> 139/11 <b>access [1]</b> 213/6 <b>accidental [1]</b> 86/7 <b>accompanying [1]</b> 165/6 <b>accord [1]</b> 11/11 <b>accordingly [1]</b> 171/16 <b>account [11]</b> 14/25 17/7 48/22 49/23 68/5 68/6 68/11 68/13 76/16 169/20 213/20 <b>accountability [1]</b> 4/9 <b>accountable [2]</b> 3/22 4/6 <b>accounting [3]</b> 3/23 4/12 80/11 <b>Accounts [1]</b> 172/6 <b>accredited [1]</b> 153/12 <b>accruing [1]</b> 185/24 <b>accuracy [3]</b> 92/3 133/19 202/7 <b>accurate [3]</b> 20/8 87/20 202/14 <b>accusation [1]</b> 85/13 <b>accusations [2]</b> 28/12 28/13 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<p><b>Y</b></p> <p><b>you know [32]</b> 7/25 15/16 15/23 18/9 21/23 35/2 35/5 35/5 39/24 41/4 41/24 68/3 71/6 75/23 82/19 86/10 87/5 89/23 89/25 90/7 99/22 106/25 107/7 135/24 138/5 151/14 184/8 202/19 205/21 207/6 211/20 214/25</p> <p><b>you'll [9]</b> 11/11 77/21 90/12 97/7 106/22 112/9 139/23 155/7 207/14</p> <p><b>you're [36]</b> 1/13 8/12 9/19 13/4 28/16 34/15 34/17 35/21 41/20 41/22 43/14 50/13 55/5 56/7 58/11 61/11 66/24 72/24 77/9 80/10 93/5 93/12 106/23 112/4 114/22 119/15 122/7 127/5 152/6 161/5 161/6 165/4 166/24 189/19 206/11 208/18</p> <p><b>you've [35]</b> 1/15 6/6 6/7 6/12 7/15 11/9 13/13 15/1 31/22 32/9 39/1 63/9 77/22 85/25 100/12 107/9 112/14 126/23 131/7 155/20 156/11 157/22 157/23 161/3 168/12 169/3 174/7 174/15 177/19 183/23 191/12 194/16 195/6 206/20 209/5</p> <p><b>young [1]</b> 164/16</p> <p><b>your [150]</b> 1/8 2/2 2/9 2/15 3/20 4/5 6/2 6/7 6/14 6/15 7/15 7/16 8/11 9/19 10/14 11/7 11/11 13/7 13/14 14/1 20/2 20/2 22/1 25/8 25/18 25/20 27/15 28/1 28/21 29/9 31/11 33/8 33/14 34/18 37/13 37/17 38/22 38/25 40/17 43/5 45/24 46/3 46/7 46/7 50/12 52/6 53/20 54/23 57/1 63/2 63/15 64/4 69/9 70/1 70/8 70/22 71/1 72/13 74/5 75/7 77/1 77/15 77/22 78/4 79/12 82/20 84/1 84/1 84/4 84/11 85/16 88/18 88/24 89/19 90/22 92/2 92/2 92/5 92/9 94/6 94/9 101/11 102/7 103/24 103/25</p>	<p>104/3 106/8 112/20 112/24 113/23 117/12 123/8 130/6 131/3 131/3 131/3 135/1 136/7 136/14 141/19 141/25 146/11 147/18 151/8 153/2 153/3 153/8 155/4 155/20 155/21 156/17 156/21 157/18 158/16 159/3 161/23 162/3 162/17 164/1 166/2 167/5 167/6 168/12 169/18 173/9 175/1 175/14 175/18 176/6 178/8 178/11 179/5 180/24 181/11 182/16 184/22 190/11 192/3 192/5 192/6 198/20 199/6 200/25 202/13 202/24 208/23 209/5 210/13 210/17 210/20</p> <p><b>yourself [13]</b> 15/6 80/9 80/10 101/17 102/14 111/21 112/9 121/7 125/5 135/4 173/2 174/7 188/10</p> <p><b>YVONNE [3]</b> 174/24 175/2 217/25</p> <p><b>Yvonne Doyle [1]</b> 175/2</p>			
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