Tuesday, 21 November 2023

| (10.00 am) | 2 |
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| LADY HALLETT: Mr Keith. | 3 |
| MR KEITH: My Lady, today's witness is Professor Sir | 4 |
| Chris Whitty. Could he be sworn, please. | 5 |
| PROFESSOR SIR CHRIS WHITTY (sworn) | 6 |
| Questions from LEAD COUNSEL TO THE INQUIRY | 7 |
| LADY HALLETT: Sir Chris, may I give the same apology to you | 8 |
| as I gave to Sir Patrick yesterday, I'm sorry that we | 9 |
| have to keep imposing on your time. Thank you for all | 10 |
| your help. | 11 |
| THE WITNESS: Thank you. | 12 |
| MR KEITH: You are of course Professor Sir Chris Whitty. | 13 |
| A. I am. | 14 |
| Q. Professor, thank you for, again, the assistance that you | 15 |
| have already afforded the Inquiry by way, this time, of | 16 |
| further witness statements. You've provided a corporate | 17 |
| witness statement dated 15 August 2023, we needn't bring | 18 |
| it up, a fourth witness statement dated 22 August 2023, | 19 |
| together they run to hundreds, I think around about | 20 |
| 340 pages, and you've produced for us hundreds of | 21 |
| primary documents as befits, of course, the magnitude of | 22 |
| your role in the response to the pandemic. | 23 |
| I'd like to start, please, with your qualifications | 24 |
| and to detail some of your professional background. | 25 | 1

Novichok poisonings; is that right?
A. That's right.
Q. Most importantly, you were appointed Chief Medical Officer for England on 1 October 2019, and you held that post of course throughout the period considered by this Inquiry.
A. Yes.
Q. Do you remain the Chief Medical Officer?
A. I do.
Q. We know from evidence that you co-chaired SAGE with

Sir Patrick Vallance during the pandemic and you played a very significant and often public role in response to the Covid-19 pandemic.

There is in your statement a reference to the fact that, in addition, you were head of the National Institute for Health Research, and I want to just depart for a moment from the chronology to look at what the nature of the NIHR is and what you did as its CEO.

What is the NIHR?
A. So the NIHR is the largest of the government funding bodies for medical research, and specifically it concentrates on practical medical and clinical research. The more basic science tends to be done by the Medical Research Council. Together they form the government's contribution to medical research in the UK in terms of

You are an epidemiologist and physician specialising in infectious diseases. You are or have been an NHS consultant physician in infectious diseases and tropical medicine at the UCL Hospitals NHS Trust and at the Hospital for Tropical Diseases. You hold a medical degree, a doctorate and a degree in physiological sciences all from the University of Oxford. You hold masters in epidemiology from the University of London, as well as an MBA and LLM in medical law and diplomas in economic and tropical medicine and hygiene.

You were, I think, for a while, professor of public and international health at the London School of Hygiene and Tropical Medicine, and you are a fellow of the Royal College of Physicians, the Faculty of Public Health, the Academy of Medical Sciences and honorary fellow of a significant number of other learned bodies. Have I got it about right?
A. Correct.
Q. Most relevantly for our purposes, you were also the Chief Scientific Adviser to the Department for International Development between 2009 and 2015, and the interim Government Chief Scientific Adviser and head of the Government Office for Science between 2017 and 2018.

You co-chaired SAGE during the Zika epidemic in 2016, and you chaired SAGE in respect of the 2018

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funding. And as you know, and I think most people know, the UK is very strong in this area, and I think this was important during Covid.
Q. As you give evidence, Sir Chris, may I just ask you to slow down a little bit. Our stenographer, who is absent and is working remotely, will need to of course keep up with what you say.

The relevancy of the NIHR and the discharge by you of your role as CEO is that in the early stage of the pandemic, in March 2020, did the NIHR -- was it able to achieve funding for certain important areas of research related to the possible response to the pandemic?
A. Yes. So from quite early, from late January, we were planning to do this, we made the first calls with the UK research organisations, particularly MRC, in early February, and actually had studies up and running in March. So this was important in the way we were able to respond to the pandemic.
Q. Was funding provided for a number of different areas, including clinical trials, phases of what then became the Oxford-AstraZeneca vaccine, funding for CO-CIN, which the Inquiry has heard is a system by which data was collected from hospitalised patients, and also for something called the Covid-19 Genomics UK Consortium, which provided vital research in relation to the

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sequencing of Covid-19 variants?
A. Some of that was NIHR funding, some was from a combined funding group that Sir Patrick Vallance and I together controlled, but the same in practice applies. And I think we should add one more: there are many other studies that were covered but I think a very important one was the RECOVERY Trial, which was the first to demonstrate that dexamethasone significantly reduced mortality in Covid.
Q. Is dexamethasone what is known as an antiviral or at least a therapeutic which became extremely important in being able to provide support to patients who were ventilated or who were receiving oxygen?
A. It's a therapeutic, it was an anti-inflammatory steroid but it led to a significant reduction in mortality for those who were on oxygen.
Q. So drawing back from and looking at it overall, did your ability to be CMO as well as CEO of NIHR, did it assist you in being able to respond strategically to the demands of the pandemic?
A. I think that it was slightly double-edged, Mr Keith. I mean, I think that overall my view is that it was beneficial because it allowed me to combine the strategy for the research, which I directly controlled, with the overall strategy for Covid. Of course, by having two 5

CMO England is also the UK Government medical adviser,
is there are a small number of areas, mainly of international importance, where it is the UK Government that leads rather than individual nations. But for practical purposes it's England that was the majority of my responsibilities.
Q. Is the CMO a professionally independent position?
A. Yes.
Q. Do you have a line manager? Do you report officially to another individual or entity?
A. I report up to the permanent secretary, but I don't think the permanent secretary or indeed anyone else would wish to infringe the independence of the role of the Chief Medical Officer, which is a long-established one, going back to the 1860s.
Q. So the CMO's been giving advice to government on public health and clinical matters since that time, 1855 in fact?
A. Yes.
Q. All right.

Do you also sit on the executive committee and the board of the Department of Health and Social Care?
A. I do.
Q. Are you also part of the collective leadership of the medical profession which requires you, therefore, to
roles it did mean that I was quite stretched so there were arguments either way, but I think it did actually overall help me in helping to make the response effective and quick.
Q. And then turning to some aspects of the role of the Chief Medical Officer, does the Chief Medical Officer act essentially as the United Kingdom Government's principal medical adviser?
A. Yes
Q. Are you the professional head also of the public health profession in England?
A. Yes, not the managerial head, but I am the professional head, yes.
Q. So you provide public health and clinical advice to the Prime Minister, to ministers, directly to the DHSC, and that includes of course its Secretary of State and permanent secretary, and other senior officials across government?
A. That's correct.
Q. It's important to emphasise, isn't it, that you are the CMO for England? Is that because health is essentially a devolved matter and therefore there are CMOs in the other nations of the United Kingdom?
A. That is exactly correct. I think the one slight difference in terms of the UK role, because the 6
meet with the presidents and the chairs of the medical royal colleges, and also with the NHS?
A. One of the things I was very keen to do in Covid was to ensure that it was seen there was a collective leadership of the medical profession. It's not exactly defined, but I think it is essentially the senior people in the royal colleges, the General Medical Council and the senior clinical people in government.
Q. The Inquiry is of course well aware that there are also deputy chief medical officers. The DCMOs support you, the Chief Medical Officer, but as senior medical advisers are they also functionally independent?
A. Yes.
Q. And do they provide advice similarly on public health and clinical matters?
A. They do.
Q. Are the roles of the DCMOs separated in any way?
A. Under ordinary circumstances, there is a principal DCMO for health protection, so that would be major infections, but also other emergencies, and one for health improvement, which would be things like strokes, heart attacks and so on. During the Covid pandemic this distinction was almost entirely blurred, but under ordinary circumstances that's the normal situation.
Q. Because all of them lent their collective and impressive
weight to the demands of the pandemic?
A. Yes.
Q. I think there were three full-time DCMOs in post during the pandemic: Professor Sir Jonathan Van-Tam, from whom we'll be hearing in due course, I think tomorrow; also Professor Dame Jenny Harries, from whom we'll be hearing; and Dr Thomas Waite and Dr Aidan Fowler, who led on a variety of different aspects of the clinical and medical advice that's given to government?
A. That's correct.
Q. All right.

Just before we turn to the mechanics of the first two months of the pandemic, was there any significant difference between you and the DCMOs in relation to who initially responded to the emerging news of an epidemic within China?
A. So the very first parts of the knowledge about Covid, right at the beginning of January, the response was led very clearly by Professor Van-Tam, as the health -quite rightly, as the health protection DCMO, but in co-ordination with me.

As the probability of this becoming a significant threat to the UK rose, I took an increasingly prominent role, and by the time I think we were clear that this was the biggest threat we were potentially facing,
A. Yes.
Q. There really wasn't any area to do with the clinical and public health response to the pandemic upon which you did not advise?
A. I'd put it more -- a bit more constrained than that, actually. Where I thought we added value was where having a doctor or a scientist giving an opinion was going to be useful.

We were flooded with requests, many of which in my view were actually about policy, and we tried to avoid those areas. So the question really should always be: why does a doctor or a scientist need to answer this? And if the answer was "it's not obvious it needs to go to them", we tried to encourage other people to do it, remembering that in total, at the absolute peak, the office had less than 20 people in it, including myself and the DCMOs. So we had to constrain what was done. But we could range wherever we felt public health, clinical advice or science was relevant.
Q. But by and large, requests from central government were required to be responded to, there wasn't a question of the CMO saying, "This is an area upon which I'm simply not going to advise, albeit it's an area of public health or clinical importance"?
A. Quite frequently we would say, "This is an area that

I took the leading role, but very much with
Professor Van-Tam and, in due course, Professor Harries.
Q. Did you start to take that lead role in late February, early March, or at an earlier stage?
A. I would say I was probably taking the lead role in terms of central government by the end of January.
Q. Looking at the nature of the advice that you gave to central government and the means by which you gave it, could we have, please, your statement, INQ000248853 on the screen at pages 50 and 51 .

We can see there, Professor, some examples of the areas upon which you advised. You advised on the accuracy of risk assessments, on the re-opening of closed sectors, comments on Prime Ministerial speeches, and then, over the page, on the roadmap, on national/local messages, Tier 3 and the use of a circuit breaker.

Then if we go over to 52 , we can see "Specific areas of advice", upon which the Office of the Chief Medical Officer -- is that the office within which you and your colleagues, the deputy chief medical officers, work?

You advised on indirect causes of mortality, principles behind the 2-metre social distancing provision, ethnicity, schools, holidays, variants, and so on and so forth?

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doesn't look appropriate for us". This wasn't because we thought it was wrong, we just thought we were not the right people to give the advice.
Q. You worked also very closely with expert advisory groups, with scientific and medical colleagues in government, with PHE, and so on and so forth. Did you attend a vast number of central government meetings?
A. Yes.
Q. If we could have your fourth statement, INQ000251645, at page 61, we can see there at paragraph 6.2 a description of the sorts of meetings that you attended: COBR (M), COBR (O), Cabinet as required, the MIGs and, over the page, Covid-S, Covid-O, the "quad" meetings, meetings of course with the Secretary of State for Health and Social Care, and a multitude of other meetings with the Prime Minister and his advisers and with UK CMOs.

Focusing just for a moment on the Department of Health and Social Care, did you meet formally throughout the period of the pandemic with the Secretary of State for Health and the permanent secretary?
A. I did.
Q. I think you met around about 233 times according to your statement. Did the CMO therefore, yourself, did you formally feed, therefore, into the DHSC decision-making process? So were you part of the functional structure 12
within the DHSC by which it responded to the pandemic?
A. Where a clinical, scientific or public health opinion was needed, yes.
Q. Were you therefore what was known as "silver" within the command structure within the DHSC?
A. I think that makes it sound slightly different to how I, at that time, perceived it, but I was the person who chaired the technical meetings, which collected and gave technical advice to the Secretary of State at various points along the path of the pandemic, particularly at the stage where there were regional approaches to the Covid pandemic.
Q. All right.

We will see in due course that you were also responsible for the clinical alert system or at least for promoting the use of that system and for the sending out of alerts throughout England in relation to the pandemic.

Did you also meet with a number of experts and scientific and medical peers internationally?
A. I did, I met with many.
Q. Did you meet repeatedly with officials from the World Health Organisation?
A. I did, including going to the World Health Organisation and meeting the Director-General. 13
given time there was usually several countries that were actually at the leading edge and where their experts were working flat out, I think it worked as well as reasonably could be expected.
Q. So will you give us, please, then, some indication of the areas in which you were particularly assisted, the emergence of the Delta wave in India, or the Omicron wave in South Africa?
A. At each one of the waves inevitably we got our first information from people in-country. Sometimes, for example with the Omicron wave, with the Delta wave, I and my colleagues had direct bilateral discussions, and they were extremely generous with senior scientists in those countries. And in the original Wuhan wave we had some direct interactions but a lot more indirect. And of course we relied for our early understanding of this on Chinese science and then subsequently science from other countries, for example Italy. In time we ended up having multiple routine groups of scientists across Europe, colleagues from the US, Australia, New Zealand, for example, there were many different groupings, but they were -- these were all ways of us sharing information bilaterally. And of course when we had the Alpha wave, which was first detected in the UK, most countries wanted to get information from the UK,
Q. Some have suggested that there was a general failure on the part of England and the United Kingdom to liaise sufficiently with overseas experts, with other countries, with other systems that were responding in their own ways to the pandemic. Did you in fact keep yourself extremely well informed throughout the pandemic as to how other countries were responding and also as to the technical and scientific medical information which they were accruing?
A. We did, and we were absolutely dependent on that. And I would say there were kind of three levels of interaction: there were bilateral meetings I had with particular experts at particular times; there were meetings of groups where -- for example, the World Health Organisation would organise a group of people to come together and give advice from all around the world, as an efficient way of passing on information; and then there were either publications or indirect links, because many people in the UK have very good international links, and then they would feed in to us. So we were getting information internationally from multiple routes and, as I say, were dependent on it.
Q. Do you consider that the system of international collaboration worked extremely well?
A. I think against what was realistic, given that at any 14
and we tried again to provide that both bilaterally and in multilateral fora.
Q. So on that occasion the information flow was the other way?
A. Yes.
Q. You have in your statement provided some details of the number of meetings that you attended. I believe you had around 44 meetings between January 2020 and July 2020 with the representatives of other countries, and between August 2020 and February 2022 you participated in a further 107 international meetings, we presume multilateral meetings?
A. That's correct. But it's also important to stress that a lot of information in medicine is passed on in written form, by papers, by emails, by alerts of different sorts. So this is only -- the direct meetings were only part of the way we were learning from the international experience.
Q. You have described how you were the chair of SAGE. You were of course the co-chair with Sir Patrick Vallance. Was he the principal chair of SAGE?
A. We agreed at the beginning that it would be much more efficient for one person to actually chair the meetings if they were present, and Sir Patrick was at virtually all of them. So he chaired them. Occasionally I would 16
one between waiting and wading in, between yourself and Sir Patrick in those early weeks of January and into February of 2020.

Did he overstate the position? Was there a degree of difference between you?
A. Well, Sir Jeremy, who is a good friend and colleague, had a book to sell and that made it more exciting, I'm told. My own view was that actually the differences were extremely small, and the main one, and Sir Patrick I thought put it very well, was that I saw as part of my role within SAGE, as -- and this is my first role -- as an individual, to reflect some of the very significant problems, for particularly areas of deprivation, I saw from many of the actions that we were taking in terms of what was going to be advised to ministers to consider for what they did next.

And I think that was an appropriate thing for me to do, and Sir Patrick also thought it was appropriate. Inevitably it meant that we appeared to have slightly different starting points in SAGE, but the end product was the SAGE view and we reflected the SAGE view when we went to ministers. Which was, in my view, the correct way to do it.
Q. You refer in your own statement to the fact that there are risks associated with undercalling a crisis,

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chair them if he wasn't there. But we would agree agendas, agree minutes, and, I think most importantly actually, try accurately to reflect the output of SAGE to policymakers together, as co-chairs, and to agree what we -- where we felt the centre of opinion at that point in time was.
Q. We're going to come and look at that process by which advice and information from SAGE was funnelled through yourself and Sir Patrick to central government in a moment, but just focusing on your overarching approach to SAGE and your working relationship with Sir Patrick, did you try to formulate a common position in relation not just to the funnelling of advice from SAGE but to the technical advice that you both gave to government?
A. Yes. And I think it's important to, in a sense, differentiate. I felt I had two roles with SAGE. In one role I was actually a member of SAGE and had expertise in areas that were complementary to other people and gave an opinion as myself, if you wish, as an expert in this field. But once the agreement had been made and the minutes were agreed and we'd agreed where the central position was, I would then try accurately to reflect the views of SAGE as a body rather than my own views, because I thought that was -otherwise, in a sense, why have the extraordinarily
effective, in my view, model of SAGE sitting on top of expert committees, sitting on top of a large scientific effort, so funnelling up. So very much once we had agreed a SAGE position, that was Sir Patrick's position and that was my position.
Q. It's self-evident that the ramifications of this epidemiological and public health crisis were enormous, these were difficult and nuanced issues, there must have been room for a wide spectrum of advice to be given; was it not in practice quite difficult to ensure that yourself and Sir Patrick were singing always from the same hymn sheet?
A. Well, I mean, I think we spent -- firstly, the SAGE process of course helped because a lot of discussions were had in that group and different ideas could then be tested more widely. Where we were unsure or where we were having to give advice in advance of SAGE or in an area where SAGE was unlikely to work, we did everything we could to have our discussions before we gave the advice to ensure that we'd thrashed it out and had a common position to put to the Prime Minister or other ministers as needed.
Q. You will be aware from the evidence given by Sir Patrick Vallance that in his book Jeremy Farrar observed that there was a friction, a tension perhaps, 18
for example missing the start of a major epidemic or failing to get ahead of it, and overcalling, so leading, I suppose, to multiple false alarms.

Sir Patrick, in his dairies, and again Jeremy Farrar in his book, refer to a tendency on your part to be perhaps more cautious than Sir Patrick, to a tendency to wait, perhaps with the experience of your long and highly distinguished career in this field, to wait to see how things pan out, that -- to recognise that you've seen it all before and we must be cautious and wait to see what the data tells us. Would you agree that, by contrast to Sir Patrick, that was more the stance that you took?
A. I think we should be very careful of the narcissism of small differences here. The differences were small, but my -- I did have a stronger concern, I would say, than some, that the biggest impacts of everything we did, and I was confident we were going to have to do them to be clear, but when we started the disadvantages of all the actions, not just full lockdown but other actions before that, for example what was initially called cocooning and then shielding, as an example, stopping schooling is another, the biggest impacts of those would be in areas of deprivation and those in difficulties and those living alone and so on. So I was very aware that we 20
essentially had two different things we were trying to balance, the risk of going too early, in which case you get all the damages from this with actually fairly minimal impact on the epidemic, and the risk of going too late, in which case you get all the problems of the pandemic running away.

Now, as we will I'm sure come on to, my view is, with the benefit of hindsight, we went a bit too late on the first wave, and I've been clear about that for some time. We can come on to the reasons for that. But the idea that there was not some tension between those two and that you could somehow go without cost earlier than was needed I think was incorrect.

And again, everyone around the SAGE table would have agreed with that position. The degree of weighting -I'm talking here in terms of putting weight, rather than wait as in time -- between those two inevitably varied a bit between people and I was probably further towards: let's think through the disadvantages here before we act, and also in making sure that in giving my advice that ministers were aware of both sides of the equation.
Q. You've referred there to the very well known harmful consequences of intervention, to the damage done economically, societally, by non-pharmaceutical interventions. Were those issues not, however, 21
public health, and I don't think any public health expert would disagree that they are, they might disagree on the exact approach I or others took but I think the principle that those are firmly within the scope of public health I think is widely accepted.
Q. Inherent in this system, in this process, and in the government's response, is this very difficult balance between the public health obligation to reduce mortality, directly and indirectly, to stop the number of deaths, stop the number of indirect deaths that might be brought about by, for example, a collapse in the NHS system, against the harmful indirect societal consequences of intervention.

In those early days, in January and February, was there not a greater need to get on top of the first side of the balance, to make sure that in public health and epidemiological terms everything had to be done to reduce direct and indirect mortality, as opposed to focusing on the indirect consequences of intervention?
A. Well, I think that one of the problems with that argument is if you get -- up to and including the beginning of certainly March, we didn't have any mortality in the UK, and we'd only just in fact heard evidence of internal transmission. There then is a very difficult period, really from the beginning of March
something better for government to resolve, these being intensely political decisions, as opposed to the CMO, who of course is primarily concerned with public health and clinical matters? Were you entitled to weigh up the adverse consequences of early intervention when advising on public health and clinical matters?
A. So the point you make is absolutely correct. I was not only entitled but should have and did weigh up the negative aspects from a public health point of view. It was no part of my job, nor did I ever do this, to say: what are the wider economic, what are the wider social, what are the wider geopolitical questions? That was not my job.
Q. Sorry, I'm going to interrupt, please try to go a little slower.
A. Apologies.

So let us take some practical examples. The question of someone who goes into shielding before need and then ends up with loneliness, depression and so on, that is a clinical and public health problem. The problem of someone living on the borderlines of deprivation pushed over the edge into deprivation is a public health problem. Questions of the wider economy are not a public health problem and were not for me, but the first two in my view firmly are within the realms of 22
till the 16th and then 23 March, where the exact point along that path where the intervention should happen was a matter for legitimate technical debate from a public health point of view. Then after that there is a wider set of discussions, exactly as you say, on the wider impacts on the economy and society. Which are not for me, SAGE or others, this was not our role.

But in those, you know, those technical questions, what we should actually give in terms of the public health advice, you had to actually give both sides of that advice.

Let me give an example in a slightly different way, if I can try and make this clearer. If as a doctor you only say to someone "You need an operation", and you don't lay out to them all the things that will potentially go wrong with this operation, even if you think personally it's the right thing to do, you are failing in your medical role. In fact, if it came to a court, there would be a direction on that from the legal profession. So it is important that when giving advice you give advice on both sides of the equation. That is central, in my view. Additionally, you have to actually think through the public health implications.

One of the problems I had in thinking this through was I think some people were thinking that this was just 24
a matter of getting through a few weeks and then we're out and then it's all fine. My view was you had to think about this over the course of the epidemic as a whole, and that was clearly going to go on for a lot longer, hence why we put so much emphasis, for example, on research. My view was always that you were only going to get to a situation you would not have to consider NPIs, for the sake of argument, once you'd got medical countermeasures, so vaccines, drugs and other areas, and that was going to take some time, so you had to be able to do whatever you were doing for the period of time until, essentially, the cavalry came over the hill in the form of medical science.
Q. In that period before it became apparent that there were cases and then, subsequently, deaths in the United Kingdom, there are references to you in the email correspondence with government and also in meetings referring to the risks of overreaction. On 23 March, as late as 23 March, in a meeting with the Prime Minister, you were reported by Imran Shafi in his notes of that meeting to have said "Overreacting will have impact".

So I want to ask you: to what extent did the need for the accumulation of data, to be sure about what the position was, knowing the lie of the land before systemically the country reacted, impacted your 25
there was a danger that if the country went too soon, too rapidly, there would be other -- perhaps indirect but other significant consequences?
A. Well, I can only in a sense repeat what I've previously said. I was certainly not in any way deviating from the position of SAGE. That was the position of SAGE, we'd agreed it, and that was clear that the view of SAGE was if you wish to avoid loss of life you were going to have to act. It is certainly the case that you need to be clear that there are going to be downsides to that action, and indeed if you didn't give that advice, when the downsides emerged, which they surely would, then the ministers involved would be much more likely, in my view, to reverse position. So they need to have a firm foundation when they take an advice that this is -- if you wish to reduce loss of life, this is a path down which you are going to have to choose a number of very, very unpalatable options, but be aware of the fact that there are downsides, we are telling you that now, don't say in two months "I didn't know that", this is what the situation is now.

That, in my view, is an appropriate way to give advice. And I don't -- again, I doubt any doctor listening to this or any civil servant listening to this would disagree that is the appropriate way in which you 27
decision-making or rather your advice?
A. My advice was -- by the time that SAGE had advice my advice was the advice of SAGE, and the advice of SAGE at this point was extremely clear: that without action we were going to be in very deep trouble. And they'd said that from the 16th onwards really, in my view, extremely clearly.

You know, it is important that if you're -you know, in giving advice, that the downsides of the advice are also laid out. That is good medical practice. It's also actually, as it happens, good civil service practice. That is what you should do. It doesn't mean you do not think that the action should occur. And in my view, by the time we got to the 23 rd, the options available to ministers, unless they wished to see very heavy loss of life, were pretty narrow actually. But they needed to be aware of the downsides nevertheless.
Q. There is obviously a difference between advising on the downsides of a variety of options, different courses that could be taken, and a general appeal not to overreact, and it's that latter issue that I want you to address, please.

Did you, during that time, January, February, March, call the risks of overreacting? Did you call out that 26
give advice to a patient and it's the appropriate way to give advice to a minister. That's the correct thing to do.
Q. You've referred, Sir Chris, a couple of times now to the fact that you were merely relaying the position of SAGE. Did SAGE itself warn against the dangers of overreaction in those weeks from late January to early March?
A. I don't think that I would have used the phrase and certainly SAGE would have used the phrase
"overreaction"; what we'd have said is "Here are some downsides, and these are things you need to be aware of". And, you know, again to go back to my earlier point, the differences between different people on SAGE on this were not of "Are these downsides there?", et cetera. All of these things were agreed. There was some difference as to the degree of weighting people would put on them, but I don't think that was inappropriate. You know, again, it's important there is a serious debate about these things before a central position is put forward.
Q. Of course there is a debate and of course individual epidemiologists and advisers would naturally differ as to the speed with which the system was required to react, whether or not steps should be taken, whether or not further data should be accumulated and a better 28
understanding accrued. But the material does appear to suggest that you were prominent in calling out the risk of overreaction, and that, as Sir Patrick Vallance has suggested, you were more cautious than others in wanting to wait to see how things would eventuate.
A. So l've --
Q. Is that fair?
A. No. I've rejected and I will continue to reject your characterisation of this as "overreaction", because that implies I thought in a sense the action should not happen. What I thought should happen is that people should be aware that without action that very serious things would occur, but the down sides of those actions should be made transparent. I don't consider that's incorrect, and I actually don't think that that was -and, you know, Sir Patrick was in a sense saying exactly that, that the advice we gave was identical but the debate we had about this was how do we actually get the balance of these clearly in front of people. And that's an appropriate thing to do.
Q. In principle, and obviously you've explained very clearly what your position was, but in principle, if generically the response of government was too cautious or the advice that was given was too cautious, can that in the field of pandemics, in the field of 29
Q. You gave a presentation at the Royal College of 1

Physicians on 12 February, and if we could just have up a note of what you said, INQ000274050.

I'm bound to say, you expressed in beautiful
language, Professor, the dichotomy that was faced both by you and of course by the system generally when dealing with this pandemic, by saying these words:
"And then we will come out the other side and at the other side one of two things will happen ... either I will be with [some colleagues] in front of the committee or inquiry explaining why it is that we failed to prepare adequately for this armageddon (which actually would not be an armageddon) [I think that was a technical explanation] or we will be sitting in front of the committee saying why did you spend all this money on an epidemic which never happened. Those are the two solutions and I am basically ready for either of them."

Is that -- obviously this is an excellent demonstration of gallows humour, Professor, but does that reflect, do you think, fairly the dichotomy which is faced, which was faced by you and your colleagues and by the government?
A. Well, I think it's important to put some context on this. I actually stand by what I said but I'm going to explain it. And, I should say, here we are, so this was 31
epidemiological study, lead to government responses being behind the curve? So, putting it another way, antithetic to the notion of which the Inquiry has heard quite a bit, that when dealing with pandemics, the precautionary principle demands that you go early and you go hard?
A. So I think that some of the evidence to the Inquiry on the precautionary principle misunderstands it quite profoundly actually.

So the precautionary principle is useful if you're dealing with something where there are, for practical purposes, no downsides, or very minimal downsides relevant to the advantages, in which case the argument has got to be: well, just go ahead and do it.

So an obvious example was advice to people to wash their hands. There is no downside to do that, it's a good thing to do. The more you get into things where there is significant cost -- I do not mean that in an economic sense, I mean cost to individuals, cost to families, in terms of their health, mental health and so on -- the less you can say, "Well, it's just a precautionary principle, I'm going to impose this on you just in case"; that's not an appropriate understanding of what precautionary principle is or should be.

30
not an entirely unfair thing to say.
The -- I was giving a talk to the medical profession at a point where we were over two weeks, I think from memory, before the first internally transmitted case in the UK, more than three weeks before the first death in the UK, and in fact before the first death in Europe from Covid. So my point at this stage to them was -this in a sense was part of a two-hour briefing in which I and colleagues were laying out the science and saying "We're going to have to do a lot of things here, many of which are going to be difficult", and if you actually watch my whole talk I think it's pretty clearly a kind of eve of battle talk to people, a "Brace yourself, and this is already difficult, it's going to get harder, and it may be that at the other end we'll decide that we shouldn't have done all those things and this was an overreaction, but the fact is we've got to do them".

By this stage, for example, I'd already committed public money to doing research on Covid, that decision was already taken, and a variety of other things were already in train that were causing significant difficulties to colleagues in other bits of the health service.

So in my view this was in a sense saying yes, we've got to act, but be aware of the fact that that this 32
could go -- even at that point I think I was increasingly doubtful about that, but this could go either way.
Q. The reference to spending all the money on an epidemic which never happens is, of course, another way of describing overreaction?
A. That I would go -- you know, you're trying to ascribe discussions in mid-March to a point where I was trying to explain a rather different set of things to the medical profession in early to mid-February --
Q. Indeed.
A. -- which was a very different set of circumstances.
Q. By that date, 12 February, you were of course aware of what is known as the Report 4 from Imperial College London of 10 February which described the overall case fatality rate in all infections, both symptomatic and asymptomatic, for this emerging coronavirus as approximately $1 \%$, so the death rate overall was $1 \%$.

And SPI-M-O, the Inquiry has heard evidence about this, had reported on 10 February, again two days before, that:
"It is a realistic probability that there is already sustained transmission in the [United Kingdom], or that it will become established in the coming weeks."

In light of the information made available to you, 33
both of those sides.
Q. Of course.

Can we now look, please, Professor, at an entirely separate subject, by way of trying again to put into place some of the important building blocks.

You met regularly, did you not, with the CMOs of the other United Kingdom nations? That was obviously envisaged by the system, the system requires that there be regular and significant collaboration with the CMOs from the other nations.

Did you start to work with them significantly from a very early point in the chronology?
A. Yes, and, I mean, I -- obviously the four UK CMOs, or maybe not obviously, work closely together in any case but we all saw this as a shared threat to the four nations of the United Kingdom.

We came from slightly different disciplinary backgrounds. That was an advantage. So, you know, to re-stress, having different opinions and different backgrounds and different approaches is a strength, not a weakness. And it allowed us to make sure that the advice we were giving ministers, from a technical point of view, remained as aligned as possible. Ministers then obviously could take different political decisions. And that remained the case all the way through.
my question therefore is: in the application of that balance to which you refer, was it not already clear by 10 February which way that balance surely had to be operated?
A. Well, by this stage I was doing the great majority of my work and my team's work around this. We were putting a large amount of time into communicating it, putting resources into it, trying to get the medical profession ready for it, at a point where, in my view, we were moving increasingly far away from a probability this could go back to nothing, but we weren't yet at a point where we could say that definitively. We were still a long way away from, for example, the WHO declaring a pandemic. And as I say, we did not at this stage and did not for some time in fact have internal transmission.

So the statement by SPI-M-O that we would probably at some point have it, I'm paraphrasing, I thought was a reasonable one. That didn't mean that we had it at that point in time.

And I think it is also important to recognise that it would have been wrong to swing the whole of the medical profession over to this. Even at the height of the pandemic more people died of causes not Covid than died of Covid. Every one of those deaths is tragic on 34

I would like to pay great tribute to the other CMOs and DCMOs in the four nations. I think we worked together collectively as a team quite effectively throughout. Very effectively actually.
Q. I think you met around about -- well, according to your statement, 274 times?
A. That's true, and we were messaging each other in between those and so on, so it was a very close interaction.
Q. No doubt you gave advice collectively?
A. We gave advice collectively where there were important issues that -- so we gave advice collectively under a number of circumstances. The most important one was where we thought there was an issue of great public importance where we wanted to signal to the public that this was a collective view. Shall I give an example of that?
Q. Please.
A. So, for example, when schools were going back, we wanted to give a collective view about the risk/benefit in a very clear way to the general public and to teachers and staff members, we wanted to give a clear view about vaccination of children, and we gave those views as a collective because our view was, as a collective, in a sense we were demonstrating this was not just one person's opinion, this was a general opinion of the 36
profession, as represented by the chief medical officers. And in some cases we did it collectively also with the deputy chief medical officers.
Q. So you were doing it not just to aid collective decision-making for trans UK matters, but to make a strong collective public statement?
A. Correct. And then sometimes we would get other senior clinicians from other areas to do this as well. And I think one bit of that, which I think -- I hope the Inquiry will find useful, we collectively wrote a report to our successors, along with Dame Jenny Harries in her new role and also Steve Powis from the NHS, to say: this is our professional opinion on the technical matters. Fully saying, to be clear, that the narrative of the Inquiry -- the narrative of the pandemic will come from this Inquiry, but we wanted to have a collective view to whoever was next having to face a pandemic in the UK, here's what we learned from this.
Q. Can you recall any significant scientific disagreements between you, albeit I'm sure there were times that you were testing each other's thinking and testing the conclusions that the others might have reached but any significant disagreements?
A. Not that I can recall. I think there were several 37
demonstrably did a lot together. The different public agencies did a lot together and, for example, the issues around PPE were agreed on a four nations basis, usually at a technical level. The presidents of the royal colleges, with whom I met regularly, are on a UK-wide basis principally, some of them are more Scottish-based or English-based, for example, but they are UK-resourced, so -- and the General Medical Council which is involved in some of these is a UK body, so we were working as -- from a purely professional, technical point of view, clinical and public health, in my view very closely all the way through and at multiple levels, and this carried on all the way through the system.

That doesn't mean that there weren't different and perfectly legitimately different responses to the pandemic at an operational or political and other areas, so I'm not claiming this was identical across the UK, it clearly wasn't, but I think at a technical level we did whatever we could to ensure that the advice was shared and also tested across the UK, and I think that was actually a real strength.
Q. As a matter of interest, it's obvious that there were, well, a very large number of meetings from 24 January 2020 onwards. In terms of the formality of that process, do you recall whether or not your various 39
points where we had to chew something over quite hard to reach a collective view, but these were usually things which were in practice $49 \% / 51 \%$ calls, where it's not really clear what to do and there is a legitimate spread of opinion and we wanted to, when we gave our collective view, be pretty confident that we were giving one that we could all sign up to and felt comfortable with and we'd thought through the pros and cons of that. But I don't think there were any on a -- from a technical point of view. The most difficult one tended to be on borders.
Q. And you gave advice on borders, balancing risks and benefits in education, of course vaccination, dosing schedules --
A. All of these.
Q. -- clinical trials and also winter challenges --
A. Exactly.
Q. -- challenges faced by all the nations.

There has been some suggestion from some quarters that there was an absence of proper collaboration on the clinical medical front with the devolved administrations. Do you consider that there was in fact the closest of collaboration with all four nations?
A. Well, I mean, just commenting on the areas where I was involved, there are many others, I think the CMOs 38
meetings with the other UK CMOs were minuted?
A. We had -- essentially we met in kind of three different ways. There were some -- there was just informal discussions, there were formal things where we were trying to come to a decision, and essentially that either ended up with a minute or it might end up with a joint letter, but that essentially is the minute of "these are the positions we've taken". And then there were discussion groups, of which the most -- probably the most prominent was something called the senior clinicians group, which I chaired, and that didn't just have CMOs, it also had people from the NHS at some points, it had chief nurses and others, so this was very much not a decision-making -- it was for just people to share information principally. But these were -you know, where a decision was taken then there would be a formal record of it, and that I think was the key point about this.
Q. Moving on to another part of the system, Public Health England. You say in your statement that, because you were asked to comment on the effectiveness of Public Health England, that it did play to its considerable scientific strengths in January and February, and of course we remind ourselves that it was in January that it created, at great pace, a PCR diagnostic test 40
for SARS-CoV-2, but that operationally it struggled thereafter to scale up the system of testing based upon the diagnostic test that it had invented; is that a fair summary?
A. That is a fair summary.
Q. There has in fact been a great deal of evidence before this Inquiry that there was a wholescale absence of a sophisticated scaled-up test, trace and isolate system in the United Kingdom at the beginning of 2020. You must have reflected long and hard on this issue. To what do you ascribe that absence?
A. I think that in a sense there's two levels of it. The countries which were best able to scale up, particularly using their public system, and l'm going to use South Korea as a proxy for that but there were others, had had very significant investment in public health infrastructure. In the case of South Korea, and I discussed this with colleagues from South Korea, it was after they had a bad -- a bad experience with MERS, and they thought they wanted to beef things up, and they did. And in the case of Germany, which took a slightly different approach, they used their very strong industrial base to be able to do that. time, you can't just switch this on at short notice, or
splitting off the public -- the health protection system from the rest of it, and, you know, I actually think the UKHSA system that's been created is a very good one, but this wasn't a situation where I was sort of sitting down in meetings and saying "Shall we lead to this change?" That was not part of what I was doing. And to be fair, I don't think it was necessarily a good reason why I would have been, because that was a structural question not really a clinical or a public health one in the ordinary sense.
Q. All right.

Can we now look, please, at SAGE, of course the Scientific Advisory Group for Emergencies, which you co-chaired.

You say, again rather pithily, in your statement that as co-chair of SAGE you're likely to be biased in its favour and that it's not obvious to you what an alternative better mechanism for the provision of scientific advice would be.

Were you aware of how other countries had set up their scientific advisory systems?
A. Yes, so because I'd been a Chief Scientific Adviser in government during several emergencies of different types, including being Government Chief Scientific Adviser for a short while on an interim basis, I'm --

Absent either public investment over some period of 41
an industrial base well designed for it. It was much more difficult.

There were a number of other reasons, and in a sense, I think, this is probably not the moment to go into them in great depth, but those were major barriers to it. I think there were also some issues about how -the interrelationship with the NHS laboratory system but I'm not really the person to answer questions on that.
Q. We've heard some evidence about the multitude of small laboratories which were perhaps institutionally incapable of being scaled up. You must have -- well, of course you were absolutely well aware of the absence of such a system in January 2020. Your understanding shows of course also, doesn't it, that you were well aware of how other countries were responding, of course you were on top of the detail of what other governments and countries were doing to respond to the pandemic?
A. Yes.
Q. Was the CMO consulted during the course of the pandemic on the decision to disband Public Health England?
A. I don't recall being consulted either formally or informally, I think it was sort of told that this was going to happen. My view was my colleagues from Public Health England did this extraordinarily professionally. I think there were arguments either way in terms of 42
was well aware of systems around the world going into the pandemic. And we've also -- Sir Patrick and I have had the privilege of talking to a lot of our colleagues from other nations about their systems from around the world. And there are many good systems. So the fact that we have the SAGE system was not something where we were doing it in ignorance of all alternatives. In general, and I think most people certainly in Europe would agree with this, the UK system of integration of science into government, in my view, still is short of where it should be, arguably by some distance, but in fact it is better than a large number of our neighbours. We do at least have a network of Chief Scientific Advisers, we do have the SAGE mechanism, we do have a very empowered and rightly empowered Government Chief Scientific Adviser.

So I think the SAGE system had some pluses and minuses but, as I say, I couldn't see another system internationally where you looked at that and said "If only we'd had that, we'd have been in much better shape".
Q. Just looking in a more narrow way at some of the particular aspects surrounding how SAGE worked, a number of witnesses have noted the tension that you identify in your statement between having a group that's small 44
enough to allow significant, proper expert debate and having a body that's large enough to be more representative but so large that it acts contrary to the ability to have a proper focused debate.

Do you assess that that balance was correctly drawn in the case of SAGE? Was its membership sufficiently diverse in terms of comprising not just epidemiologists and modellers and behavioural scientists, but members of other disciplines?
A. I think in the very first meetings of SAGE, I think it was too small, and I think it was recognised as that, and Sir Patrick and GO-Science did a lot of work to deal with that. Arguably -- at other bits of the pandemic it actually arguably got too large. There was a very wide spread of outstanding scientists, but it was less easy for people to challenge one another. So there is undoubtedly a sort of point between those which is the most effective one.

It's important also to recognise that SAGE is not a fixed body, even in a single emergency. So people come on to it and go off it depending on what the set of problems are that are being considered. So the only person who's actually fixed on SAGE is the Government Chief Scientific Adviser, Sir Patrick. All others -and obviously now Dame Angela, again who you will be 45
biomedical specialists dealing with issues such as modelling and epidemiology and so on?
A. Well, I think -- I think probably there are -- I mean, in a sense, you can make a case for almost infinite numbers of scientists -- sciences perfectly reasonably. I think that in the case of, for example, PPE, all the various kind of things that are needed to do in terms of infection control, that wasn't actually dealt with by SAGE, that was dealt with completely separately on a four nations basis, so the sciences that were dealing with that were a different -- it was done by a different strand, just as, for example, the deployment of vaccines was done via the JCVI mechanism not through SAGE.

So it's important to understand that even for science advice the only bits of science advice that really SAGE was supposed to and did have as its central actions were things that were advice to ministers on the more general areas, and there were large numbers of other scientific bodies, formal and informal, feeding into other bits of advice, including into government, but also to the medical profession and indeed to the general public. So I don't think SAGE should be seen as the only vehicle, it was the vehicle for -- formally it's the vehicle for getting science into COBR; in reality it had a wider remit than that, but it was
speaking to I think later during the week -- all others come or go as needed for the particular needs at that point in time.
Q. Can you recall whether or not those additional members of whom you have spoken came from other particular disciplines beyond epidemiology or behavioural science or modelling?
A. There was a -- quite a wide range of people came and went at different points, some of very -- all of them of very considerable eminence. I think it depends how far you're talking about going. So I don't think that we went into -- we certainly didn't go into, for example, economics at all --
Q. We'll come to that issue.
A. Yeah. So there were sort of boundaries for SAGE. Quite a lot of the hard work scientifically was in fact done in subcommittees, and by the middle of 2020 there were a -- quite a number of subcommittees that brought in experts in areas that were relevant to, for example, social care, to childcare and so on.
Q. May I then ask you directly, Professor: a number of witnesses have spoken of how there was a deficiency of experts dealing specifically with matters such as infection control or community mobilisation, the public-facing side of public health, as opposed to the 46
definitely bounded.
Q. But the reality, Professor, was that SAGE, which was of course the only -- was the sole or primary perhaps scientific advisory body for the government in the face of this pandemic, did include in its membership a significant number of modellers, biomedics, behavioural scientists. There wasn't, in fact, a significant number of experts who were dealing with the coalface of how the pandemic might impact upon the country and therefore aware of what measures might have to be taken and recommended in terms of infection control, community mobilisation, intensive care, beyond the attendance of Public Health England and the NHS, who were obviously attending the committee. Would you agree?
A. I mean, as I said previously, you could have enormous infinite membership, but SAGE's job was not to either promulgate policy -- promulgate practice, although I was very keen and Sir Patrick was very keen that it only considered things that were practical, so discussing theoretical things that were not practical is not a good use of time, but very many of the scientific inputs to government were not via SAGE. And I can't repeat that strongly enough. SAGE was only a route for certain sorts of questions to a particular bit of government, it 48
was not the only mechanism by which government was in receipt of scientific advice, there were many other mechanisms formal and informal.
Q. Would you accept that the government came to see SAGE as the primary route of advice dealing with all scientific aspects of the pandemic, and therefore would have been looking naturally to SAGE to have reflected in its advice appropriate elements of infection control and community mobilisation, and so on and so forth, because SAGE was advising on non-pharmaceutical interventions and on social interventions --
A. Yes, I'm not actually disputing the basis on which the question's being asked, but I think you also have to accept that if you want challenge and if you want timeliness -- and remembering particularly at the beginning of SAGE we usually had a maximum of two or three hours between SAGE beginning and COBRs actually meeting -- you do have to have a limit to the number of people who are around the table and you do have to make judgements, many of which will not be ideal judgements. And it's not that they're not the best -- they're not in our view the best available, but other people could have come to a different set of conclusions about who should be round the table. What I think other people wouldn't do is come to a different conclusion that this should be 49
maybe this is where some of the confusion comes from.
SAGE only really advised ministers, and only ministers for particular sets of questions. Government is a much larger body and was advised via multiple different routes.

I think it's also -- we need to be a little bit careful that a few of the people, when they say SAGE didn't have all the expertise, what they actually mean is SAGE didn't have their particular expertise, and preferably them. That is a different thing again. But I think many of the challenges were quite legitimate. I got written to by specialist groups, as did Sir Patrick, distinguished groups of distinguished scientists, quite regularly saying "Why are we not represented better on SAGE?" And they were all legitimate questions. So I'm not disputing this, I'm simply saying you have to make a judgement at some point but you do have to have a group which is not unwieldy.
Q. I don't wish to spend too much longer on this point, Professor. I think some of those witnesses may baulk at the proposition that they were only advocating a wider membership in order to reflect their own sectarian position. But --
A. No, that's not what I was trying -- saying. I think they genuinely would feel that their expertise was one 51
infinitely larger. I think that would -- I think whoever was chairing SAGE would say there has to be a manageable limit where people can actually challenge one another rather than simply everyone goes round and says their piece. Because if that's the case you might as well not have SAGE at all. It's got to be seen as, you know, a discussive and challenging environment not simply a representative body of people reading out "This is my script for today".
Q. Professor, the question wasn't inviting a view as to whether there should be infinite membership or a hugely expanded membership. It addressed the balance between members of the research and teaching institutes, the biomedics, the modellers, and public health practitioners. Given that, as is obvious, SAGE was formed and constituted itself, certainly in the eyes of the government, as the primary form of scientific advice to help it through the pandemic, would you agree that that balance wasn't correctly struck?
A. I agree that other people might have struck the balance differently, which is a different point completely, and were they the Chief Medical Officer they could have come to a different conclusion, but Sir Patrick and I took the view that given the questions ministers were asking -- I think I'd like to differentiate here, and 50
the country would have benefitted from. I'm not in any sense disputing that. But I'm just saying that it wasn't often virology wrote to say "Can't we have more anthropology?" Or anthropology wrote to say "Can't we have more public health?" It tended to be groups saying, "Our group is not sufficiently represented". Perfectly legitimately.
Q. And equally legitimate the argument that there should have been more public health practitioners, more experts with infection control, and so on and so forth?
A. And legitimate --
Q. As you say, a judgement call.
A. Yes.
Q. In hindsight, it's no doubt a proposition with which you would agree?
A. That the --
Q. There should have been a greater --
A. Sol--
Q. -- focus on that sort of discipline?
A. Well, in terms of the advice that I -- you have to remember that I also had the benefit of huge numbers of people giving me advice, and not through SAGE. So for example I met regularly, very regularly, with the directors of public health across the entire country, an extraordinarily able and dedicated and very 52
experienced group. They gave me public health advice from all parts of the country, not through the SAGE mechanism. And these kind of mechanisms were replicated for Sir Patrick in other areas and so on.

So I think it is in -- you know, I just think we should be a bit cautious of implying that SAGE was the sole mechanism by which science entered government; it was one route for one set of issues. And I think that is where some of the misunderstandings sometimes arise from.
Q. In your statement you make the point that legitimate outlier opinions often tended to dominate media discussions but the job of SAGE was to provide a central view of current science. Central in whose view?
A. Well, that is part of the judgement of these. So what we wanted to do with SAGE, and this is true for all SAGEs, not just true for this, is, as best we could, say: at this point in time, at this level of knowledge of this pandemic, as it happened -- in this particular case -- which of course developed very substantially over the first 18 months of the pandemic -- this is where we think the mid-point of national and indeed international science is.

So it wasn't the job of SAGE to advocate for one position or another, it was the job of SAGE to sense the 53
a failure of imagination?
A. Well, I think that ... so within SAGE, certainly I was one of the people who was most concern -- most concerned that we captured the reality of previous pandemics. So let's start off with that. And, for example, I was throughout, and I think this has been pointed out by some of the other witnesses, concerned about the fact that there would be a surge in winter, irrespective of where the first wave occurred, and that was partly for logical reasons but partly because if you look back over the last -- certainly over the three significant flu pandemics, for example, in the 20th century, starting with the 1918/19 one, the first wave was actually fairly moderate and the winter surge that followed it was -- in fact killed a lot more people than the first wave. That was a really critical, in my view, fact. That wasn't picked up in the modelling as that wasn't the reason -you know, it wasn't that the modelling couldn't pick that up, but that wasn't -- didn't -- wasn't derived from modelling, that was derived from, in a sense, historical experience. So there's a lot of things that we could usefully pick up from previous pandemics.

Secondly, within previous pandemics, a large number of NPIs had been used, and we were aware of them and modelled them, including for example --
mid-point and say to ministers: at this point in time here's the mid-point, and also at this point in time here's the spread. Which of course was, in some areas, quite narrow, there was some areas where there was basically pretty universal agreement, and then there were quite a lot of areas where there was quite a wide spread, and it was appropriate and necessary that that was to the best of our ability reflected in the way we described it to ministers.
Q. One last question on this topic, if I may. Elsewhere in your statement, in the context of describing how difficult it was to contemplate in January and February the notion that there might in due course have to be a full lockdown, a mandatory stay-at-home order, effectively suppressing day-to-day life and closing all high-risk -- well, indeed, every major economic and social activity -- and you say this, that the absence of contemplation of that notion, of that possibility, might be "considered a failure of imagination by a group of scientists who understood the nature of epidemics and their history".

If anybody was going to understand the lessons to be learnt from past pandemics, and the necessary epidemiological lessons, it was, of course, surely the members of SAGE. What did you mean by that reference to 54
Q. Just pause there. Do you mean -- is that a reference to quarantines and --
A. Yeah, so it would include --
Q. -- isolation -- self-isolation and the like?
A. Exactly, quarantines, self-isolation, school closures, stopping high-contact professions. These are things which have been done over decades or centuries, so these were mechanisms that were well known.

The idea of essentially, by law, locking down all of society is not something which had previously been used, and you could argue -- and I think it is reasonable to argue -- that that's something we should have cottoned on to at an earlier stage.

In reality, my view is that the band of situations where that would be relevant is in fact relatively narrow. So if a pandemic was much milder, like the swine flu pandemic, then it would be seen quite reasonably as disproportionate. And if the R was, let us say, 12 , rather than 3 , then it would probably not be effective because there wouldn't be -- the force of transmission would be too great. So --
Q. I'll pause you there, please, Professor. We will be coming back, of course, to the epidemiological justification for lockdowns in a later part of your evidence. But just on this point of principle, if there 56
was a failure to cotton on to the notion or the possibility of a mandatory stay-at-home order, does it not necessarily follow that the government wasn't made aware in good time of that possibility, that the government wasn't advised in good enough time that this was an option, and had SAGE been alert, perhaps imaginatively, to this being a possible intervention, consideration would have been given to that possibility at an earlier and more appropriate stage?
A. I think what you see with SAGE, and maybe we'll come on to it later, because there's quite a lot of layers of technical points behind it, is that what SAGE was clearly advising by the time we get to the middle of March was that if ministers intended to prevent the NHS from being overwhelmed, which was their -- one of their principal drivers, they have many others, and reduce the loss of life, they were going to have to significantly reduce interactions between households and individuals. And there are a variety of ways by which this could be done. The question about whether it was done by law actually is not a scientific question, it is a political and, to some extent, legal question, not a scientific one.

Now, when you say: were they aware of this possibility? Well, it clearly had been used by China, 57
really what we were talking about, and I think the phrase I used was that China had thrown the kitchen sink at this and we needed to work out what was the way we could achieve it with the least damage. I'm paraphrasing, but you'll find the email there. Which really, essentially -- it's not just my view, I think that would have been a shared view around -- around SAGE members.

You know, you can argue that we should have gone for a maximalist model, if -- I think -- I don't think -I don't want to sort of put anyone into a difficult position, but were we to have been instructed by ministers, "Can we do -- you know, what would happen if we did a Chinese approach", that would be something which SAGE undoubtedly would have looked at.

The question actually I think is: was it -- would it have been appropriate for a group of scientists to come up with what I consider is quite a radical proposition to put to government. And I think that's a debatable question actually. But, you know, we were already very clearly making the case that we would need to significantly reduce interaction between households and a lockdown is one of the ways in which you can do that.
LADY HALLETT: We're going to leave it there, I think -MR KEITH: We are.
so there was very recent -- it was all over the newspapers, politicians were aware that that possibility existed, and indeed it started to be used across Europe, although not that far in advance, actually, of where we did in the UK by a matter of really days in general.

So the principle that this was actually available as a policy response didn't require SAGE to make that point. That was just simply a minor kind of, in a sense, commentary on what you've just said. But did SAGE look in detail at a mandatory lockdown as part of what they were thinking about in early and mid-February? I think the short answer is no, and that's pretty clear from the minutes. We did, on the other hand, look at ways of keeping households separated, including advice to stay at home and so on.
Q. As the primary provider of scientific advice on these issues to government, surely it was incumbent on SAGE to put forward -- not the Chinese, but SAGE -- as a possible policy response the notion of a lockdown and to do so in good time; would you agree with that general proposition?
A. I think you have in your, as you said, many documents from me, one where I make the point that we need to find a way of getting $R$ below 1 , which in principle is the key thing for getting a wave to turn over, which is 58

LADY HALLETT: -- otherwise l'Il get protests.
I shall return at 11.40 .
(11.23 am)

## (A short break)

(11.40 am)

LADY HALLETT: Mr Keith.
MR KEITH: Professor, still on the subject of SAGE, it's very apparent from the evidence that the SAGE committee produced minutes, which you of course approved, in a way that tried to reflect a consensus position, and whilst some of the minutes do provide levels of certainty rating, for example in relation to subject $X$ there's a high confidence or subject $Y$ there's a low confidence, would you agree that in general terms dissenting opinions, changes of opinion or differences of opinion, were not, as a general rule, reflected in the minutes?
A. Yes. I think I'll make one very minor gloss on what you've said, I basically agree with the position, which is that in my view this was a central view not a consensus view. So -- and that difference I think is important, and it comes to your second bit, which is, there were, in some discussions -- in many discussions everyone agreed at the end, and on a few occasions we even said that, but in many discussions there would still be people at the end of the discussion who would 60
say, "Look, I'm not sure I completely agree", but would agree that the central view of the meeting was X . So that is an important point.

I think we were much -- we got better but we should have from the beginning had the discipline more thoroughly of saying high confidence and low confidence. I think that was a sensible way to do it. In part because of lack of time and in part -- to actually do this properly, and in part actually because of people actually reading it, recording all the opinions, which you could do under certain other circumstances, didn't really -- wasn't really a realistic or probably, in my view, sensible proposition. But we did try -- and this I think is really critical -- Sir Patrick and I tried to reflect the range of views when we were briefing ministers to the best of our ability. So we tried to capture the fact that there were outlier opinions -I don't mean that in a negative sense, I mean that in a positive sense -- around the central view.
Q. But that process was, of course, often not recorded, because you were communicating your views in verbal briefings, and the government, as a general rule, didn't therefore fully understand or appreciate the full range of dissenting opinion.

Obviously one understands the point you make that if 61
dominates.

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\begin{aligned}
& \text { But there was a different mechanism, and I think } \\
& \text { people have underestimated this in some of their } \\
& \text { commentary on this, which is it was available to and } \\
& \text { used by very large numbers of government departments to } \\
& \text { have observers at this who listened to the debate } \\
& \text { directly. For example there was almost invariably } \\
& \text { someone from Number 10, there was certainly almost } \\
& \text { invariably someone from Cabinet Office, there was almost } \\
& \text { invariably someone from the Department of Health. So } \\
& \text { they were able -- and indeed the Treasury for large } \\
& \text { parts of it -- they were able to reflect, as they saw } \\
& \text { fit, and certainly if they had felt that the minutes } \\
& \text { were actually not what they had heard, it was entirely } \\
& \text { open to them to say, "I know this is what the minutes } \\
& \text { say but I was at the meeting and that isn't what } \\
& \text { I heard". And then what I would expect to happen were } \\
& \text { that to occur was that the relevant minister, if they } \\
& \text { thought this was important, would summon Sir Patrick or } \\
& \text { me and say, "I've got two versions of this, the minutes } \\
& \text { and what my own woman/man has said, what do you say?" } \\
& \text { That never happened but that -- certainly that mechanism } \\
& \text { could have occurred if people had wished to. Because } \\
& \text { they all -- the many, many departments and the devolved } \\
& \text { nations had observers. }
\end{aligned}
$$

there had been long detailed minutes, perhaps government ministers and officials wouldn't have read them with the same degree of detail that they would have read a shorter document, and it's important to get the key points out. But in the sphere of these extremely difficult issues and the very difficult judgement calls that were having to be made, might it not have been better for government to have a better understanding of the range of scientific opinion, of the dissenting opinions, of the lone voices calling for a particular option but which were not reflected in the consensus opinion?
A. Leaving aside the occasions when lone voices chose to share them with the general public via the media, but that's a -- there were two mechanisms by which people could get the spread of opinion. One was Sir Patrick or me briefing ministers. And that -- you know, many of the things in SAGE were for specific ministerial meetings, and one or both of us would give a briefing on the spread of opinion, and if either of us or the other had not fairly reflected it, we would then chip in. So there was -- in a sense, the fact we were both there was helpful, just as, for example, the fact that co-chairs of some of the key committees were on SAGE was helpful, so you avoid a situation where one person's view 62

LADY HALLETT: Sir Chris, Mr Keith's question was premised on the basis that ministers would read the minutes. Was it your impression that they read the minutes or somebody read the minutes and told them what they were, or was it your impression that ministers relied on your verbal advice?
A. I think that in most cases the ministers were more reliant on the verbal, but that depended on the minister. Some ministers are more, in a sense, paper-based in the way that they absorb information, others are more verbally-based, and, as always, our job was to fit our communication style around that.

But the minute was there also for -- you know, we weren't in every meeting with the ministers, so the minute was also there for other officials to have as an anchor point as to what had SAGE actually said as their central view. So, you know, that was part of what they're there for, and of course they are also a record, and in due course, and I was very pleased by this, a public record so that others could comment if they wish.
LADY HALLETT: Thank you.
MR KEITH: But the dissenting views, such as they were, were not recorded, generally speaking, in the SAGE minutes, and of course only those persons who were in the room 64
with you and Sir Patrick would have been privy to the verbal briefing, which you've described was a useful conduit for perhaps giving a wider range of the reflection of SAGE views.
A. No, that is correct.
Q. All right.
A. And I fully accept that this is a potential weakness. All I'm saying is that there were -- there's more than one mitigation: there was the verbal, with two different people in the room to check the other wasn't misunderstanding, and there were observers.

So I think -- you know, you can come up with better solutions to this, but something where the minutes run to 20,30 pages would move from a situation where a few people read the minutes to nobody read the minutes, in reality in these kind of situations.
Q. These things are always a judgement call, are they not, Professor?
A. Yep. They are.
Q. There are plainly degrees by which they can be altered without throwing the baby out with the bathwater?
A. It would have been possible, in my view, in retrospect, and there is an argument for this, to have had two sets of minutes, an immediate set that accurately reflected the central view and a longer set that people 65
needed", so that was why members of the Cabinet Office and Number 10 began attending SAGE, because the minutes didn't adequately reflect the full range of dissenting opinion?
A. And there was a mechanism for them to pick that up.

I think my reading of Mr Cummings' evidence on this, which I found very interesting, was he actually felt it might have been helpful for some ministers themselves to have come and listened to the debate in SAGE. I think that of course would have been open to them. When
Mr Cummings himself -- when it was known that Mr Cummings himself sometimes came to SAGE, this caused quite a row, actually. I wasn't the person who made the decision to make that possible, but I thought it was perfectly sensible that a -- one of the -- you know, one of the most senior advisers to the Prime Minister, if he or she wished to, could listen in on SAGE, struck me as a sensible thing to do. What wouldn't be sensible is if they then tried to --
Q. Contribute?
A. Well, they could ask questions, potentially, but tried to bias the answer that was given, that would be extremely unacceptable. But that wasn't the situation, in my view, that happened.
Q. Another aspect of the SAGE process that's been reflected
subsequently did
But the one slight caution I would have on that is my experience of minutes in difficult areas is that everybody feels their own view has been misrepresented almost whatever you do, and clearing minutes is a slow and quite laborious process because you have to be accurate, and if you make them longer it therefore becomes a longer process. So I think there are arguments either way, but I think that would be the only thing I can see would be easy to do that would meet that need.
Q. You've mentioned by way of mitigation, Professor, that there were other attendees at SAGE, but of course those PHE and NHS and other government officials who were attending SAGE were not necessarily present in your verbal briefings to the Prime Minister?
A. Some were, some weren't, so --
Q. But not always?
A. Of course. To have had that would have meant a very large room.
Q. Indeed. And Mr Cummings has given evidence that one of the reasons why he asked that there be attendees from Number 10 and Cabinet Office at SAGE was because the SAGE minutes did not, in his opinion at any rate, capture anything like, to use his words "what we 66
in the evidence before the Inquiry is that because of the commission basis upon which requests to SAGE were made for particular advice, because of the way in which that system operated, there was an inadequate opportunity for SAGE to understand what decision-makers and ministers were driving at, on the basis that if they had been able to speak to them directly, if they'd engaged with them, they would understand better what the ministers' needs were and what it was that they wanted from SAGE. Can you think of any way in which the system might have been recalibrated to allow that, that one way street to be opened up or reversed?
A. Well, l'll give you a narrow answer but you may want me to go wider. The narrow answer was when we were certain what ministers wanted we did our best to reflect that to SAGE participants so that they could reflect that in their pre-work and in the meetings. Sometimes, and this is not a criticism, it's simply a statement of fact --
Q. Can I pause you there. Do you mean you would speak to members of SAGE individually outwith the formal meetings and outwith the minute process --
A. Yes.
Q. -- and say "This is what government has in mind"?
A. What we would do was, where we were clear that we knew what government wanted, we or others would reflect that. 68
The problem here is iterative, and this is where I think many of the problems potentially can come from, is SAGE -- you know, it wasn't helpful to say to SAGE, "There is a considerable debate going on in Government and lots of people have got different opinions". That wasn't actually a terribly useful thing to say. It was helpful if we could say, "Well, government's strategic aim is $X$ ". But the danger was SAGE was not in a position to say what government's strategic position was until the government itself had a strategic position, and sometimes the government was waiting for SAGE to make a strategic position. And that potential circularity I think is something which I think bears some thought.
Q. Those communications where you relayed government thinking back to individual members of SAGE were not necessarily recorded because they were perhaps given in verbal conversation, and secondly it's apparent that -from the minutes, because there are no references to SAGE's understanding of what the government is looking for or what it wants, to what those needs are. So it does rather appear as if the formal process for recording the range of debate didn't adequately reflect what it was the government needed, and in its hour of crisis it needed the assistance of SAGE. 69
place upon you and Sir Patrick too great a burden? How could you possibly be expected, after this multitude of meetings, to relay the ebb and flow of debate on these extraordinarily difficult issues in, bluntly, side meetings with the government?
A. Well, firstly, I mean, we weren't trying to relay the whole ebb and flow but we were trying to relay the range of opinion, slightly different.

I -- the alternatives would actually have been even more burdensome, which would have been to have to write up the whole thing, get it agreed by everybody and then send it in. In a fast-moving pandemic, the principal aim is to be accurate and to be fast. I think that the big advantage we had -- and, you know, I would really like to pay tribute to Sir Patrick because I thought he was absolutely extraordinary on this -- was having both of us meant that if one of us had inadvertently relayed information in a way that was misunderstood, and you could sometimes see this happening in both directions, there was another person to say, "You know, I agree with Sir Patrick", in my case, or he with me, "however, I would just like to clarify the following points". So I think that mechanism of having two people who are relatively wide-ranging scientists able to check one another's recollection and onward relay, I think did
A. I think that -- I mean, I think there are probably two answers to that. I mean, I think, again, it's a fair point.

The first is that SAGE was often commissioned directly from Cabinet Office, so what you have is essentially you have what Cabinet Office wanted of SAGE, and Cabinet Office is the clearing house for all of government, including, importantly, Number 10. So that was one vehicle. But it would have been, I think, incorrect, at several levels actually, for the SAGE minutes, which were a scientific record, also to have been a record of my or Sir Patrick's view about what government's current policy positions were. That's a completely different thing, and I don't think that would have been an appropriate thing actually for us to have recorded in the SAGE minutes.
Q. I've not suggested that.
A. No, no, I know, I'm just sort of explaining where I think the balance potentially lies.
Q. Ultimately, you and Sir Patrick were required to relay verbally, in an undocumented -- largely undocumented, process, your own recollections of the ebb and flow of the debate within SAGE. You were required verbally to reflect back to SAGE, unrecorded, the response of government and what its thinking was. Did that not 70
provide some degree of, in a sense, error prevention in the transmission of the information.

I fully accept that in a less frantically paced system, it would be -- there are better ways you could do it, and of course they would be much more convenient to a subsequent Inquiry, because then it's all written down, but that of course wasn't the principal aim at that time.
Q. One final aspect of SAGE. You've repeatedly referred to the fact that of course SAGE was a scientific advisory body, it produced the scientific advice.
A. Yes.
Q. There was no analogue and there could not properly have been within SAGE an analogue for economic and societal considerations. That was a matter, and it's a political decision, for the government. You must have oft reflected upon the fact that SAGE would be giving advice on the scientific issues, the advice would be relayed through you and Sir Patrick to government, and then on occasion that advice would be trumped -- I don't mean that in a pejorative sense, but the advice would be made subject to intervening advice, if you like, on the economic and societal issues in your absence and in the absence of SAGE. Did you come to believe that there ought to have been an analogous recorded transparent 72
body that could do the same for economic and societal issues as SAGE was doing for the scientific issues?
A. I certainly think that there is a strong case for having the technical economic advice -- remembering of course the economic advice is itself quite often quite market-sensitive, so that's a slight caveat -- made transparently available to people and, where it's possible, for external experts to challenge it. There is a case to be made.

My suspicion is that this is one that the Treasury would -- have not yet warmed to and are fairly unlikely to warm to, but that's a -- that's for a large number of legitimate reasons. But, you know, what you say is correct. It would however -- you know, the one bit of what you said I would just be a little bit more cautious of is the idea that l'd be worried that the science advice would be "trumped" by the economic advice. My view is political leaders should take both bits of advice and then they should balance them. That's not a -- in a sense that is their job, and in a sense not mine.
Q. I've referred to that expressly by virtue of my reference to the fact that that was a political decision for ministers.
A. Yes.

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actual data was relatively easy to interpret. It was much harder earlier on. So that was the first thing.

Models also have a separate use, which is in testing out various scenarios and saying: if you do this, what's the likely effect? I think it's always important, and again modellers will also agree with this, this is a cliché of modelling, that all models are wrong but some models are useful. And the point about these models was they helped to explore and test some policy options. They were not predictions of the future. And I think this is where some of the problems arose: these were not meant to be predictions, they were not presented as predictions, but they were often interpreted as predictions.
Q. I'm going to come back to the public perception of models in a moment, but remaining focused, please, Professor, on this issue of the extent to which modelling was required to understand the basic data which would inform your advice to government as to what the state of the emergency was, how quickly the virus was emerging, and in relation to the spread of the virus, its transmission.

Modelling wasn't required, was it, to inform you of the infection hospitalisation rates, how many people who were infected would be hospitalised, how many people
Q. Modelling. Some witnesses have suggested that there was an over-reliance on epidemiological modelling within SAGE, particularly between January and March. It's notable, Professor, that when you gave advice yourself to the Prime Minister and ministers in early and mid-March about the likely numbers of deaths, on the impact on the NHS, and possible infection peaks, you used actual data and short-term forecasts, actual scenarios, as opposed to models.

Ultimately, and I appreciate this is a very wide question, was too much reliance or at least too much time spent on modelling in February of 2020 in -- and thereby damaging focus upon the actual data of infection hospitalisation rates, infection fatality rates, and the obvious emergence of the virus?
A. Well, I have and actually Sir Patrick has, and if I'm honest most sensible modellers have, a strong preference for actual data over model data where that is available. The problem we had -- and models have many uses. The problem we had early in the pandemic, in the first three months, was we were dealing with very sparse data and data that had to be integrated from lots of different areas, where the actual data didn't tell you a terribly clear story. As the numbers sadly ticked up, and there were many more cases in the UK, then the 74
would die of those who were infected, the infection fatality rate, or what the impact on the NHS was likely to be? Those judgements rested upon actual data or short-term scenario planning, just basic standard assessments of what was likely to happen.
A. When we had, from late March onwards, unfortunately a lot of people with Covid in the UK, a lot of people going to hospital, a lot of people dying, a bit later than that we had very good data flows that meant we could see where things were going. I completely agree with you that that was far preferable to rest on those as the principal reasons for making decisions, presenting data to ministers, presenting data to the general public. That wasn't the situation though we had in January, February and early March, remembering the numbers at that point were extremely small and in fact we were not picking up very large numbers of them. If you look at the decision-making, it had to be based on extrapolations of the true numbers, so, for example, early on, there was a very useful analysis done by Professor Ferguson saying that the numbers in China must be substantially greater than the numbers being reported based on his modelling about what must have happened if it had left China, if it had --
Q. I'm just going to pause you there, I'm so sorry. 76

That was not, however, a modelling exercise. He looked at the number of flights that were coming out of Wuhan, worked out for the number of people in hospital how many people therefore were likely to have been infected, and worked out the infection hospitalisation rate from that, it wasn't a modelling exercise --
A. That sounds like a model to me.
Q. All right. Well, then let me ask you this: it's obvious from the 28 January SAGE meeting, for example, that SPI-M were asked to advise and the modellers in SPI-M were asked to advise on the actions the United Kingdom could take to slow down the spread of the outbreak. Why was it thought necessary to ask modellers to be in the vanguard of that response, to give advice to SAGE about how in practice the government should respond? Modelling could never be a substitute for basic epidemiological analysis of death rates, hospitalisation rates and impact on health services.
A. I think you're probably using modelling in a much narrower sense than I would, so a lot of the things you've just talked about in my view do depend on models, so for example how you calculate a clinical fatality rate or a population levelled fatality rate is a modelled number, particularly early on when numbers are changing very rapidly. So I think modelling has

London School of Hygiene and Tropical Medicine reports telling you what the death rates and the hospitalisation rates were likely to be?
A. Well, I mean, firstly a lot of those data were coming from modelling groups, just to clarify on that point. It's also important to realise that there were huge strands of scientific work that were happening in parallel with the modelling work.

Now, the modelling work tends to get a lot of prominence, and one of the reasons it's lodged itself in the public mind is some of the prominent modelling groups were led by people who were very good at explaining it in the media and they tended to hear a lot more of that than they did from virologists or others, but actually alongside this was very large research and analytical effort across multiple domains and modelling was only one of those. It was an important one but it was not the only one.
Q. All right.

Two final points on modelling. Firstly, can you return, please, to the point you made earlier about the public appreciation of modelling. There is very plain evidence before the Inquiry that a quite inappropriate degree of alarmism was apportioned to some of the scenario forecasting modelling done by ICL and

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some quite small and discrete uses, and these are laid out quite nicely in several of the witness statements you've already received so I'm not going to go into them in detail, so I think quite a lot of the relatively simple data are still model-derived. I think what you're talking about are scenario models, which actually test out -- but the point about this is they don't propose, they test various approaches and say: how will these -- if you did this or if you did that, what, in the view of the model -- with the big caveat I made that models are not predictions -- which are the ones that would have big impacts and which ones would not?

Now, you can try to do that without a model, but a model will give you a lot of information you otherwise would not have.
Q. So was this the position: that a great deal of time and energy and resource was spent in February on that sort of future modelling, that is to say trying to model what the various contingent outcomes would be of steps that might be taken by the government, what measures, what impact measures would have, but that of necessity relatively less time was spent focused on the actuality of the scenario faced by SAGE and the government, which was that there was emerging data from China and from the Diamond Princess episode and from the basic ICL and 78

Professor Ferguson, and also by the London School of Hygiene and Tropical Medicine. In general terms, was that alarmism and criticism justified in any way at all?
A. I think that -- I thought Sir Patrick did an excellent job of laying out his discomfort and my discomfort at trying to explain models in very short-form press briefings because they have to come, rightly, with large numbers of caveats, which the modellers themselves would agree, and what inevitably happened with models, unfortunately, was you can't actually argue with the number of people going into hospital and the number of people sadly dying, you can argue with the model. So they tended to become a way in which both sides of a polarised debate tended to have their debate, with some people saying "This is all made up, it's all exaggerated. Look, this is all modelling and the modelling is exaggerating", and other groups saying "The models show this is going to be absolutely terrible, why aren't we doing more?" And so on.

So the models tended to become the focus for the debates between people who had strong opposing views because they were more debatable, actually. Also because they weren't fully understood. And a large number of the people who were debating them in public were doing so -- essentially they had a position they 80
 81
a government-ordained legally-backed change in behaviour. What do you say to that? Did you think that the issue of voluntary or spontaneous changes in behaviour was correctly understood and put in its place -- in the correct place?
A. Well, in a sense, in the model, you can -- and I'm going to cause deep pain to my modelling colleagues in the way I'm going to describe this, but I'm going to do it in a sense for a general audience. The model can say, for example, what would happen if you reduced interactions between households by $75 \%$ or more. That's a straightforward -- in fact some of the models asked exactly that question. You can then make an assumption, which you can vary, as to how far you would get by simply saying, "Please everybody, stay at home", and how far you can get by adding on to that "And the government will insist". Those are perfectly possible to model. That's not actually particularly difficult to do. All you're doing is you're just saying, "What proportions do I assign to these?" And it could be that you get 100\% adherence without any government action or it could be there's quite a big difference between the government insisting and people doing it voluntarily.

I think one of the problems that of course we had in March in particular, but also at other points in the 83
where we thought we were in time and where we thought we were in terms of the force of transmission, and therefore the number of measures you would need to actually get on top of things changed quite significantly once actual data started to flow that was more reliable. And that is a -- that's kind of inevitable. Data trumps models every time. Everybody agrees with that. And any model is only as strong as the data on which it is based.
Q. Coming back to the criticisms that were made in the public sphere in relation to models, is the nub of it that models model numbers of deaths, in essence, that may occur in the event of, for example, a step is not taken or they may model a variety of mitigations that may or may not be put into place, but of course if those mitigations are put into place and the government does take steps, then the number of deaths estimated will not come to pass?
A. Correct.
Q. All right.

Finally on models, some evidence has been given to the Inquiry that the modelling that was relied upon by SAGE failed to give sufficient weight to spontaneous changes in behaviour on the part of the population as opposed to weighing up the likely consequences of 82
pandemic, is there was no way of being confident really about what the relative contributions of those would be, and by the time you would be confident you would be several doubling times further along the path. So there wouldn't be time in a sense to look back and say, "Well, that's fine then, we probably don't need to take more radical steps".

Would it be helpful for me just to put a bit of background to this or shall we --
Q. I don't think so, but thank you, Professor. It would appear, and I hope I summarise your position fairly, that the question of the weight to be given to voluntary as opposed to compulsory changes in behaviour is extremely hard to estimate?
A. Correct
Q. And an attempt was made repeatedly to try to estimate what weight should be given to that particular issue, but we'll never know?
A. I think in practice we won't, and we'd probably get different answers between different waves as well.
Q. And that rather reinforces the point you made earlier, doesn't it, about the care that needs to be applied in placing weight upon modelling outcomes, particularly of that more sophisticated type?
A. Yes.
Q. All right.

You refer in your statement to the fact that, disgracefully, abuse was directed from the public and some sections of the press and social media against yourself and the Government's Chief Scientific Adviser and members of SAGE, and I'm not going to ask you for your reaction to that, it's absolutely self-evident that that was a disgraceful thing to occur.

You must have thought, you must have wondered, though, during the course of this pandemic, to what extent yourself and your fellow scientists on SAGE would -- may, by virtue of your Herculean contribution, be laying yourself open to future legal liability?
A. Yes, I mean, I think I was not -- in my own position of being in a government employee I was much less concerned, but l've always been worried and I have been for some time that it is ambiguous, at best, where scientists who are either seconded in to something or not employed by government at all but are giving their time in various forms, formal or informal, to what extent are they automatically covered by some form of indemnity against frivolous or indeed actual civil claims. And I think that is a worry and I think it's one that should be solvable in my view.
Q. I now want to turn to look, please, at the 85
therefore it is legitimate, they are open to political debate. I think within that I had -- there's a bit where I completely thought that the debate was not illegitimate but healthy and there was a bit which I thought was less healthy.
Q. Yes.
A. The health -- would it be helpful --
Q. Yes, no, please.
A. The healthy bit of the debate was, I think it was quite right that -- in, for example, the balance between a public health intervention and essentially, for the sake of argument, freedom to do what people want -- is had openly, and within a democracy I think that's quite right. Where I thought it was not legitimate was for people essentially to change the facts to fit the political agenda that they came with. And there is no doubt that there are examples of that, where people essentially ignored facts, twisted facts, in my opinion, that were facts, they weren't model outputs or anything, they were facts of life, because they were inconvenient to the political position they took. That doesn't strike me as healthy in the environment of a very major national crisis. But the debate seems to me something quite rightly that should happen and ideally happen in the public domain and in Parliament.
decision-making structures, into which of course you contributed your advice and the advice of SAGE.

It is obvious that those momentous decisions to impose lockdowns, so stay-at-home orders backed by the force of law, and decisions in relation to circuit breakers and tiers and rules of six, whatever they may have amounted to, were decisions for government, they were not decisions for SAGE or for the CMO or the GCSA.
A. Yes.
Q. Does it follow that they are all, ultimately, political decisions?
A. I think they are all very clearly political decisions because they had very profound implications for society and I think they are clearly ones that only an elected politician, within a democratic system at least, can reasonably finally make. We can give advice of a technical nature as to what would happen in this situation or that one, but ultimately these are political decisions.
Q. Is that why, do you think, that these matters have become of course so divisive, why this whole debate has become so politicised and why so many commentators have taken such entrenched positions?
A. Well, I think, yeah, in a sense they are political and 86
Q. And therefore there is a fundamental point to be made, isn't there, about the role of SAGE and of the CMO and the GCSA: firstly, you could only advise in the public health sphere?
A. Correct.
Q. Secondly, whilst you could advise of course on the indirect and direct consequences of whatever decision the government might make in terms of the effect on mortality, bluntly on how many people would die, it was exclusively a matter for government to weigh up the mortality issue, the number of deaths, to weigh up the economic and societal harmfulness resulting from, for example, a lockdown. That was never anything that SAGE or you or Sir Patrick could advise on directly?
A. Correct. Can I add just a slight addition to that? Completely agree with the point. So let us take an example, if people are moved into a greater degree of poverty, that has a public health implication.
Q. You referred to this earlier --
A. Yes, so I think that is a legitimate thing for us to put before government, but the decisions absolutely have to be for government via elected ministers.
Q. Because there is a very clear and recognised link between poverty and deprivation and public health?
A. Correct, and also education, the same is true.
Q. All right.

You've described in some detail how you relayed the advice from SAGE, and you've now described the limit on the role of SAGE and on the CMO and the CSA. Does it follow that you never said ever to government, "My personal opinion is that you must follow a particular route or outcome, you must, for example, impose a mandatory lockdown, you must impose a circuit breaker, you must do this"? Did you hold yourself back from opining on the ultimate issue, if you like, and restrict yourself always to giving advice on the outcomes, the risks of whatever decision the government might make?
A. I think -- I hope, and I think the evidence from the ministers has said this, that I was -- I was and Sir Patrick was -- very careful to be clear and blunt about the public health implications of decisions taken or not taken, but not to say "Therefore you must" or "I think you must", because that is absolutely a political decision at the end of the day.
Q. Having asked you to address that point, in fact when we come to lockdown 3 in January 2021, was there, curiously, a process by which all the UK CMOs did advise on the public health position and on the state of play across the United Kingdom in terms of the transmission of the virus at that stage, which did lead directly 89
that is a legitimate thing for a public health person to do. My director of public health colleagues around the country would give similar kinds of advice in their regional areas, the CMOs in the other four nations. So that is intrinsic to the job of a CMO or a public health adviser, but that is very different from things that involve government or the force of law or the use of taxes.
Q. In order to shoot as many hares as possible, does it also follow that ministers were absolutely clear that, as the democratically elected representatives, it was exclusively for them to make the decisions and not for you or SAGE or any other part of the government machine that wasn't an elected representative?
A. I think that a few of them in the early stages needed some help to see that that was -- there was no option but for them to make the decision. But that wasn't because they were trying to shirk their responsibilities, I think they saw it as a technocratic exercise and I saw it as a political exercise, at the end of the day, that the technocratic bit was giving the technical advice, the political situation follows on from that. But I think once people had internalised that and there was no push-back on it, then I think ministers were clear that they ultimately held the
of course to the government imposing the third lockdown?
A. Yes. And, I mean, I think there are two situations on this. The first one is the UK CMOs advised a move up to alert level 5, as this was then termed, I won't go into the details, knowing that that was something which would be politically important, but this wasn't us telling ministers in any of the four nations what to do, it was making clear our view that if they did nothing the outcome would be very bad, from a public health point of view. Ultimately the decision is still that for ministers. And in fact the decision as to whether to accept our advice on the alert level was in fact for ministers, but my view was they were pretty unlikely to refuse our request to move.

The other situation, and I just want to be really clear on this one, is it is also legitimate, in my view, and I did this from time to time, for me to give advice direct to the public, which they can choose to take or not. And in, for example, the winter of 2021 I did, for example, advise -- which was not government policy -- that people were extremely careful in that period around Christmas. That wasn't, in my view, political advice, that was public health advice. They could take it or not, it wasn't the government speaking. A very large number of people did take that advice. But 90
responsibility to balance the various issues.
Q. In truth, were there ever any good or easy outcomes?
A. So there were two things I said right from the beginning and I, you know, still don't think there's any reason to doubt them, the first of which is there were no good options, all the options were very bad, some were a bit worse, and some were very, very bad. And the second is this was going to go on for a long time. So if you took an option, you had to be prepared to see it through for many months to years rather than just seeing this as a temporary situation. And I think, again, this took a while for some people to internalise, that this was not going to be in any way easy and it also was going to be long and it was also going to involve significant loss of life almost irrespective, unfortunately, of whatever decision was taken, but where some decisions would lead to substantially worse outcomes from a public health point of view.
Q. And is it because ultimately these momentous decisions could only be for ministers that a mantra that they were "following science" was, in your opinion, inaccurate?
A. Yeah, I mean, both Sir Patrick and I when it initially happened, remembering that our job was to get science into government, thought, well, this is a good thing, the government is recognising that science is important. 92
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that were taken during Covid in the UK, my view is I don't think they -- they were not intending to cherry-pick, they may have done so by accident but it wasn't by design.
Q. You obviously spent a great deal of time in Number 10, you worked very closely with government ministers and government advisers for an inordinate amount of time. A certain degree of administrative confusion can be expected in any government dealing with a crisis of this magnitude, but how efficiently did you assess the administrative system around the Prime Minister to be operated?
A. I thought that the -- the civil servants, including the -- particularly the health and economics private secretaries, did a very, very good job in difficult circumstances. If I'm honest, I think that the political system around the Prime Minister was more mixed, but I don't think that was really as much to the fore in this set of decisions as it was in some other areas. It was quite often chaotic, but actually l'd be very doubtful if it wasn't chaotic in multiple other governments, and in fact that was what our fellow advisers from other countries said, in many other environments, that this was, you know, difficult for every country, it was being faced by extraordinary 95
understood diplomacy when we were discussing ports. I think this has to be a decision fundamentally for ministers. Who do they want to take their advice from has to be for them at the end of the day.
Q. Were there ever times when you assessed that there was a degree of cherry-picking of the science that was being proffered by SAGE and yourself?
A. What, that we were cherry-picking or that other people were cherry-picking --
Q. No, no, obviously other people are cherry-picking the advice you're giving?
A. Could have been the other way, but yes, no doubt about it at all. But that was inevitable and, in my view, wasn't -- didn't apply, and I really want to clear about this, to, in my view, the principal decision-makers in government, so the Prime Minister, the then Secretary of State for Health, the then Chancellor, the then Chancellor of the Duchy of Lancaster, for example, nor did, in my view, it apply to the great majority of political leaders. But they were definitely some that chose the science they wanted to hear, let's put it that way, and undoubtedly there were political commentators whose view of science started with "What is my political position?" and then derived from there.

But in terms of the decision-makers in the decisions 94
circumstances.
And I think, if I can -- if I can take a step back, I think it's very dangerous for people in my kind of job to say who is -- who would I have as my fantasy Prime Minister at this point in time. The choice is put before the electorate. If the opposition had won the election, it would have been Mr Corbyn, if Mr Johnson hadn't been able to continue, it would have been Ms Liz Truss, they would have had different sets of challenges and advantages as leaders. It's the job of the technical people to work with whoever is there, that is their job, and I think it is important not to personalise, in a sense, the situation between technical advisers and ministers, I think it's important to work with whoever is there.
Q. Professor, so that there can be no doubt, the Inquiry has not asked you and we're not seeking to ask you to express your views on the political attributes or ability of any individual.

My question was directed solely at the issue of decision-making and the processes by which these momentous decisions were taken.

There is clear evidence, although ultimately of course it is absolutely a matter for my Lady to determine, that there was a difficulty in -- the 96

Prime Minister had a difficulty in reaching clear, consistent positions, ample evidence relating to oscillation or backing and veering, whatever have you.

Did you observe that? Because of course you were there.
A. I think that the way that Mr Johnson took decisions was unique to him --
Q. Now, if I may interrupt, that's a euphemism if ever l've heard it. What do you mean by that?
A. Well, I mean, he has a quite distinct style, but I think lots of people have got quite distinct styles, and I do want to, in a sense, take your invitation not to make commentaries on individual politicians, I don't actually think that's my role particularly.
Q. No, but you gave advice within the confines of SAGE and your role, of course, on the public health issues, and you expected the government to be able to respond efficiently, speedily. You've referred to the need for speed earlier. It must have been apparent to you that the government encountered significant difficulties in being able to reach collectively, through the Prime Minister or otherwise, decisions that it was then -- that they then stuck to and they consistently abided by? This degree of oscillation and chaos is apparent?

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done in good faith, I'm just making that as a comment -inevitably.

A lot of the way by which senior ministers, including the Prime Minister, came to their position was done informally in conversation and, for example, one of the times where we had the most conversation with the Prime Minister in a small group, where he tended to be at his most focused, was in the briefing just before we did press conferences. That was not a formal meeting, that was really just working things out, but actually it allowed him to test out ideas not in public, which I think he valued and I think helped the decision-making process. But that wasn't a formal meeting and it wasn't minuted.

But I think that the decision-making minutes in meetings were -- from fairly on -- early on my sense was the record-keeping in the very first bit of the pandemic was less strong. But I wasn't the person who the minutes were aimed at and I didn't see a lot of them, but that was my sense at the time -- for -- for legitimate reasons of people being stretched all over the place, but that fact -- the fact of it is, I think, relatively clear.
Q. All right.

Can we now turn, please, to some of the early steps, 99
A. That's correct, but I don't -- I think it's a matter of record that many other nations had similar problems, expressed in different ways, in this major, major international crisis.
Q. Finally on the subject of decision-making, you've already confirmed that obviously there were verbal briefings in Number 10 that were unrecorded, but in the nature of these things principal private secretaries, private secretaries and advisers would keep notes, there would be read-outs of all the meetings.

Do you assess that all the meetings that you had, all the engagements, the verbal briefings, were adequately recorded? There were thousands of hours of meetings between yourself, Sir Patrick and government, and they're not all recorded. Do you think in hindsight that the lack of formality, the lack of transparency may have contributed to that degree of chaos or perhaps to the oscillation which witnesses have described the Prime Minister suffered from?
A. I think that -- well, firstly, I didn't get to see -rightly, didn't get to see ministerial minutes for many of the meetings I went to. And in fact one of the interesting things in this process has been reading minutes where my memory of the events is not exactly in accordance with the minutes -- I'm quite sure they were 98
the early information that you received in January of 2020.

It forms no part of the Inquiry's function with you, Professor, to go through every single one of the thousands of meetings and documents, and so l'm going to ask you to try to keep your answers at an appropriately high a level as possible.

On 5 January, in an email to Professor Sir Jonathan Van-Tam and to Yvonne Doyle and others, you referred to triggers.
A. Yep.
Q. "... three triggers [which] would mean we should start taking a close interest in considering the risk to the UK."

Could we have, please, INQ000047484. If we go down to page 3 , we can see that the genesis of the email string was a report from the press, I think, but of a report from ProMED, the organisation about which the Inquiry has heard which provided information about the undiagnosed pneumonia in China.

If we go back to 1 , we can see that yourself and your colleagues were talking about this report, and then you say this:
"My view is that any of three triggers would mean we should start taking a close interest in considering the 100

| risk to the UK. | 1 |
| :--- | :--- |
| "1) Healthcare workers dying ... | 2 |
| "2) Evidence of person-to-person spread eg in | 3 |
| families. | 4 |
| "3) Geographical spread implying a zoonosis is | 5 |
| spreading ..." | 6 |
| Just a couple of questions about those triggers. In | 7 |
| subsequent email correspondence Sir Jonathan Van-Tam | 8 |
| referred to that first trigger as meaning not that | 9 |
| healthcare workers would die but that there was | 10 |
| transmission of the virus between healthcare workers. | 11 |
| $\quad$ Which is the correct trigger, is it death or | 12 |
| transmission? | 13 |
| A. Well, I meant mortality, and I'll explain why, but | 14 |
| actually I thought the way that he moved it on to | 15 |
| healthcare workers having transmission was probably | 16 |
| sensible for the later stage, because it was clear the | 17 |
| first one was less relevant. | 18 |
| $\quad$ So if I can explain -- if you want me to, I can | 19 |
| explain why I chose those three triggers. | 20 |
| Q. Well, just briefly, if you -- | 21 |
| A. Yes. The first one, which I think is important, is what | 22 |
| I wanted to capture was a disease which had a high | 23 |
| mortality if you had very close contact, even if it | 25 |
| didn't spread very widely in the population, and | 25 | 101

A. Yeah
Q. On 13 January, there was a NERVTAG meeting in which NERVTAG noted that it had:
"... been stated that there had been no
'significant' human to human transmission, which implies there may be some evidence of limited human to human transmission which has not yet been made available ... we should be cautious about making conclusions about the absence of human to human transmission."

My question to you, therefore, is this: in relation to the continuing assessment of whether or not there was sustained human-to-human transmission, did SAGE and indeed you apply an appropriate precautionary approach, that is to say, to recognise that, unless and until it has actually been positively excluded, it's better to assume and to work on the basis that that human-to-human transmission will be or is sustainable?
A. Are you talking about human-to-human transmission in general or specifically asymptomatic, just to --
Q. No, I'm talking about in general, because this is a 13 January meeting before the issue of asymptomatic transmission becomes truly apparent.
A. Yes, I mean, in general, my view is we were, by that stage, putting a really quite considerable degree of interest and emphasis on this particular outbreak, even
examples might be MERS, SARS or Ebola. And those wouldn't be captured by something that had very widespread community transmission, at least until quite late on in the situation. So that was the reason I put that one in, in a sense, separately from person-to-person spread.

Sir Jonathan, I think very reasonably, said, well, healthcare workers are people who come particularly closely to people who have got significant symptoms, and they're an important subset in the sense of two, so I think he moved my triggers on. I didn't think that was unreasonable when I subsequently saw that.
Q. All right.

It's obvious that from this point on a number of you, but particularly you and Sir Patrick and SAGE, were focusing on the issue of person-to-person transmission, how transmissible was the virus, also on the issue of asymptomatic transmission, because, as we've heard from other evidence, you need to know the degree of asymptomatic transmission to work out the body of the iceberg of which death and hospitalisation are only the tip. You need to know what the body of the virus is doing.

And also, of course, the degree to which cases were in reality spreading beyond China.

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though we didn't at this point have clear evidence of human-to-human transmission that we can, in a sense, put our foot on, it's also the WHO position, but I think there was a general view that it was looking worse rather than better as time went by.

So when this first -- you know, just thinking it through from the beginning of January to the end of February, you start off with a situation where you have an outbreak. The probability this will turn into a major epidemic, relatively small. And probability of a pandemic, very small. The further on you go in time, the less the probability this is just going to be an outbreak or indeed disappear at all goes -- that probability goes down, when the probability of a major epidemic and then, subsequently, a pandemic goes up. So it's a continual process that happens over that two-month period.
Q. On 14 January, Sir Jonathan Van-Tam alerted you to a Reuters report which had been issued on 14 January in which there is a reference to limited human-to-human transmission of a new coronavirus, and it's obvious to Sir Jonathan and it's obvious from that report that there is human-to-human transmission among families but that it's not become sustainable in a wider setting.

The trigger, going back to the triggers, or one of 104
the triggers, was, in addition to healthcare workers dying and geographical spread, evidence of person-to-person spread eg in families.

So my question to you is this: the very trigger that you had identified or one of the triggers that you had identified as being of importance didn't require sustained wider community transmission, it only required transmission in a more limited setting, for example in families. Was that not already occurring and was not the evidence that that was already occurring already apparent by that date, 14 January?
A. I think by that stage we were pretty clear that there was at least some person-to-person transmission in close settings, so that's to say healthcare and family settings. That's a long way from saying this will become a community outbreak, let alone a pandemic.

And I think one of the things that bedevils some of the discussion of this is people think of this in a binary sense, of its either likely to be or it is not likely to be a pandemic. It was a gradually shifting probability curve. At this stage it's still on the less rather than more likely on the basis of just this evidence. But what this does demonstrate is that you're heading the wrong way rather than the right way compared to where you would have been five days previously, 105
trigger was met?
A. So in any given week I will get dozens of reports of outbreaks around the world, my colleagues will as well. What you're trying to do is to essentially pick up the needle in the haystack of that information at the earliest possible stage. That was the reason for having the triggers.

Now, I had not done prior to this and I have not done since something where I said we need to do triggers at all. So even on 5 January we were behaving in a way different to what we do with any of the other ones we had previously talked about, and the fact we were having a lot of conversations around this, at this point what looked a very small outbreak in a country the other side of the world, demonstrates the level of concern that we had relative to the multiple other outbreaks we get every month.

So this was -- you know, in a sense, I think the system -- I don't think this is a sign of the system not working, this is exactly what we should be doing, which is funnelling down, winnowing out the ones where it's improbable and left with the ones where you've got to take it seriously. So the degree of concern was ramping up by this stage.

A trigger -- I think possibly the word "trigger" was 107
because you now have evidence that is not overwhelming but pretty confident there is now person-to-person spread, at least in this narrow sense.
Q. The question was not designed to elicit when you might properly understand there to be a pandemic.
A. No, I'm saying --
Q. It was addressing the fact that, by your own trigger, by your own self-identified trigger, it does appear that, at that relatively early date, 14 January, there was family human-to-human transmission --
A. Absolutely.
Q. -- and therefore the trigger which you had identified for government action, because that's what the triggers were designed to meet, had been met?
A. The trigger was designed for government to take it seriously, which is not the same point as -- it takes another, I think, from memory, seven days before we get to the point of saying, "We've got to call SAGE, this is going to -- this is going get into very" --
Q. But what is meant -- I'm sorry. What is meant by wanting government to take it seriously?
A. So --
Q. You're dealing, with respect, with the emergence of a virus which kills. What did you have in mind by way of wanting the government to take it seriously when this 106
an unhelpful way to frame it for the benefit of people who are not in this area, because it implies a binary state, but it really -- basically it should have probably said these are things which should mean that we take it more seriously.
Q. By 16 January it was obvious, and Jonathan Van-Tam emailed you, that Japan had declared a confirmed case?
A. Yes.
Q. On 16 January Professor Ferguson had made available Imperial College's Report number 1, in which he said past experience suggests self-sustaining, ie sustained, human-to-human transmission should not be ruled out. Therefore, by 16 January you were aware that there was a novel coronavirus with a $12 \%$ case hospitalisation rate, that was on the limited data coming out of Wuhan, there had been geographical spread, only a small number of infections had been identified, it was obvious that the outbreak was much greater than the cases would indicate, there was human-to-human transmission, albeit not sustained, and Professor Ferguson was saying in principle, in a precautionary way, you can't rule out the fact it is sustainable.
A. Yep.
Q. Did not that, all together, indicate that a higher degree of alarm should have been sent round government 108
than was in fact sent round government?
A. I think on the 16th and with that information, remembering that the cases that were found outside China were not ones that were transmitted outside China, these were people who had been in China and had travelled out, so these were Chinese cases just detected in another environment, so that's quite an important non-trivial distinction, but what you're now getting is a rippling out of people getting more and more concerned, remembering that this is only just over two weeks since this thing that is been declared at all, and the amount of information is still quite minimalist. So I think -personally I don't look back on this and think, well, it was obvious that we should be calling SAGE and getting COBR involved on the 16th, I think that would have been difficult to sustain, nor is it obvious what they would have discussed other than the facts that are there, which are relatively clear, don't need further interpretation.
Q. I ask, Professor, because in his statement Sir Jonathan Van-Tam says this:
"The date on which I recall first being seriously concerned about the threat that this virus potentially posed to the [United Kingdom] was 16 January ... By that date, it was clear this was a novel coronavirus, it was 109
his view that this was a serious issue, I don't recall him actually saying this would become a pandemic but I certainly recall him being very concerned about it, and rightly concerned about it. But that -- you know, I don't see evidence that is this is not the system working as it should at this point, because it is not clear to me what an alternative path would have led to a better outcome on 16 January.
Q. The Inquiry's been treated to a debate in a completely different context about the difference between process and substantive outcome. You have already referred to the precautionary principle, and Professor Costello in his evidence said in an emergency there is a need for fast decision-making, emergencies require rapid action based on precedent and best practice. We would suggest to you instinct plays a very important role in this.

Were, was Sir Jonathan Van-Tam's instinct not correct and was your response, which was to wait and see whether more data should be accumulated, with hindsight, the wrong approach?
A. I don't think I can see anything obvious that should have been done on 16 January that would have changed, even marginally actually, the outcome subsequently.

So I think -- you know, in a sense, it is all very well saying theoretically you should start panicking;
fairly clear that human to human transmission was occurring ..."

And then he uses these words, and obviously we'll hear from the professor himself:
"... my view was that this would be [so not may, but would be] a significant [so not trivial] pandemic [not epidemic]."

And he says he raised this with you and, to the best of his recollection, your response was "to agree that the situation may well escalate but for now we needed instead to wait and monitor developments".

In hindsight, and of course this is a hindsight debate, should you have raised a greater alarm at that stage than that piece of evidence from his witness statement would indicate?
A. I don't see what I would have done differently at this particular point. Sir Jonathan, and I think he would agree with this, is quite instinctive in some of his decisions, very often rightly. He's a very able epidemiologist and thinker in this area. But if I'd said to him, "Okay, what's the evidence on which this is going to be a pandemic and lots of other things aren't?", he would have said "This just feels like that to me", that's quite a narrow basis on which to make quite big decisions. But I think -- you know, I took 110
actually the question is what should you do. And at this point we had a large number of people who were now engaged in this, we were taking it very seriously, it was being discussed quite widely. This was a short period before we ask for SAGE, which l've almost never called for a SAGE before. So, you know, we were taking this very seriously indeed. But at this point, unless you can point to something where it is obvious we would have done something different, I'm not sure --
Q. You're the CMO, with respect.
A. Yes, I know, that's why -- that's the point I am making, is that was my judgement and that is still my judgement.
Q. The triggers were designed to identify an appropriate response on the part of government, they weren't just there for your scientific amusement.
LADY HALLETT: I think to be fair, Mr Keith, Sir Chris said that they were to make sure the issue was taken seriously, and he has just said we were taking it seriously. I think we need to be --
MR KEITH: And my question to you is this: you did plainly move on to call a SAGE, and the chronology shows that SAGE was called at a relatively early stage in the process, but with your experience as the Chief Medical Officer, what do you mean by wanting the government to take it seriously? You call for SAGE, a SAGE is 112
a platform at which there may be a debate, but what in practice, epidemiologically, did you have in mind when these triggers were met?
A. So I think there's a large bit of the apparatus of government which is, in a sense, being ignored in that question, potentially, and I'd just like to highlight it.
Q. Please.
A. Public Health England, which is a large body, as opposed to my own office, of several thousand people whose job it is to deal with this, and the Department of Health and Social Care, both of which were by now taking this very seriously, and this was part of the discussion that was being had in the appropriate bits of government, which is not at this point, in my view, Number 10 or the central system. We'll come on to where I thought that changed, but at this point I think the right bits of government were taking this very seriously. So I don't think -- and that's the basis on which l'm saying I think this was a reasonable level of response for, as you -- leaving aside Sir Jonathan's gut feeling -- as you show, is still quite limited data. And if you look at Professor Ferguson's analysis, it shows pretty wide confidence intervals, quite rightly, he's basing it on incredibly sparse data. So I think we just need to be 113
what the geographical spread is likely to be. But also what can be done by way of preliminary steps to prevent a virus coming to this country or what steps can be put into place preliminarily by way of controlling the virus if it comes to this country, and I want to know to what extent you had in mind steps being taken by the government beyond the accumulation of data, what practical measures, if any, were already within, under the horizon of these, well, the bodies that sat, of course, from 21 January onwards and yourself?
A. So all I can point to is that government has extremely able specialist groups, of which Public Health is the principal one but also emergency bits in the Department of Health and Social Care, which were by now, at this point, taking this as a major part of their work, that was correct. "Wait and see" did not just mean Sir Jonathan and I had a chat and that was the end of it, government took no further action, it simply means in this situation that more data will allow us to actually decide whether we need to activate at a central government, cross-government basis, or whether this stays within the specialist agencies within which it was, at that point in time, still being assessed.

Now, and this is quite an important differentiation, there is rightly a stage along the process which is done 115
careful.
And this is -- the reason I'm saying this and the reason I'm going to defend this position, where I know it would be easier for me just to concede, is if as a result of this Inquiry we start having a hair trigger for large numbers of things where the professional judgement is "let us wait and see", and that is the correct professional judgment, that would not be an advance. It's -- the judgement as to when you're moving too slowly and when you're moving too -- too precipitately is a judgement call ultimately, and you have to be able to make it at particular points. There are various points along the path which we'll come on to where I would, in retrospect, have made different decisions. This is -- and all I'm saying is this is not one of them.
Q. You've used the phrase just then "let's wait and see". Did you say that, Professor? Because at this stage, around about 16 January, your primary consideration was "let's wait and see what the data shows". The reason I ask you is obviously there are any number of things that might or need to be done, finding information about the transmission of the virus, getting data about its impact, hospitalisation and death rates, whether or not it's likely to spread from China or surrounding regions, 114
within the technical sphere, is done by Public Health England, done by the Department of Health, and there is a certain point where you cross some threshold and there is a judgement call where this becomes a cross-government problem where wider bits of government, wider bits of the system need to be brought into play.

Your implication, I would take it, since I'm saying that the health bits were activated at this stage, is that on the basis of this data alone, central government outwith the health system should be being activated in some way, and I'm saying my judgment at the time and my judgment still now is I don't agree.

I hope I'm plain.
Q. No, that's very plain, Professor.

You've referred to whether or not the government took no further action, obviously there is an issue there for government, but I want to press you: was this the position, then, that it was important, as you saw it, to wait to see, to use your words, what data there was out there, how things would develop, and also -- and this is your reference to PHE and other government bodies -- bringing government into play, bringing those important and necessary parts of government to life to be able to respond to whatever might eventuate? Is that 116
a fair summary? You wanted to see what the position was, what data could be accumulated, and generally bring the government to life to be able to deal with whatever your enquiries discovered?
A. If -- yes, but if you -- if consistently you go to all of government and say "I have no data on this, I'm a bit worried, got to bit of a gut feeling this is going bad", you don't get very much traction, and the time you need to you also get not very much traction. Waiting and seeing, as the record clearly demonstrates, was a matter of a few days, and in that time we got enough information to be able to start making some really quite serious judgements as to what the level of risk potentially could be.

I think that the argument for always acting early can be made in the absence of looking at all the occasions when you decided not to act early and that was the correct thing to do. In medicine you have the idea of sensitivity and specificity, where sensitivity is you're good at picking up the thing that matters and specificity is you're good at not picking up the thing that does not matter. Sometimes in medicine the other aphorism is time in small doses is what gives you the diagnosis. In my view this was one of those occasions.
Q. The question was not in fact asking you, Professor, 117

In a few sentences, could you just outline for us, please, where the deficiencies in capability were to which you were referring?
A. So I think that there were problems with planning, but the much more important ones are problems of establishment. So if you compare -- let's start off with the establishment and I'll go back to the planning point.

The model for healthcare at the foundation of the NHS was a very heavily -- a very heavy bedded one, large numbers of beds, many more beds in the NHS at that point for a much smaller population, a medical system that was largely designed around infectious diseases or infectious diseases as a major part of -- as a major -sorry, as a major part of its work, for example a lot of TB in the early parts of the NHS, and so many -- and then the erosion of public health facilities, which wasn't a dramatic one, but it was a continuous one, over really quite a long period of time, and I think the Inquiry has had, from expert witnesses, a laying out of how essentially that was whittled away over a whole series of administrations over a long period of time.
Q. So that's the system in terms of public health.
A. That's the system, exactly.
Q. What about plans?
whether it's important always to act early. Was it necessary, in fact, to have acted earlier?
A. Than the 16th?
Q. Than the 16th.
A. Not in my judgement. That was my judgement at the time, and I'm going to repeat it, that is still my judgement.
LADY HALLETT: And I think you have answered the question very carefully, Sir Chris.

Right, we shall pause there, and I shall return at 2 o'clock, please.
( 1.01 pm )

## (The short adjournment)

( 2.00 pm )
LADY HALLETT: Yes, Mr Keith.
MR KEITH: Professor, in your statement, in fact at paragraph 7.39, you say this:
"As of January 2020, I had a good awareness of the UK's capability to respond to a pandemic."

You thought that it was -- or you considered it was capable of responding effectively to small outbreaks, and then this:
"I had no illusions that the [United Kingdom], or for that matter any other Western nation, was well set up to meet the challenges of a major pandemic with significant mortality."

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A. So I looked at the pandemic flu plan at the point when we were beginning to worry about this, about the time we're talking about now, and it was pretty clear that it wasn't going to give us any particular help, frankly. So my view was we didn't have a plan that was going to be useful from a prevention or management point of view. It had a large number of useful components within it, there wasn't nothing helpful there, but the idea there was a respiratory pandemic plan for the kind of pandemic this was going to be, if it was going to be a problem, that we could just take off the shelf and follow the playbook, was optimistic at best.

So --
Q. Can I pause you there --
A. Yeah.
Q. -- just before we move on to perhaps the last part of your answer.

Could you just explain why -- although we've obviously heard a great deal of evidence about the 2011 pan flu strategy and the planning for flu. Why, in essence, was the flu plan, whether it be the government strategy or any associated material, not of great or any particular help to this coronavirus outbreak with different characteristics and different potential countermeasures?

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A. Yeah, I mean, there were some differences that were to do with the difference between flu and Covid, which are more technical. Actually my view, having looked at it, was had we had a flu pandemic, with a virus that had a mortality of, for the sake of argument, $1 \%$ to $2 \%$, which is what we were thinking of at this point in time, it would also have been woefully deficient.

So it was not that it was about flu and this was Covid, that had some important differences; it was about the fact this wasn't designed, in my view, to meet this particular need at all. And I think -- if I'm honest, I think it really was clearly written by people who had just been through a pandemic in which the mortality was very low.
Q. H --
A. The H1N1 2009 pandemic, and I think that had just led to a -- it wasn't that they were modelling it just on that, but it clearly didn't really meet the needs of a 1918 -style flu pandemic, which, in my view, was the kind of model we needed to be thinking about. So the three big flu pandemics of the 20th century -- so 1918, 1957, and 1968 -- seemed to me much closer to what we were going to see than 2009, if we saw anything at all.

I'm not talking about 16 January, to be clear, but I think this was by the end of January, this was my 121
Q. There was effectively a complete absence of plans to be able to deal with this particular crisis, this particular virus and this particular emerging pandemic; the system, in terms of beds and public health facilities, was on the edge anyway; and there had of course been no earlier consideration of what might be done because this was the first coronavirus which potentially was going to hit the United Kingdom in a major way.

Your statement at paragraph 7.43 says this, that:
"From 20 January onwards, we commenced preparations
in earnest to be ready for a pandemic were one to occur."

Now, you'll know, of course, because it's in your statement and you were there, that there was a meeting on 25 February with the Prime Minister, the Health Secretary, Foreign Secretary, Sir Patrick, and yourself, in which ministers ordered that a plan be brought together, be drawn up, by the Civil Contingencies Secretariat, and as you know, they did produce a plan. But that plan was produced on 28 February. It was a paper called "The UK's Preparedness". That was, self-evidently, over a month later.

Do you have a view as to the length of time that was 123
view.
Q. Yes, you say as of January 2020.
A. Yeah.
Q. Then coming back, please, to plans. You've dealt then with the genesis of the existing plan; were there any other developed plans on the part of DHSC or the Civil Contingencies Secretariat or central government generally to deal with the crisis as you saw it emerging?
A. Not that I personally thought were massively useful to my role. There were some important things, many of them rather morbid, like, you know, how do you --
Q. Excess deaths.
A. Excess deaths and how do you have -- number of body bags and all that kind of thing, but in terms of actually: what do you do about the pandemic, my view was we were thin on the ground on plans.

That in itself would not have been an issue if we had large numbers of capabilities, because I think in all emergencies, the key thing is capability. Capabilities trumps plans every single time, and it was the lack of capability which was the bigger problem, in my view.
Q. So this was obviously a very serious problem.
A. Yeah.

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required to elapse before even that first attempt to bring together a combined plan was produced?
A. There was a lot of planning for individual components. There wasn't, as you say, an overarching plan.

For what it's worth, I, with some others, came up with the formulation -- which I think has been misunderstood -- of contain, delay, research, mitigate, principally to get the first three under way, and I think if you look at some of the plans as they came out, those three components were the components that were relatively worked through in terms of having some kind of meat on the bones of the plan.

The bit that I was directly responsible for was obviously the research bit, in my role as head of the NIHR, and we really moved on that quite fast, I think, we didn't wait for a plan from anyone else. And then there were various elements on contain. I think those were really the ones where I would say we were moving practically in by the end of January.
Q. Professor, I'm going to ask you again, please, to slow down.
A. I apologise to the stenographer in her absence. Sorry.
Q. I know you know that I'm waving my hand at you to try to slow you down.
A. It's my enthusiasm to answer your excellent questions.
Q. Well, long may it continue, Professor.

You must obviously have been very considerably concerned by the absence of plans because, whilst there were no doubt many documents dealing with particular hospitals and NHS trusts and high dependency or HCID beds or facilities and ICU beds and so on and so forth, there was, in essence, and there had been no real consideration of what sort of countermeasures might have to be thought about and ultimately deployed; is that a fair summary?
A. Yes, but can I --
Q. Before you answer: noting, of course, that such countermeasures as had been used or envisaged for the purposes of flu were not necessarily applicable to coronavirus.
A. Yes, but can I gloss on what you've just said, because I think this is a very central point.

If there had been a plan -- and I'm going to cause upset to some of my planning colleagues, but l'm going to do it anyway -- that was laid out: this is how the playbook should run, it would almost certainly have been the wrong plan and could even have slowed us down, because we'd have then spent ages arguing about whether this was the right plan and adapting the plan.

So sometimes it is easier actually to start with 125
A. It did, and I completely agree.
Q. So when you say in your statement "preparations commenced in earnest to be ready for a pandemic were one to occur", is that not just a reference to such strategic thinking as was done that led to the action plan and to various disparate parts of the system? There was no central plan telling the government how to respond nationally to the crisis until the end of February?
A. That -- yeah, basically that is my view, and if I'm honest, I would go a little bit further than that. I would say that I -- this may seem a long way down the track, but in mid-February -- mid-March, rather, I wrote a kind of three-page strategy document with tactical pillars underneath it, and I did so really because I thought it wasn't clear what else there was. So that was my attempt to do that. But it was a retrofitting of a strategy and tactical pillars, in some senses, to individual components that were there. It wasn't that nothing was happening and -- you know, I think the thing which people often assume is you get strategy, then plan, then operations. Actually, in emergencies, often that is reversed and the plan almost comes last in terms of the strategy, how you lay the thing over the top, and arguably, to some extent, that was true during these
a new plan, but what we needed was all the building blocks, and in my view we had some of the building blocks, intellectually and practically, but we definitely did not have all, and they were constructed in many cases in quite a rush, really, in February and early March.
Q. But preparations, although you say they commenced in earnest, had to await, did they not, the outcome of whatever planning central government decided needed to be done, in large part?
A. I would say that, as is usually the case in emergencies, in my experience, the people who needed to act started acting well in advance of the plan they were supposed to be acting on.
Q. Well, you've referred to the action plan to which you contributed, and we'll come back to that in a moment, that's the coronavirus action plan of 3 March, which set out the government strategy. It's been described as a comms communication by some witnesses. As you have accepted, obviously there were plans within NHS trusts and within particular parts of the system. But none of those plans, such as they were, or thinking, went directly towards the issue of: what sort of countermeasures nationally might we have to contemplate? That came later, did it not? 126
next six weeks.
Q. You've accepted, and Sir Patrick has accepted, as have other witnesses, that we could have gone earlier, in very general terms, in relation to the first lockdown.

Do you consider that, had there been either existing plans -- fully formulated, thought-out plans concerning possible countermeasures, how the country should respond -- or if these plans had been produced somewhat speedier, more speedily than they had, acknowledging that it took from 20 January to 28 February to produce them, then we might have been in a position, or a better position, to have gone earlier?
A. I don't think that -- so I think that components of the plan were possible to draw up quite early on, and my view is that the action plan, which is a perfectly sensible document, at the beginning of March, had those components in it. The fundamental bit, though, was what was framed as mitigate, which is interpreted by lots of people in lots of different ways, but l'm --
Q. Can we avoid the conceptual debate.
A. No, but the reason I'm making this practical point is that bit of the plan actually really had to wait until ministers had decided what their strategic goals were and the end point was, and additionally, you know, I think the big problems we had in early March, in my 128

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| view, principally arose from the fact we didn't realise | 1 |
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| how far on the path we were and the force of | 2 |
| transmission, which was a data problem and sort of | 3 |
| a testing problem, rather than because we lacked | 4 |
| a document in February. | 5 |
| I apologise for sounding slightly cautious about the | 6 |
| importance of documents, but -- of this kind, but l'm | 7 |
| just being practical about how emergencies tend to play | 8 |
| out, and the documents are often quite late in the | 9 |
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| Please don't apologise for being something that I've | 11 |
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| ministers. That's another important part of the -- it's | 14 |
| another important component. | 15 |
| Along with the delay in bringing together formulated | 16 |
| plans for how the country should respond, what could be | 17 |
| done to prevent the spread, either by way of suppression | 18 |
| or mitigation, it matters not, but the spread of the | 19 |
| virus, there was the issue of the lack of strategic | 20 |
| decision. Ministers did not grasp the nettle | 21 |
| strategically until relatively late in the chronology, | 22 |
| thereby enabling the planners and the doers to be able | 23 |
| to say: this is how we should respond to this | 24 |
| throughout. |  |

view, principally arose from the fact we didn't realise how far on the path we were and the force of transmission, which was a data problem and sort of a testing problem, rather than because we lacked cument in February.
I apologise for sounding slightly cautious about the importance of documents, but -- of this kind, but I'm just being practical about how emergencies tend to play out, and the documents are often quite late in the process.
Q. Please don't apologise for being something that I've suggested you are by nature, Professor.
You've referring to the strategic decision-making of ministers. That's another important part of the -- it's Along with the delay in bringing together formulated plans for how the country should respond, what could be done to prevent the spread, either by way of suppression mitigation, it matters not, but the spread of the virus, there was the issue of the lack of strategic strategically until relatively late in the chronology, to say: this is how we should respond to this throughout.
very clear, I'm not saying I think this is the problem of the politicians. I think it might be worth us re -looping back to this discussion when we get a little bit further down the track, because I think there was a point where it could have been possible to accelerate this and where that did not happen, and I think that's probably worth reflecting on.
Q. Which point do you have in mind?
A. That was when I and others, particularly I, briefed the Prime Minister on 4 February.
Q. 4 February, all right.
A. And this was not so much the Prime Minister, but I thought the system at that point could have taken a given have different tack to the one it did.
Q. Is this on account of the obvious delay that there was in terms of output between the beginning of February and the later --
A. It's probably worth going over that in particular, because there's no specifics to it, but I think there's a reason why -- I think that that was an example where we probably need to learn for the future, without blaming any individual. I thought all the individuals themselves did a good job.
Q. I want to come back, please, to the SAGE meeting to which you referred earlier, and we're just going to look 131
A. So I think that within that, within this, there were some -- and I'm going to, I hope helpfully, actually, divide things into what I consider are technocratic elements and what I consider are political elements.

The technocratic element -- and I've given an indication that the bit I was most responsible for was on the research side -- could just get on. They just crack on: "We've got a job to do, we've just got to do it".

Once you get into things that require political decisions, and the big decisions, whether it be issues of borders, whether it be issues of lockdown, all these kind of issues, these require -- or things that have huge economic implications, either direct, ie they cost a lot, or indirect on the economy, those fundamentally are ministerial ones, and I think there is where we were definitely slower than we should have been for a variety of reasons.
Q. And it may well be, Professor, I'm sure you'd agree, that given the momentous nature and the political nature of those decisions, it's not altogether surprising that the system doesn't allow for a particularly speedy response; it takes time for government to be able to make up its mind as to what needs to be done.
A. Yeah, and on this one I'm not actually -- I want to be 130
through, quickly, some of the most important meetings and some of the most important events in January and February.

So the SAGE meeting of -- it's in fact a precautionary SAGE meeting of 22 January, INQ000174700. On page 2 at paragraph 7 , there is a reference to this:
"This is evidence of person-to-person transmission. It is unknown whether transmission is sustainable."

So this is a reference to the earlier debate that we had, Professor.

There was produced for this meeting a commonly recognised information picture, to use the wonderful nomenclature of government, a CRIP.

CRIP 1, could we have that, please. INQ000047544, page 4.
A. Is this CRIP for a SAGE or a COBR?
Q. Well, it's dated, the information correct, as at Friday 24 January, but the date given there on page 4 is a PHE risk assessment of 21 January. So it may have been produced for --
A. Yes, this would be typically be a COBR document, rather than a SAGE document.
Q. In the middle of the page, it does say:
"Sustained human-to-human transmission (i.e. long 132
chains of transmission within a community)." 1
Is that because there was a significant change between 22 January and the 24th, or around 22 January; in essence, it became clear that the human-to-human transmission wasn't limited, it was sustained?
A. Yes, by this stage I think there was confidence that there was at least some sustained transmission.
Q. In fact, the Imperial College report, report number 3, to which you referred earlier, reported on 23 January to government that human-to-human transmission --self-sustaining human-to-human transmission -- was the only plausible explanation for the size of the outbreak.

Were you certain, nevertheless -- or how sure were you, nevertheless, at this stage, that human-to-human transmission was sustainable?
A. I was confident and I think everyone was confident that it was sustained -- sustainable at this point in time. That doesn't necessarily mean that it remained sustainable indefinitely, and if I can just take two recent examples, because I just want to illustrate, because I think it's quite a critical point in the way we thought about it for the next few weeks.

If you think about the major Zika epidemic in Brazil, and if you think about SARS, which has got some similarities to this, including being a coronavirus, 133

Patrick Vallance and Chris Whitty last night."
So probably an evening, maybe 23 or 24 January.
So along with the clear evidence of sustained
person-to-person transmission, along with their concerns, based upon the WHO material, there was no doubt in your mind, was there, but that there was a high degree of transmissibility, there was sustained human-to-human transmission; in essence, this was a very dangerous and transmissible virus?
A. Yes, I think -- I don't think there's any doubt that that was true, yep.
Q. On 28 January, you emailed a health special adviser in Number 10. Could we have INQ000047585. You identify -and we've seen this email before -- two of four scenarios as being probably only the ones worth considering for planning at this point, and they are of course at either ends of the risk scale: the first one is China has a major outbreak but brings it under control; the second one is the opposite end, which is the reasonable worst-case scenario, which is that it spreads, and it comes out of China, and there are those consequences that you set out in terms of the estimated -- and I emphasise the estimated -- R, reproduction, value, the mortality, the doubling time, the incubation period and so on.
both of those were sustainable and along long chains of transmission for a period of time and then they died out.

So the idea that there is ongoing person-to-person transmission along long chains, and that inevitably means that you then go on to have a sustained -- I mean in a different sense, over multiples of months to years -- transmission, those two are one -- the first is necessary for the second but not sufficient.
Q. Professor, I must ask you to slow down again.
A. Sorry.
Q. You're going very fast.

Around this time, in fact on 25 January, there were some emails between Professors Woolhouse and Ferguson and with Jeremy Farrar, in which they debate -- and Professor Woolhouse is particularly strong on the issue -- whether or not the central estimates published by the World Health Organisation indicate that half the people in the United Kingdom and many other countries were maybe infected, there would be at least a doubling of the gross mortality rate and a completely overwhelmed health system.

Now, you weren't party to those emails, but Professor Ferguson, in one of those emails, says:
"Fully agree. Jeremy and I were saying the same to 134

So at that time, you were aware of the general concerns about transmissibility. You were aware, were you not, that if the virus does spread from China, then, given these characteristics in terms of mortality, doubling time, transmissibility and so on, there was going to be a very real problem insofar as the United Kingdom was concerned?
A. Yes, and that's the reason I wrote to Number 10.
Q. Indeed.

What thought did you give at that time to what practical measures might be put into place between this date, 28 January, and the end of February, which is when we got the plans back from the Civil Contingencies Secretariat, to stop or prevent that spread, to stop that worst-case scenario eventuating?
A. Well, I think that one of the things that I was trying to do in this email, and I tried to do in quite a lot of the advice I gave, was I was concerned that government would think that there was likely to be a middle way, and I wanted to remove that possibility from their planning assumptions.

So my view was either this -- we would get spillover cases, but actually this would get contained in China, it's less bad than it currently looks, and fine, that would be a big problem in China, but it would be a much 136
more limited global impact, or it was going to become 1 a pandemic. I couldn't see, based on the characteristics it had at the moment, a middle path where it was a moderate problem, and that was the point I was trying to make here.
Q. Which is why it is a dichotomous decision.
A. Exactly, why there isn't a fudge in the middle, which is obviously the temptation for people to go into. And if you have a pandemic, but not starting in your own country, there isn't a great deal you can actually do yourself to stop it. You can then do the things we talked about, so slow, delay, research and mitigate, but you can't stop it. That genie is out of the bottle and you have no control over it. So I wanted people to be aware that was basically the dichotomous position we were facing.
Q. And that is why, isn't it, you identified that the priority -- and we can see this at the bottom of the page at (4) -- is to prevent any UK transmission, because if the virus leaks out of China, then the wave is coming, that is what you're essentially saying, unless it can be prevented. This virus with these terrible characteristics is coming, because that's what viruses do.

So that's the key: prevent any UK transmission. 137
cannot be stopped if it is a pandemic, if it's
sustainable human-to-human transmission and it's
geographically spread out of China, it cannot be
stopped; all we can do is slow -- delay the upswing, if
you like, using different terminology?
A. Yeah, and I say that explicitly in the next sentence.
Q. Yes. So you were recognising, at this relatively early stage: once it leaves China, we're in trouble.
A. If it establishes -- well, I mean, spillover cases from China in themselves --
Q. Not spillover, but sustained human-to-human transmission.
A. Once you get into that situation, there is an extremely high likelihood you are in trouble, yes. Nothing in biological is certain, but an extremely high likelihood.
Q. No, but by this date, all the signs were that it was sustained human-to-human transmission. By this date, there were cases outside China; Japan, South Korea. By this date, or shortly thereafter, SPI-M-O was beginning to suggest that there was a probability it would come at some point.
A. I think -- so I'm going to just point out that, you know, the WHO, which is the normative organisation, had, I think, as of this point, still not called even a public health emergency of international concern,
A. Well, the key -- in a sense, this has two different aims, the prevent, in this context. If this was a SARS-like situation -- which I have to say looked increasingly unlikely by this stage, but if it was, for the sake of argument -- the point of this is simply to make sure that any spillover cases can be rapidly contained so this never establishes itself in the UK. You're not then saying this will turn into a pandemic, in fact you're saying no, this won't, but what you don't want to do is get any backwash from this. We had importations of SARS, we had importations of MERS, we had importations of Ebola; we picked them up and we treated them. That, in a sense, is the first element here.

If it's going to be a pandemic, you're never going to be able to stop it, and I think there's always an illusion you can stop it. You can't. You can delay it, and that was where a lot of the debate, of course, around border and other measures then took us.

But what we wanted people to realise is once you're in pandemic territory, the idea of stopping it is an illusion. You're not going to stop it. You can delay it, potentially, maybe.
Q. So when you referred to the priority being to prevent any UK transmission, what you really meant is the virus 138
which is well short of a pandemic. Pandemic was not declared until, I think from memory, 11 March. So, you know, international views, as with many things, you look back on this and say: how could they be so blind? How could they not see this? At the time, there was still quite widespread international debate amongst serious experts.

So, yes, there were experts who were saying, "This is definitely going to happen", there were experts who were saying, "Very doubtful", and there were points between. You know, I think it's very important we don't look back and say, "Well, of course you can see this is what would have happened", and I'm just pointing out the international evidence on this at the time is relatively clear. It was uncertain at this stage. But I think most people would agree it was heading further and further towards this is going to get bad, and my view is, you know, if this does get bad, this will be a pandemic. It's not a kind of an in-between.
Q. But your position was not predicated upon the WHO; far from it. You had your own views, your own expertise and, of course, the expertise of SAGE.
A. Yes, but --
Q. Right.
A. -- in a sense, what I -- actually, in this area, the UK 140
and WHO -- you know, WHO is a reasonable anchor point. If you diverge from WHO -- and it was appropriate for us to do so sometimes -- you have to have a good reason why you're doing so. I think it's a reasonable, in a sense, point of international comparison. It is the international normative agency.
Q. Professor, you gave advice, you received advice from SAGE, you relayed advice, and we can see from this particular document, without any express regard being made to the WHO's technical position and whether or not a PHEIC or pandemic had been declared; correct?
A. The advice I consider is perfectly sensible advice. What I'm saying is I think I would have been wrong at this point to have said to Number 10, "The game is over here, this is going to be a pandemic, there is no chance of anything else". That would have been incorrect technical advice from me to them. So what this gives is two scenarios, one of which is a pandemic and one of which is not, but both of which are worth taking very seriously.
Q. And concurrently, you knew there was sustained human-to-human transmission, or at least the signs were all pointing in that direction. You knew, because you've described to us how you were aware, that the United Kingdom was poorly placed to be able to respond 141
previously it was reasonably housed.
Q. We presume, of course, that you wrote to the health SpAd at Number 10 because, by this stage, the formal process by which you gave advice to ministers and the Prime Minister, of course, hadn't yet been set up because, of course, SAGE itself wasn't yet operating at full pace.
A. Yeah.
Q. There is a SAGE meeting on 28 January, INQ000203936, so a week or so later, and on page 2 at paragraph 9 there's a clear reference to sustained human-to-human transmission, we can see it there.

Then on page 3 at paragraph 28 , SAGE says this:
"For [United Kingdom]: SAGE agreed that the current triggers which would require a change in HMG's approach ... are appropriate."

Can you help as to why SAGE was still debating the appropriateness of the triggers, as opposed to what change in the United Kingdom Government's approach was required in light of triggers being activated, which of course you have agreed already they were?
A. Well, we -- if you're looking at those ones, "sustained human-to-human transmission outside China", that's a key rider to that, "and/or a severe UK case", which we had not at that stage fortunately had.
in terms of the public health capability, in terms of the absence of plans, in terms of the absence of control measures to stop physically the virus reaching these shores. So was it not therefore the case that this was the point at which you appreciated we were in a terrible bind; it was coming, and there was very little practically that appeared to be possible to be able to deal with it, other than delay the spread?
A. Well, I think "it was coming" implies certainty, which I think is not where I'm saying I think we should have been at this point. But, you know, it's pretty rare that someone in my job -- not just me but my predecessors -- writes this kind of email into Number 10. This is not the kind of thing you do on a kind of monthly basis or, indeed, yearly basis; this is a rare event to say: we are very concerned. So we have by this stage activated the SAGE mechanism, we're writing into Number 10. As we'll go on to talk about, a lot of briefings of very senior people across both the official and the political system happened in short order after this.

So I fully agree with you, this is a point we are starting to move and escalate this as a major issue across government, not just within the technical agencies which, as we previously discussed, I thought 142

The point about this, though, is we think that both of these are potentially very close in time, and that was the reason that SAGE was meeting at all. I mean, SAGE meets very, very rarely. To be clear, this is not something which meets every time there is a mild concern; SAGE meets because we think there is the potential for a very serious all-of-government response. If it's just a health department response, then you would normally expect it to be dealt with within the technical agencies of the health department.
Q. Why were there different triggers being utilised by SAGE and, it would appear, building in a delay because SAGE's opinion was these triggers haven't yet been triggered, to the earlier triggers that you had advised were appropriate, which was family-to-family or family human-to-human transmission, geographical spread or infection amongst healthcare workers? It rather appears that these triggers had shifted the goalposts; they were higher levels of trigger which would be required to be --
A. Yes, and accepting that I rather regret that in my first ones I used the word "triggers", because that's an unhelpful -- probably an unhelpful framing. But I think it was clear, and I think you're exactly right, that they were to achieve two different levels of escalation.

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So the ones that I did on 5 January were to say this needs to be escalated quite seriously within the health system, particularly Public Health England and the emergency response in the Department of Health and Social Care, which then it was. Part of that response was to trigger the SAGE system, also meetings of the permanent secretary in the Department of Health and Social Care, and at this point the SAGE triggers are about: what shall we do in terms of cross-government response, which is a significant step up from the ones that I was previously doing.

So you're right that they are different triggers, and the reason for that is they are to do different things, and this one is a: now the whole of government needs to be thinking about this if this is met.
Q. So from what you said earlier, the earlier triggers were there to identify a level of seriousness, you said you wanted government -- or government would then take it seriously. These triggers require, if triggered, a change in approach.
A. Yeah.
Q. What did SAGE mean and what did you understand that reference to HMG's approach to mean? Consideration of countermeasures, health campaigns, border measures? What is it that SAGE had in mind? 145
being triggered? What in practice does it amount to? Can you help us?
A. Well, the earliest things that would have to be considered -- and they are not easy and we should really talk about them either seriously or not at all -- are border measures, which require a lot of thinking, they've got implications for trade, they've got implications for diplomacy, they've got implications for the economy, they've got implications for consular, et cetera, but that's because one of your earliest things is to reduce the risk of importation. You also need to alert the overall economic system that this -that something which may well be a significant economic shock is in the vicinity -- doesn't mean it's going to happen, but they need to think about it -- et cetera. There are a very large number of different things which will need to be considered which are for --
Q. Is this all in the context of borders?
A. No, this is in the context of -- the point about these are: what are the things which cannot just be done within the health system? That's really the question on this. And there are some things that -- very many things that can be done within the health system, but there are many things also which cannot be done within the health system, and I've just given some examples. 147
A. Well, I think at this point you're talking about measures which inevitably will require cross-government agreement and considerations, and I think you chose -you took the example of border measures, which are an extraordinarily complicated issue you might want to come back to --
Q. Professor, forgive me, we'll come back to borders.
A. No, but, in a sense, what I'm really saying is there is quite a big difference between things which are entirely within what is sometimes called the health family, where you can sort it out with a combination of NHS, public health and academia, and those things which are inevitably going to require, not just need -- indeed, not just desire, but require a cross-government response, and what these triggers would mean is a change of the whole of government. That's the HMG point. This is not a DHSC response, it's not an NHS response or a PHE response; this is an HMG response, ie whole of government.
Q. This entire debate, Professor, is of course taking place in the context of how a country and a government responds practically to an emerging crisis.

What in practice did SAGE understand the government would do? What was it advising it would do, what did it think it would do, in the event of these fresh triggers 146

There are many others.
Q. Well, let's look at borders.

By this date, advice on port health recommendations had already been given. You'll recall yourself and a DCMO, probably Sir Jonathan Van-Tam, advised it was too soon to do any additional measures on the basis of one case in Japan or one in Thailand.

On 2 February, so a few days after this, you engaged the advice of Professor Edmunds and Professor Ferguson. You made a request for their views on travel advice.

In relatively early February, 5 February, at a COBR meeting, you advised that, practically speaking, significant border measures -- and putting aside all the issues about the trade and commerce and flow of persons and the political connotations -- a stringent border process would be unlikely to achieve much, other than a delay to be measured in days of the emergence of the virus.
A. Yes, so that was a technical judgement.
Q. Yes.
A. And I wanted to check that other people who have different experience in this area thought this -you know, were able to challenge if they thought that this first view was incorrect. I didn't want it to be the last word. But my worry was l'd be asked for 148
an opinion, and I wanted to be sure that others who I thought were good in this area had had a chance to disagree if they felt that my opinion -- my provisional opinion was wrong.
Q. Indeed, and I think we can deal with borders relatively speedily, because in terms of the merits of border measures, evidence has been received by the Inquiry to the effect that less stringent measures, such as screening and leafleting and temperature checks, are unlikely to work because they can be circumnavigated, there are very real practical difficulties with any border system of restriction, and, scientifically, there was no support for complete border closure or quarantines because (a) they are very difficult to maintain, (b) they are politically very divisive and, thirdly, they were just unlikely to work.
A. Yes, and I think -- in a sense, I think that the technical judgements were -- there's no evidence subsequently that has come to light that they were wrong, and -- but if I were to re-run this period again, and I think it's important to be reflective, the thing which we didn't I think consider enough was: should we be asking people coming back from China to self-quarantine, irrespective of symptoms, for probably 10 or 14 days? We were beginning to do so on the basis 149

So what other --
A. Can I just be --
Q. Yes, please.
A. -- very, very clear: unilateral border measures by the

UK, I think we were all very confident would have very minimal effects. Had, for example, China chosen to close its borders right at the beginning, it's difficult to tell what would have happened and that could have led to a different situation.

But in terms of the decisions the UK had sovereignty over, ie its own borders, that was the situation, yes.
Q. I'm not concerned with what China might have done, because coming back to the 28 January SAGE meeting and that paragraph 28 on page 3 , I was asking you: what in practice did SAGE or you envisage HMG's approach to mean? And you said borders was one issue and there were a number of other public health issues -- public health measures. But borders, bluntly, closure of borders, was never a runner, and that was generally appreciated by that date, by the SAGE meeting.
A. Actually, I'm going to add a caution to this. One of the other things that are important in borders is the maintenance of public confidence, which is not an epidemiological or public health issue, but there have been examples, I know, where borders have been 151
of symptoms.
Now, as it turns out, this wouldn't have made any difference. As you've got evidence from others, the importations that happened, as we actually were anticipating, were mainly from our neighbours, not directly from China.
Q. And they were largely in half term. It would have taken time for any effective quarantine to be set up.
A. Yeah, no, in practice I think it would have made no difference. All I'm saying is it's very -- you know, in many areas, I think hindsight has led people to take unduly harsh views about what should have been done. Here's an area in which I think we probably should have done something different, even though it probably wouldn't have made much difference. But I think in terms of, you know, what's our future doctrine, I think this is an area we should probably re-examine. So that's not the same as stopping flights or screening, both of which I think have very profound difficulties. This is a rather different approach.
Q. But the point, Professor, is that it was already understood by 28 January, that SAGE meeting, or very shortly thereafter, that in terms of efficacy, border measures were impracticable or unlikely to work or just impossible for a variety of reasons. 150
closed essentially for that reason, and that was a reasonable political decision. So I just think it's important -- I just want to be clear that it's an example, slightly counterintuitively, where the political choice might be to go further than the public health advice necessarily would lead.
Q. My question, though, was all predicated upon your description in paragraph (4) of that email to William Warr, the health SpAd, that the priority was to prevent transmission in the United Kingdom. So we are only concerned with measures that could be taken by the United Kingdom Government.

So I ask you again: what other practical measures were in mind at the end of January/the beginning of February, other than borders, which we've debated, which would have been reflective of the change in HMG's approach which SAGE envisaged would be brought about by the triggers being triggered? What in practice was available, Professor, and what could be done in practice?
A. Well, I think that we should have taken a -- so there are several different things we could have done, none of which I think would probably have made a lot of difference in reality, but I think that this is an area where, in my view, government should have started, not 152
necessarily that day, but within the next week -- and I'll come back to where I think we had an opportunity and didn't go there -- to start seeing this as a massive threat to the whole UK, economic and social as well as medical, as indeed transpired, and that really is the question, I think, which this should trigger.

But the problem we would have here -- and this is repeatedly going to be the case, I'm afraid -- is the point at which you can make these kind of comments in SAGE. We didn't at this stage have any cases in the UK --
Q. 30 January.
A. 30 January -- that we knew of. That we knew of.
Q. Well, the first case was published on 30 January, the person in York.
A. Yeah, exactly, but --
Q. One day later, two more.
A. Yes, exactly. Once we get to this point, we're starting to take off, but I'm just saying the numbers are very small, we haven't got any deaths in Europe, fortunately, for another two weeks -- at all, not just in the UK, UK was later, fortunately -- so whether you could get political movement based on those extremely small numbers I think is an interesting question that we will never know the answer to.
officials, COBR met, I briefed the Prime Minister directly, briefed parliamentarians, briefed the opposition, this is all over the newspapers. So the idea that government was unaware of this because they hadn't read this paragraph in SAGE I think is probably a little unfair. I think --
Q. Professor, no one --
A. -- it is very clear we were escalating at quite a high level in government. It's -- you know, these are all things that you wouldn't do under ordinary circumstances.
Q. No one is suggesting that the government should have been aware of that particular paragraph. I'm referring to your own answer, which is that perhaps -- perhaps -the nature of the massive threat wasn't understood or it wasn't called out clearly enough, it wasn't appreciated perhaps by those who needed to understand it.

You obviously called for a precautionary SAGE and there was a precautionary SAGE, and there were multiple meetings of SAGE, COBR, and then a stocktake meeting on 4 February, prime ministerial meetings, Cabinet and so on throughout February. But nowhere, beyond the debate about the need for plans and then the need for modelling in SAGE and the need for a proper understanding of the position, does any part of the government openly say,

All I'm just saying is: we shouldn't assume that, even had these triggers been met, action would necessarily have flowed. I'm just saying that --
Q. Quite so.
A. But I think that it is important to note that this is not just a health problem if it happens; this is clearly going to be a societal problem that needs to be escalated across government.
Q. Why did SAGE and yourself and other scientific advisers in government or other advisers in government not shout out, beyond the extent to which you did, which you wrote an email to the health SpAd, shout out that there was in fact a massive threat, and it was massive because the practical means of ensuring control or keeping the virus away from our shores were effectively absent --
A. Well, as you'll --
Q. Sorry, if you'll allow me just to finish the question -and the data was then already clear that there was sustained human-to-human transmission with chains of transmission? So it's a massive threat because there was a massive problem, and you were aware that there was a massive threat. Why wasn't the government aware?
A. Well, as you will see over the next few days, of my statement, which I think lays it out reasonably clearly, over the next few days we briefed national security 154
"There is a massive threat and we are woefully under-prepared for it, and something must be done at the very highest level and with real urgency". That tenor, Professor, appears to be missing from that material.
A. Well, in my view, it might be more useful to go through the next few days, because I think they lay out how we did escalate this right to the top of government, and indeed more widely, not just the governing party. And, you know, your point is right, but therefore we did something. So I think that's the --
Q. You did something?
A. Yes.
Q. But why wasn't the degree of the threat, of the problem, the massive nature of the threat, seemingly fully understood?
A. Well --
Q. You escalated the problems and you pulled every lever open to you in terms of the government process.
A. Well, I think it depends whether you'd like to have this discussion now or walk through the next few days and then I can try and retrospectively say where I think we could have probably gone in a different direction, if our doctrine within government was definite -- was better in this area.
Q. All right. Well, we are going to look at those 156
documents, as you know well.
A. I mean, I can do it now if you prefer.
Q. No, no, no.
A. I think it works better if we kind of see some of the actions we actually did take, rather than the ones you are not allowing me to move on to.
Q. Professor, we will be moving on to them, and I'm allowing you to move on to them.

By the end of January, in addition to the material which we've debated, of course it was obvious that there were cases in Thailand, Japan, South Korea, the United Kingdom, Germany. There was also a Lancet article, was there not, at the end of January which had made plain the nature of the human-to-human transmission? It concerned a family that had travelled to Wuhan.

So on 2 February, you were emailed by
Professor Ferguson, who I think gave you a central estimate of the case fatality rate; is that correct?
A. Yes.
Q. What did that tell you about the likely level of morbidity -- mortality, I apologise, amongst identified cases?
A. So without pulling it up, because I was sent, by multiple people, multiple different versions, but all of
available which have, with the fullness of time, proved to be broadly correct? So case fatality rate, infection fatality rate, hospitalisation rate.
A. If you look at, for example, the email we've just discussed to Number 10, none of the figures I put in that have actually substantially moved since the time that I read them. These weren't my numbers; I was reporting other scientists' excellent work. But we'd already settled -- although at that point we had wide confidence intervals around all of them, actually as the confidence intervals have narrowed, we've still ended up in a pretty similar central position, which I think is a great tribute to Chinese and UK scientists, amongst many others.
Q. So we may be clear about the information available to you, those were matters such as the reproduction number, the doubling time, the incubation period, case fatality rates, that sort of information?
A. Yes. I mean, some of those are probably intrinsic to the virus, so things like the incubation period. Things like doubling time and the effective R number, not necessarily the R0, they will vary over time and depending on a number of other factors, including actually NPIs, as we will no doubt come on to.
Q. Yes.

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them triangulated around somewhere between $1 \%$ and $4 \%$ mortality in cases that had been found, but with a very heavy health warning -- and they would have agreed with this -- that calculating mortality rates early on in a pandemic, when there's an upswing and you don't have the ability to detect minimal or asymptomatic cases, is fraught with technical difficulties.

So I think all of us thought that there was a very wide range around these estimates. So no single one of them, in my view, you get and you think: well, that's it solved. It took quite a while before we were confident. But the ballpark I thought was got right, actually. And I think if you look back over these numbers --
Q. They're pretty good.
A. -- I think they were pretty good, actually. You know, three weeks in to a completely new to the world disease, relatively few of these numbers have moved very much since. So that is quite a -- you know, the technical response was, in that sense, impressive.
Q. And when you say since, you mean, do you, by the end of January?
A. No, I mean, up to the end of -- until we get to Omicron, I think the numbers that were --
Q. No, no, no, sorry, we misunderstand each other.

At what point were the majority of these figures 158
A. So they're not fixed. But some of them are fixed, and those ones I think were pretty reasonable as a first pass.
Q. There was then a SAGE meeting on 4 February. We'll have that up briefly, INQ000051925. SAGE noted on page 3 at paragraph 19 that:
"Asymptomatic transmission cannot be ruled out and transmission from mildly symptomatic individuals is likely."

Insofar as SAGE was unable to rule asymptomatic
transmission out, as opposed to saying it is in existence, was that a reflection of the data that was of course available at that point?
A. Yeah. I think this was a perfectly sensible assessment of what we knew at that point, yes.
Q. Just to be clear, asymptomatic transmission or the issue of asymptomatic transmission is quite different, of course, from the issue of human-to-human transmission that we were debating earlier.
A. Yeah, and different again from asymptomatic infection, where someone catches the disease, has no symptoms and does not pass it on. That's a different thing again, and actually quite an important distinction, those two.
Q. Yes, and you've addressed that in your statement at some length.
A. Yes.
Q. On 4 February, there was what we've been calling the stocktake meeting, and that's the meeting to which you referred earlier, Professor. That is, I think, at INQ000146558, or at any event this is a letter from Imran Shafi, who reported upon the meeting, and this was a meeting between yourself and the Prime Minister, the Secretary of State, and a number of advisers and colleagues.
A. Including the National Security Adviser.
Q. Including the National Security Adviser.

The second paragraph on that page -- it is, as it happens, the only substantive paragraph that deals with coronavirus:
"We began with a short update on coronavirus. Following an update from the CMO, the Prime Minister stressed the need to continue to explain our stance to maintain public confidence in the plan."

May we presume that's a reference to the government plan, whatever it might have been by that date?
A. Yeah.
Q. "On further travel restrictions, your Secretary of State was engaging [Foreign and Commonwealth Office] and European colleagues and would revert with a proposal on the way forward ..."

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A. Yeah.

It was reasonable to think that we would be looking, on first pass, at maybe 100,000 to 300,000 deaths, which, to be clear, is pretty accurate compared to where we are, sadly, now. I wasn't saying this was certain.

Now, the important second point, this wasn't some maverick coming in and saying this; this was on the basis of SAGE meetings chaired by the Government Chief Scientific Adviser, COBR had met, the World Health Organisation has by now declared a public health emergency of international concern, this is all over the news.

Now, the point I would like to make on this, because I think this is actually something where we really do need to think very seriously in government, is that had, let us say, the Director General of MI5 or the Chief of the General Staff come in and said, "There is a possibility of 100,000-plus people sadly dying from a terrorist attack or an attack on the UK", the chances that this would have been the response in the letter and that this is what would have -- that the system would have continued as it did next COBR meeting, still chaired by the Secretary of State for Health and Social Care, I think is quite small.

The reason I'm making that point is: this was not 163
Q. Can you go, please, much slower on this important issue. 162
a new consideration. Pandemic infection -- flu, but this is very similar to pandemic flu -- has been top of the National Risk Register for years. This is not a new potential threat. So my worry has always been -- and I think this, in a sense, reflects it -- that hard geopolitical threats are treated in a different way -and in my view an entirely appropriate way, this isn't a criticism of what they do -- to ones which are seen as natural threats or hazards. And that, I think, is something collectively that we should think about, without ascribing this to any person. I don't think -you know, I think the same could very easily have happened under a number of prime ministers and with a number of others in the room. This is not a statement about the individuals; this is a statement about the system, in my view, underplaying, relative to other threats, the natural threats, including health threats.

So that, I think, is quite a fundamental point, because I think had that -- yeah, had we essentially had the centre of government electrified by this, I'm not saying the outcome would have been different, but I think it would at least have led to a stronger all-of-government think-through of all the potential consequentials.
Q. There is a lot in that, Professor. Can I just divide it 164
up briefly.
In terms of the system, the Inquiry heard a great deal of evidence in Module 1 about how the government system is differently designed depending on whether or not it's dealing with a threat -- a terrorist outrage, for example -- as opposed to a risk.

Is it that divide to which you're making reference, in terms of the absence of an equally sophisticated or speedy system by which threats can be rapidly responded to, in the context of risks and, for example, public health emergencies? Is that the point you're making?
A. Yes, this is a -- this is something which was already top of the National Risk Register --
Q. Indeed.
A. -- with understood consequentials across all of government, and that seems to me the reason why this is an opportunity where we probably could have moved up a gear or two, across government. And, as I say, I don't consider this is a personnel problem; I consider this is a systemic problem.
Q. If you'll allow me, you've made that point, and I'm not suggesting that this is a personnel problem. This failure, if it is -- and we'll debate that -- was not a failure on the part of any given individual.

But putting aside your very valid point about 165
necessary electrification; that there was a complete absence of any understanding that the threat faced by the United Kingdom was of that magnitude, as you have described, the massive threat. Would you not have picked up the phone and said to somebody in Downing Street, "You've completely failed to understand the significance of this threat, the emergency that this constitutes, the magnitude of this crisis"?
A. I think that the response -- and you I think have seen some of the toing and froing -- was to debate which hundreds and thousands was the correct hundreds or thousands, which didn't strike me as material, although I wasn't actually aware of it at the time.
Q. Indeed.
A. But that's neither here nor there.
Q. Is that a reference to the text messages between Lord Sedwill and Sir Christopher Wormald?
A. Yes, and to be clear, Sir Chris Wormald was trying to push on this point. But I don't think that there is a -- and he was the person who got this into the agenda.

I think that the point I'm making here is: this is how -- you know, the system is not designed to understand a threat, even when it is top of the National Risk Register, where it is a health or, I would say, other natural phenomena, in fact, but let's stick to
whether or not there might have been a different reaction if this had been a full national security crisis, the fact remains that the massive threat that you yourself have described is not apparent on the face of this paragraph. I mean, nobody at the heart of government appears to have been electrified, to use your word, by the information that there was a massive threat. Why was that?
A. Well, I mean, I think, in a sense, that is my point, is the system is surprisingly bad at, in my view, responding to threats of this kind which are not in the traditional national security system, and I think that is a -- I don't think that's an insoluble problem, which is the reason why I want to surface it, and I think it is largely to do with the way that the national security apparatus interprets its role, and I think it's an area where we could probably make significant changes, personally.
Q. You have repeatedly, if I may observe, said "we", "we in government". You personally, did you see this letter after the stocktake meeting on 4 February?
A. I can't recall whether I did. It wouldn't have particularly surprised me if I had.
Q. If you had, Professor, you would have seen from this paragraph that there was a complete absence of the 166
pandemics, because that's what this Inquiry is more narrowly about.
Q. And whether it's called toing and froing on the part of government, whether it's called a failure to understand the degree of the massive threat or the magnitude of the crisis, there was a hugely important systemic failure at this point, was there not?
A. Yes. I mean, I think there's a big question about whether it would have made a difference to what subsequently transpired, and I don't think we should draw that line too firmly --
Q. No.
A. -- but I certainly think that it would have been something which -- let me be mealy-mouthed about it: under ideal circumstances, there would have been a different response.
LADY HALLETT: Apart from education or training, how would you change the approach to a terrorist threat and a natural hazard?
A. I think I would start off with: what's the level of damage that the UK is going to sustain, and start from that, rather than which type of threat is it we're talking about. Because the sort of terrorist threat, for example, or what kind of -- yes, if I use "threat", "threat" in a generic sense, rather than more narrowly. 168
I think that -- do people in the security apparatus in Number 10, in other areas, Cabinet Office, view the kind of work that, for example, the UK Health Security Agency does with the same degree of interest and importance as they would view, rightly, MI5, Special Branch, all these kinds of things? And my personal view is I don't think they do, and I think these should be seen as national security problems when they're on this scale.
On smaller incidents, I think it's perfectly reasonable to take it differently. But I think if we're talking about something that is going to clearly have an impact across the whole of government, including very obviously on the economy, in addition to substantial loss of life, education, all these kind of things, then I think there is a strong argument for saying: why do we not put them, in a sense, on an equal footing in terms of the degree of impact they're going to have on society?
LADY HALLETT: But how do you give them an equal footing? Is it a question of training, or is it a question of saying: when it does become a national security threat, given the level of potential consequences, the National Security Adviser gets -- how do you get that across?
A. I think -- so, in reality, the only people who can actually operate -- there are three departments that can 169
letter is a pretty clear indication of that. I just don't think this would have been the letter under different circumstances in the way I've talked about.

Others could take a different view, but I'm expressing an opinion because I think this is something which at least the Inquiry will want to take a view on, even if its view is they don't agree with my position. I'm just taking a position.
MR KEITH: But before the break, may I ask you to consider the question I put earlier. Your answer was not unhelpful, but it didn't in fact address the question, which is: on the premise that -- on the basis that there was, however one might describe it, a system failure or a failure to acknowledge the existential threat or the massive threat, why, as the weeks in the middle and later February began to roll out, you and others who were equally aware of the nature of that existential threat were not emailing Number 10 or shouting out your concern that central government had fundamentally failed to understand the nature of the threat that you had described?
A. Well, I mean, short of ... I mean, it's difficult to work out where you can go once you've talked to all the people I talked to, and there's a very long list of people who Sir Patrick -- and Sir Patrick had also --
operate across all when the government needs to do something: Number 10 obviously, Treasury and Cabinet Office. And my view is this should have led to them saying, "This is no longer your problem, Health, that is our problem, this is now a huge problem for the system, and this is going to come into the centre because the centre can then assess this".

Now, this is not to say there weren't excellent people in the Cabinet Office, in the Civil Contingencies Secretariat and so on, already on this. It wasn't that there was no interest in this from individuals within the Cabinet Office and so on. But it had not, in my view, been seized in the way that a similar kind of level of existential threat would have been from another direction.

I think there are a variety of ways this could be done, and it's very dangerous for me, as a Chief Medical Officer, to start doing the job of a Cabinet Secretary, because I'm clearly not, but what I do think we need to do is think through: actually, how do we get this very quickly into the centre so that it is able to take the necessary steps? And you could say: well, this was delegated to the Secretary of State for Health and COBR was meeting and so on, but that isn't how in my view it feels, and in this case in my view felt, and I feel this

I think he didn't get to cover it in his oral evidence yesterday, but he has, I think, covered it in his written one. He also, through the good offices of Mr Cummings, tried to escalate this into the centre. So it's not that there weren't attempts to do this, but I don't think -- and, you know, this in my view is a situation which I don't -- you know, I'm not convinced that had we done things differently, it would have led to a different outcome. I have said that --
Q. You have made that point.
A. -- and I want to repeatedly say that. Nevertheless, I think nobody looking at this could say this was ideal.
Q. That is, if I may say so, with the greatest of respect, quite an understatement. This was a hugely significant moment and a terrible flaw.
A. My view is that it demonstrates an issue which needs to be thought through.
LADY HALLETT: Very well, we'll break now.
I'm afraid I understand we're not going to finish your evidence today, Sir Chris, I'm so sorry. I think you were warned. I know the burden we're placing on you and your relatively small office, and l'm really sorry,
but you know how important this is.
THE WITNESS: Thank you, my Lady.
LADY HALLETT: So l'll return at 3.30.
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## (A short break)

( 3.30 pm )
ADY HALLETT: Sir Chris, just so you know, I know the kind of concentration it takes to give evidence all day, and as you're going to have to come back tomorrow anyway I've asked Mr Keith to finish tonight at about 4.30, and I think there's a limit to how much we can ask you to do in one day.

THE WITNESS: Thank you, my Lady. so-called, on 4 February.12 of course, throughout the rest of February, and your point about the number of occasions at which you made. I mean, there's hundreds of pages of learning produced by SAGE and the subcommittees, and obviously matter is addressed at a variety of other differen There was a paper produced, I think, by the London School of Hygiene and Tropical Medicine on 7 February rom its division, CMMID. This isn't a memory test 173
around Wuhan and the surrounding province of Hubei, it may be possible to prevent widespread infection in the UK. If the virus spread beyond China to its neighbours and across the world, then the UK would not be immune." control is lost, once the virus has leaked from China
that paper? It was a paper which dealt with the feasibility of controlling 2019 novel coronavirus outbreaks by isolation of cases and contacts.
A. I can't recall, only because I received multiple versions of multiple papers, and remembering that far back I think would be optimistic.
Q. Indeed. Essentially -- and this is the evidence of Professor Edmunds, that he produced a report, or rather CMMID produced a report, which showed that a very high number of contacts or fractions of contacts would have to be traced and isolated for effective control to work.

There was also -- and you've referred to this earlier -- a report 4 from ICL dated 10 February, this is the one you referred to, which said this: that there was an overall case fatality rate in all infections, asymptomatic or symptomatic, of approximately $1 \%$.

There followed thereafter an important Cabinet meeting on 14 February. Perhaps we can have a look at that. It's INQ000056138. If we look, please, at page 6 of this meeting, we can see the following is reported:
"THE GOVERNMENT'S CHIEF MEDICAL OFFICER said that the published figures of around 60,000 cases of the virus in China could in reality be ten times higher. There were over 1,000 people in China reported to have died from the virus ... If the virus remained centred 174
page it says this:
"Concluding, THE GOVERNMENT'S CHIEF MEDICAL OFFICER
said that if the virus became widespread in the UK, there were plans in place that could slow down its spread."

Accepting, of course, that this may not be an accurate reflection of what was said, if you said, "If the virus became widespread in the United Kingdom", would that be an accurate reflection of your understanding that, the virus having left China, spread to the United Kingdom was inevitable?
A. Well, leaving China, you could certainly have chains of transmission outside China and it would still be in the scenario where it was controlled globally, but I think by this stage it was much less rather than more likely. So, as I say, this probability was not a binary one, it was gradually shifting, but it had now shifted, I think, to this being, I think, more likely than not that we were going to end up with a pandemic.
Q. Did the government, to whom of course you were reporting at this Cabinet meeting, understand that it was still conditional, that if the virus became widespread, there were plans in place; or do you think they did understand it was a pandemic, ie it wasn't just a regional outbreak, not just an epidemic, that it had spread 176
beyond China, it was in the United Kingdom and it was sustained transmission? Do you think they got that?
A. I do think that, and actually it's extremely rare, in fact, that the Chief Medical Officer is invited to Cabinet under ordinary circumstances. This reflects the fact, I think, that government was acknowledging that this was a substantial threat.

May I just pick up one point in this which is not relevant to your question but I think may be useful later on, which is just to make the point that we were already -- we were making very clear this could be more than one peak, because I think that got a bit lost in some of the --
Q. We'll come back to that.
A. -- narratives.
Q. You also say to Cabinet there were plans in place that could slow down its spread. Mindful of what you've told us about the lack of efficacy in terms of border controls, the information which you knew anyway but which you had received saying practical measures of controlling spread were difficult, what plans in place did you have in mind when you said there were plans in place that could slow down its spread?
A. Yes, I think you should read this two ways, and both would be correct. One is that there are things we could 177
A. Certainly. I think by this stage, I think that there was quite a recognition that there was a significant threat. The way this is reported is a fairly bland way, but that doesn't necessarily mean it was a bland presentation.
Q. Indeed.
A. I can't, frankly, exactly remember what I said, in exactly which words I used it. But I think, you know, this is a -- you know, if I were listening to this in Cabinet, I would be concerned. I think that one of the things that, however, we really did not find easy to get across, and I found this surprisingly -- surprising, given that so many people in both politics and in the official system are trained in economics, is the extraordinary power of exponential growth to get you from small numbers to large numbers very quickly. People just don't get that intrinsically. I think they've got it a bit more now because of having seen it, but certainly prior to this pandemic, I think people just didn't understand how quickly you move from it's actually very small numbers to it's actually very large numbers and doubling every few days, that that can be really quite quick.
Q. I'm sorry to press you on this, Professor. You said you do think that they recognised that there was
do to slow, but I wanted to be clear that there was nothing we could do to stop, and that is an important -in a sense, that is an important -- and I was clear not to say. But this is where the slow -- this is where the delay bit of the contain, delay, research, mitigate, formulation really comes in. Obviously the biggest elements of this in the early stages was identification of cases and case-finding and isolation. For the reasons you've given from Professor Edmunds and his team, but I think this is widely accepted in the literature, once you get to a very large amount of transmission, those really are highly unlikely to work. But in the early stages, a case-finding and isolation strategy has a realistic chance, if you can find the majority of the cases -- that's the big "if" -- in significantly delaying the spread.
Q. The point l'm seeking to make is a slightly different one, which is: sitting in the shoes of government and reading those words or hearing them set out by the Chief Medical Officer, "if the virus became widespread ... there were plans ... that could slow down its spread", they might not have been sufficiently, to use your words, electrified, and therefore I wonder whether or not this is a correct reflection of what you actually said. Did what you say communicate the threat? 178
a significant threat. Did they sufficiently recognise there was a threat of the order that you've described earlier, the massive threat, the existential threat? And it may be because members of government, as you say, don't naturally understand the science. The notion of exponential growth is a difficult one to grasp.
A. I think -- and you'll cast your mind back to remembering the political environment at this stage -- the fact that at this point they were devoting a sufficient amount of Cabinet to this particular issue I think does mean that, at a certain level, this has lodged as a major issue for government, because it was quite a busy political period, is my memory. However, you know, do I think that most people round the table fully grasped what would happen if this started to run exponentially? I suspect the answer to that is no. But I wouldn't want to put -- I wouldn't want to interpret their thoughts.
Q. No, but you recognise, of course, that one of the hugely important functions of the Chief Medical Officer is to be able to get them to understand the seriousness of the position.
A. I was doing my best.
Q. Later in February, further information was received from the Diamond Princess outbreak, that's to say the outbreak of the virus on the Diamond Princess cruise 180
ship, which I think had taken place in early February, but certain time passed before all the figures could be computed and the estimates and the analysis done. But if it was not already clear, it became abundantly clear by the last week in February that the infection fatality rate, that's to say the number of people who would die having been infected, was of the order which had been estimated, the case fatality rate was of the order as had been originally estimated, that this virus was hugely transmissible, and had significant -- around about $30 \%$-- asymptomatic transmission. All right.
A. Well, actually, on the last point, I think that was a bit less clear, but it certainly strengthened the principle that asymptomatic transmission was occurring. I think $30 \%$ is probably --
Q. The estimates from Professor Edmunds, who had reported on the data, were to that effect; would you accept that?
A. Yes, I would accept that. I'm just saying -- you said it was very clear. I'm just saying I think it's not quite that clear, but that's a technical point.
Q. You mentioned earlier the debate concerning reasonable worst-case scenario, and I want to ask you briefly about your views on that doctrine. worst-case scenario concerning pandemic influenza was
Q. Slow down.
A. I'm sorry.
Q. I'm sorry, Professor, please slow down.
A. Apologies.

So you quote the reasonable worst-case scenario, which actually in the context of an unmitigated pandemic or epidemic, where you know the mortality and the $R$, is very easy to calculate. You can do it with a hand calculator. It's not a complicated process. And then they will say: well, how likely is that? To which the answer is: extraordinarily unlikely, and then everyone relaxes, but of course that's because it was the thing which is highly unlikely to happen, which is nobody will pay any attention to this, not just government but the general population, and medicine will not find countermeasures. So it can lead to a misunderstanding and, counterintuitively, it can lead to people underestimating the risk because they ask, in a sense, the wrong question, which is how likely is the reasonable worst-case scenario, to which the answer is always: very unlikely. In fact, if that wasn't the case, it isn't a reasonable worst-case scenario.
Q. In terms of efficiency of movement, or perhaps of government, spending time talking about the probability of something which is itself wholly improbable is not 183

You make clear in your statement that the reasonable 181
predicated upon an unmitigated reasonable worst-case scenario; that is to say that no steps are taken by the government significantly to be able to respond, it's unmitigated. Therefore, you make the point that, actually, in terms of the reasonable worst-case scenario being examined by government in its various forms, but particularly in relation to pandemics, it's a wholly improbable outcome, because no government will ever do nothing.
A. Yes. So I think that the principle of reasonable worst-case scenario is a reasonable one for certain planning purposes, and it's basically to ask the questions like: what is the maximum number of burials we'll need to deal with, all of these really quite morbid but important issues to consider. So to that extent it has a use. It also has a use to say how much further below the reasonable worst-case scenario do we need to get something under certain circumstances. So I'm not saying it is without use.

It has two fundamental problems, in my view, both in a sense of communication. The first one is -- and actually this was a problem both for Sir Patrick and for me at various points -- in the kind of doctrine, people say: well, what's the reasonable worst-case scenario? So you quote the reasonable worst-case scenario -182
the most efficient use of time; would you agree?
A. Arguably, yes, and I think the other problem is -- and you will see this in various witness statements, including some of my modelling colleagues -- people use the term to mean: my central estimate of the bad outcome, rather than to mean: a reasonable worst outcome as it is understood in planning doctrine.

So I think it has a number -- it is a perfectly sensible thing for people to use amongst people who are disaster planners; they know what they're doing, it's understood between all of them. But I think using it with people who are not used to it, I think it can lead to confusion of a variety of different sorts. So I'm not saying it should be done away with, I'm just saying I think it should be used with quite considerable care.
Q. As we will see in a moment, a great deal of time was spent focusing on not just what the probability was of the reasonable worst-case scenario eventuating, but also on how to plan for the reasonable worst-case scenario, what steps might need to be taken to address it.

Is there a danger or was there a danger, in your view, that, as a system, if government is focusing on something that it knows is a wholly improbably outcome, it may take its eye off the ball, it may allow a sense of optimism bias to infiltrate the system, because it 184
thinks it's wholly improbable, it's never going to happen, and that may just deprive the system of the required degree of immediacy and speed?
A. Yes. So I think in an ideal world you'd have a small number of people thinking seriously about how you deal with the reasonable worst-case scenario if you lose complete control of any environment, but the great majority of people concentrating much more on: how do we get this down to the lowest possible level given the threat we face, of whatever type, but certainly in pandemics that would be true.
Q. Because then there would be focus necessarily on the actuality, the real scenario, what is likely, generally likely, to eventuate.
A. Yeah.
Q. And I ask, Professor, because it's plain that from COBR meetings in the middle of February, from a reasonable worst-case scenario clinical alignment planning meeting on 14 February, a SAGE meeting on 27 February, numerous WhatsApps in the first week in March, a huge amount of time is dedicated towards trying to assess how probable the reasonable worst-case scenario is?
A. Yes, that's correct.
Q. And that doesn't appear to have been a profitable use of anybody's time.

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definitions, it has a role, and I don't want to undermine that role. But I think it's one of those slippery concepts, and the kind of last place you really want to be dealing with it is in WhatsApp conversations.
Q. But the wider point, Professor, is this, and would you agree with this proposition: given the immediacy of the problem, that time was vital, that the government had to face up to the immediacy of the massive threat, two to three weeks of persistent debate about reasonable worst-case scenario was not a good use of the government's planning time, was it?
A. I don't think most of the planning time was taken there, but I think more time -- I would accept more time was spent on that than I think was probably useful, compared to trying to reduce it.
Q. Can I now turn, please, to look with you at some of the other standalone issues which you had to consider and on which you gave advice in the lead-up to the lockdown, if we can call it that, the lockdown decision.

Mass gatherings. Is this the position: SAGE -- and also, I think at the beginning, perhaps NERVTAG but certainly SAGE -- advised repeatedly on the issue of mass gatherings; is that right?
A. That's correct.
Q. And was that because government, mindful of the
A. I think, as I say, it's useful if you can hive it off from the majority of the work, which should be around trying to mitigate the reasonable worst-case scenario and make it less worst.
Q. And it's not an easy process, is it? I mean, you were asked to opine in WhatsApps on 2 March, the "No10 DHSC Covid" group, what the probability is, and you said -or rather Sir Patrick Vallance said:
"... Chris and I both think ... the [reasonable worst-case scenario] is relatively low probability ... 1 in 5 ..."

That's 2 March, and on 8 March, in a meeting with the then Chancellor and Sir Patrick Vallance, the note of the meeting records a probability of the reasonable worst-case scenario being $10 \%$.

So it's ...
A. And --
Q. It's a very difficult process.
A. Yes, and one of the problems here, I think, is that people then get pushed on, and Sir Patrick and I were both pushed on, giving what both of us think are spurious numbers about another spurious number, leading to a misunderstanding.

As I say, used carefully between people who know what they are talking about and share the same 186
political connotations surrounding mass gatherings, repeatedly came to SAGE to say, "What is your view and should we still be allowing mass gathering events, sporting events, to continue?"
A. Yeah, and I think government in that sense was asking a very reasonable question, and SAGE repeatedly gave a correct but I think probably unhelpful answer.
Q. In February and in March, and then in fact in a paper dated 11 March from the London School of Hygiene and Tropical Medicine, the advice was given as follows: essentially, in terms of infection control, outdoor events are safer than indoors. That's fairly self-evident.

SAGE and the London School of Hygiene and Tropical Medicine looked at the degree, however, to which infections might spread in bars or trains and so on and so forth, and other close quarters, in queues, whether alongside sporting events, or if sporting events were to be shut, so for example if everyone goes to the pub instead to watch the game.

Do you assess now -- and obviously it's with hindsight -- that they may have overstated the -- or rather they may have underplayed the public health message which allowing sporting events and mass gatherings to remain open amounted to?
A. Yes, and I think that -- so, in a sense, I think they were -- their actual analysis is correct. Had we had a situation, for example, where large numbers of people were over for a football match and you close the football match and they all go to the pub, you are probably increasing risk rather than decreasing it, or they watched the game from the pub. So the point they were making was in one sense correct, and the risks of outdoor events, even if quite crowded, is small relative to many of the other things. So I don't disagree, in retrospect, with what was said by them and collectively by us on SAGE, so I'm taking ownership of that.

I think where it -- what we were really not paying enough attention to -- and it's sort of obvious with hindsight -- is the message this was sending; that seeing mass gatherings going on signalled to the general public that the government couldn't be that worried because, if it was, it would be closing the mass gatherings.

So I think that the problem was not the gatherings themselves, which I don't think there's good evidence has had a major material effect directly, but the impression it gives of normality at a time that what you're trying to signal is anything but normality.

So I think, again, were we to re-run, I think that's 189
"The CHAIR invited the Director of the Civil
Contingencies Secretariat to give an update on planning for the [reasonable worst-case scenario]."

So there is the reasonable worst-case scenario appearing.
"The DIRECTOR OF THE CIVIL CONTINGENCIES SECRETARIAT
said that there was work to be done to create a clear plan of activity (across the UK Government) from the moment of sustained transmission [mindful, of course, there was already and there had been for weeks sustained transmission] to its estimated peak, which was likely to be a period of three months."

Were you concerned, mindful of what you had said at the stocktake meeting about the need to plan for this massive threat, that by this date, 18 February, the director of the body required to produce central government plans was still talking about work to be done to create a clear plan of activity across government?
A. I mean, I think it was reasonable that this work was continuing, but if this was at the expense of other work, I think as you've implied, that's not really a sensible use of time.

I think around this time -- and this is just to give an idea of what's happening in parallel -- I think you can see debates between me and others where our firm -191
one of the things that we would -- I would certainly do differently or push to do differently.
Q. And, in truth, having a debate on the application of the precautionary principle over the closure of, say, primary schools whilst allowing sporting events to continue and mass gatherings to remain open, was in hindsight rather unfortunate.
A. Yes, it is in a sense technically correct and logically incoherent to the general public, quite reasonably. Yes.
Q. There was a COBR meeting on 18 February, around the time, in fact, that there was repeated advice given on mass gatherings. It's INQ000056227, and if we just have a look briefly at pages 1 to 3 , we will see the attendees.

If we scroll then forward to 2 and 3 -- I think if we go back one page -- I'm sure you were there. Maybe you weren't there. Yes, you are, thank you, "Officials".

Then on page 5 -- and mindful, therefore, Professor, that this is 18 February, so some time has wound on since the beginning of February and the stocktake meeting on 4 February.

In fact, sorry, could we have page 7, please, paragraph 17:

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my firm view certainly is -- or our aim is to find the collection of things that would bring $R$ below 1 , which in a sense is a different strand of work and I think takes us in quite a different direction.
Q. Yes. And that point, Professor, is this: is that when it became clear -- it having become clear that there was sustained community transmission in the United Kingdom, and that containment had, by necessary inference, failed, what you advocated was a delay in the upswing of the overarching first pandemic wave?
A. That's correct, although to be clear, that was not clear that that had happened at this point in time.
Q. No, no, I said when it --
A. Yeah, no, I agree, I just wanted to make sure we separate those out in time. It was later that that occurred, yep.
Q. The strategy that there should be a delay in the upswing, which some people have called a mitigation strategy as opposed to suppression, but there's a huge debate to be had about whether delaying a wave or squashing the peak or squashing the sombrero is just a form of suppression, and we're not going to go into that debate.
A. I can give you a long answer, but --
Q. Yes, that's in part, Professor, why we're not going to 192
go into that debate.
So certainly by the end of February and the beginning of March, it was apparent to you that, means of control having failed, the virus was here, it's transmitting throughout the community. We now know, of course, there were hundreds if not thousands of seedings during the February half term from Italy, France and Spain. Strategically that was, it seemed to you, to be the appropriate response?
A. What, the --
Q. To delay the upswing of the pandemic wave.
A. Yes. I mean, I think the things which delay a wave and the things that pull R below 1 are, for practical purposes, once you've lost control, the same things, at least initially. Before -- can I just introduce a public health concept which I think is useful for this, which is the ladder of intervention, where you start at the things which have the lowest, in a sense, negative impact, and you escalate up. So you'd start off with, to take this example, you know, washing your hands and cough etiquette, and you move up through isolation of cases, up to really quite intensive things like closing schools and, as we ended up, in a place I don't think we really would have anticipated, using the full force of the law to insist on people staying at 193
Q. Being aware that, of course, the Chinese had applied lockdowns and they had worked -- at least that was the general understanding by the end of February in the United Kingdom -- why, as you developed the strategy of delaying the upswing of the wave or squashing the level or squashing the sombrero, did you rule out a complete suppression strategy? Was it because of the risks of the uncoiled second wave, as we've heard, or for some other reason?
A. I think some of the output of some of the modelling is slightly misleading, in my view, because it implies you would have a completely mitigated first wave and then completely unmitigated second wave, which makes no logical sense unless -- it makes no logical sense at least.

Ultimately, I think people, in a sense, overcomplicate and think humans can do things more precisely than they can. Ultimately, my view with epidemics is they're either doubling or they're halving, and the idea that you can somehow hold something at an $R$ of 1 strikes me as fanciful. So you either are above 1 or you're below 1, and if you're above 1, it's going to carry on exponentially. You can slow it down. So delay doesn't necessarily imply that you're going to get $R$ below 1; you could just reduce the R significantly and 195
home. That escalation, the idea of that is that you escalate up as you need to, adding things that are more and more onerous or more and more interrupting of people's normal life, economic and social, as you get further and further into trouble, basically.

I'm not saying that's exactly what we were doing here, but I'm just saying that concept was part of I think what many people, including me, were I think trying to think though at this stage.
Q. And to be clear about when it became apparent to you that steps might need to be taken to delay the upswing of an epidemic, as opposed to suppressing it entirely, you had in fact started raising this issue as early as the end of January, because you emailed Professor Ferguson, I think, asking for his view as to what could be done to delay the upswing of --
A. Well, yes, and I -- from very early on, my view was we need to find out a group of things that will get $R$ below 1 , if that is possible. And the Chinese had demonstrated it is possible, so the then question is: can you do it in a way that is sustainable? And sustainability was my other big concern here.
Q. Can we come back to sustainability. It's a subject all of its own.
A. Yeah.
therefore push out the number of days it's doubling -and I'm sorry I'm giving you a technical answer, but I think it's quite an important point here. So, in theory, you could delay but still not get R below 1 . So those two are compatible. But the only way you're going to get an epidemic wave to turn over is to get $R$ below 1, in reality.
Q. The Inquiry has heard a great deal of evidence about the overarching need to get the reproduction number below 1.

Why then -- how did this whole debate -- and we've seen it reflected in witness evidence and in the press, the statement of David Halpern of the Behavioural Insights Team in Downing Street -- did this notion that -- or rather a belief that you and your colleagues were flattening the curve, were delaying the peak, rather than focusing on bringing $R$ below 1 , which is what, epidemiologically, you were seeking to do? There appears to have been an enormous debate about whether or not you were squashing the sombrero, flattening the curve, mitigating, suppressing. What was the genesis of all that?
A. Well -- so, ultimately, my view was quite a lot of rather fanciful discussion occurred, including between people who didn't, in my view, fully grasp the technical aspects they were talking about, if I'm blunt, which led 196
to quite a confused public debate. That applied to a number of things -- herd immunity was one, there were a number of other ones -- and on several occasions, as you have probably had the privilege of reading my rather dull, compared to other people's, WhatsApps, I implore people not to try and talk about some of these issues, because I think they are confusing rather than enlightening the public. But there we are. Lots of people like to talk.

So I think it was a -- I think there was a confusion. Some of it stemmed from an actual strategic lack of clarity, and some of it, in my view, stemmed from, if I'm honest, a little knowledge being a dangerous thing.
Q. In terms of strategy, you've referred to the coronavirus action plan on 3 March. Could we have that up: INQ000057508.

This was published, as you know, on 3 March. You provided comments on multiple iterations of this plan, according to your statement, and no doubt it reflected your views on the clinical and public health matters.

Why was this plan, to the extent that it dealt, as you've said, with clinical and public health matters, not put before SAGE, do you know?
A. It's a policy document. If we put all policy documents 197
"... if it does take hold, lowering the peak impact and pushing it away from the winter season."

So there is a reference there to the peak, so that refers back to our earlier debate.

But surely, as the Chief Medical Officer, you must have had a view on the publication of a document on 3 March commissioned in the first week in February, on 10 February in fact, by the Secretary of State which -and it was the sole document, strategy document, published by the British Government --
A. I think this is a --
Q. It was out of date by the time it was published.
A. Well, I think that, going back to the previous discussion, once you're in an exponential curve, you get out of date remarkably quickly.
Q. You have repeatedly said "we", "we, the government", "we", "we", "we"; you knew that SAGE had not been consulted on this. You had drafted various iterations of this document, or contributed at least to the text.
A. Contributed.
Q. You couldn't have been unaware of the fact that this sole strategy document was out of date by the date of publication. You more than anybody knew containment had been lost weeks before.
A. No, I disagree that containment had been lost weeks 199
Q. Paragr

Paragraph 3.9 on page 10 says this:
before. I think that it was close to the point where you had to abandon it around this time, but we can come back to that if you want, so it wasn't weeks before.

The problem with this document is essentially a very -- there's nothing wrong with the document, it's just too late. If it had been published when it was first conceived, as I recall it, it would have been much more in date. That -- you know, this is one of the problems of trying to develop these kind of documents on the hoof during an exponential rise. That's just a reality.
Q. And no doubt you regret that this document was published at all, given that it was out of date?
A. Well, it was a lot better than no document, according to your previous perfectly reasonable points.
Q. Professor, you cannot seek to sustain the value of a single strategy document, the only document published by the UK Government that you knew, to your certain knowledge, had been out of date in relation to its first and important strategic plan, contain?
A. There will maybe come a point where the Chief Medical Officer is given plenipotentiary powers to run policy documents across government, but that is not that moment.

You know, I think -- I completely accept there are 200
bits of this document that are out of date. There are other bits of this document I thought are actually pretty good document, and not publishing any of the document -- the problem about documents that are agreed across all of government --
Q. Slow down, Professor.
A. Sorry -- across all of government and across multiple nations is redrafting them every single time. You have to go round everybody and say, "Are you content with these changes?"

So I think the admirable aim to try to make this across government and four nations document, and I think that was sensible in one sense, itself mitigates against it being timely, given the speed at which this is going to happen. You can argue such a document should not have existed but, in a sense, I think some document is better than no document. I actually think in most elements this is a pretty good document, given that we had no document previously that anybody could look at. So I'm going to stand behind the publication of the document without saying that I agree that every single word of it was exactly current at the point it came out.
Q. Did you email anybody or call anybody in government to say, "I just don't want to put my name to a document that I know to my certain knowledge is out of date in 201

Organisation had still not declared that this was a pandemic.
Q. Well, we've addressed that issue. Your own advice, of course, simply didn't rest upon what the WHO was doing?
A. No.
Q. You, of course, reached your own view as to what needed to be done in the context of the United Kingdom.
A. May I give a slightly hard-edged answer --
Q. Professor, I think in light of the time, would you --
A. Okay, well, if you wish to push it, I will give a hard-edged answer --
Q. Professor, l've asked you a question and you've answered in your own way.
LADY HALLETT: No, I think Sir Chris should be given the opportunity to say what he wishes to say.

Go on, Sir Chris.
A. Yeah, if I had spent my time trying to redraft every document, l'd have done nothing in all the much more important things in my view that I was supposed to be doing. At a certain point you have to say "Move on". This didn't strike me as something that would do any harm and the opportunity cost at the time for me of trying to sort out wording in cross-government documents did not seem to me to be terribly material. That's my 203
material part"?
A. No, because if I had done that we would have had virtually every single document l'd have been emailing on that basis, so --
Q. That's not, if I may suggest, a good reason for not raising the problem.
A. Well, I think there was a clamour for something that people could at least hold on to, even if it was to some extent out of date. And it wasn't actually technically out of date, contain was still the strategy at the point this was published in fact. So by definition, if contain is still the strategy -- but what I said almost contemporaneously with this, and I know you can't interrogate on this, but it's all laid out for people who are not lawyers in the House of Commons, made clear that my view was that we were mainly in delay but had some elements of contain. That was largely because that was a negotiated position in government at this point, so it would have in fact have been not in line with government policy at this point of publication had we claimed at this point that contain was not there.

You can argue whether that's a good argument or not, in practical terms I don't think it made much difference. And I would also point out that at this point, when this was published, the World Health 202

## hard-edged answer.

MR KEITH: Forgive me, you're the Chief Medical Officer --
A. Correct. There's only one of me, that's my point.
Q. There is only one of you, and on this central issue --

LADY HALLETT: I think we've got his answers, thank you, Mr Keith.
MR KEITH: All right.
On 21 February there were some emails between yourself and Professor Ferguson.

INQ000236382.
If we could look at page 3 briefly, you say to Professor Ferguson and Professor John Edmunds: "Thanks for the previous emails ...
"An event like this in the [United Kingdom] could obviously happen at any point. It is not easy to predict when; it may be very soon, in weeks ... Failure of contact tracing is obviously one possible reason, but failure of people with minimal symptoms to identify their importance, or choosing not to come forward even if they do ... is another."

In this email, just in outline, you are dealing with or you're expressing your views as to the likelihood of the pandemic ensuing. You describe the email as "Local spread in Europe"; do you recall this email?
A. I do.
Q. There are references in this email to speculative scenarios, although I can't -- yes, in the bottom line.
"I am not however not convinced that presenting speculative scenarios are always helpful in public understanding."
And this is a view expressed in the context of this paragraph, which is where you say -- or you refer to the tactical aims of contain, delay, research and mitigate. What was speculative about the scenario of onward transmission or a pandemic ensuing in the United Kingdom, if that's what the reference to "speculative scenarios" --
A. No, "scenarios" I was using in its modelling sense. So as you will recall from extensive evidence you have heard from the modellers, what I didn't think was sensible was to put large numbers of different models, based on different things, into the public domain, at a point when actually what people wanted was relatively straightforward. And this goes back to a conversation -20
Q. Slow, Professor, please. 21
A. I do apologise.
This goes back to a conversation we had earlier, which is my view is modelling is not always the best way in which to communicate information, particularly at 205
first country in the world to abandon containment on the basis of this analysis, which is the logical implication if we are certain, are non trivial."

What were the implications of the United Kingdom being seen to be the first country, Professor?
Presumably the sole issue, and we've just debated the relevancy of the issue in the context of the action plan of 3 March, was had we lost control, had there been a loss of containment, or had there not? Why did it matter if we were the first country to abandon containment?
A. So the -- remembering that at this point we didn't actually have evidence of domestic transmission. From memory, the number of cases was, I think, still under ten, I could be wrong about those numbers, and we had no deaths. If we'd been in a situation where -- at two levels, either where we had said to the general public, "Right, that's it, we're going to stop trying to contain this, everyone else is trying to contain this but we're giving up now", I think it would domestically have been very difficult to sustain, but also internationally the point about containment is it is an international issue and, you know, it's much best done if this is done, in a sense, as a collective decision globally to accept this is now a pandemic and containment is really 207
a time of concern.
Q. The email does refer to modelling specifically in the third paragraph and to different interventions, but it's bound to be said that that last paragraph appears to be referring to an uncontained global epidemic, and to onward transmission.
A. I was being very clear as -- actually, if you look at my public statements, that that was a risk at this point in time. So that's not -- you know, I -- the only way that you can operate if you're a doctor or a public health person is by clear transparency of what you're trying to say. This is in no way a reference to implying we should not be being straight with the public, I absolutely think we should, this is a point about modelling, that's why I'm discussing it between modellers.
Q. Page 2, Professor Ferguson says:
"Thanks Chris, I will respond more fully tomorrow. I agree with $90 \%$ of what you say. But I really do feel it's not a matter of if but when. That is ... where all the data is pointing."

If you can scroll back out, Chris Whitty:
"Thanks Neil
"I think these debates are best done within SAGE ...
"The implications of the [United Kingdom] being the 206
a non-achievable outcome. Which is not the point where the WHO were, it took a long time before they got to declaring this a pandemic, it wasn't where other countries were.

My point was really to Professor Ferguson: yes, your models are probably right actually, by this stage I'd taken the view that this was probably correct, but that didn't flow into, given the small numbers of cases in our country, that we should therefore declare containment essentially dead. That is the reason for this discussion.

And the other point which I would reiterate and I was very firmly of the view that we -- some people, including extremely eminent colleagues like these, were having conversations in a sense out of the SAGE or any other process when my view is they were much better done in that process where the scientific debate could be had with all the right people in a minuted conversation. So, I was -- you know, that's the other thing I was trying to avoid, was this becoming a kind of informal policymaking process driven by particular people's views based on their own models. All of whom I have to say I have huge respect for, it was not a comment about the individuals.
Q. You have of course in the course of your evidence, 208

Professor, repeatedly said "we" and, as I have noted, referred to government and to "we" including yourself and government.
A. Yeah
Q. Were you concerned politically about the ramifications of the United Kingdom being the first country to be seen to abandon containment?
A. No, it's not my job to have a political view, it's a public health view.
Q. All right.

Sir Patrick an initial analysis of the potential impact of a variety of non-pharmaceutical interventions.
A. Yep.
Q. So this was Imperial College London's -- one of their first stabs at setting out a suite of measures. In essence, as you'll recall, ICL suggested or identified a package combining multiple measures and supposed or estimated that they would have, likely have major effect.
A. Yeah.
Q. That report was discussed at SAGE on 25 February, the next day. Professor Ferguson, in his statement, refers to the fact that your response to the production of these non-pharmaceutical interventions was a concern
assumed that all decisions were starting from the models they were having. My view was I was starting from what had previously happened in pandemics.

So they are correct that I was concerned about the winter, and many people say I talked about that multiple times in SAGE; I did. That didn't mean that I was worried that in February or indeed in March, I thought there was a strong risk that we were going to be able to push things just by delay alone into the winter months. That struck me, frankly, actually, as quite improbable.

So I think, in a sense, I think this is a genuine misunderstanding, misremembering by Professor Ferguson of the reasons for my concerns about the winter, but he is correct that I was concerned about it, and I think that was reasonable. There are multiple other emails of mine that make it clear that that was my view, just to be clear.
Q. INQ000151558 is a presentation from the Cabinet secretariat entitled "Interventions Overview". It's dated 6 March. There is a reference in this to -page 3 , I think it must be.
A. Is this where there's this wholly improbable suggestion that you completely suppress a wave and then choose not to in any way mitigate the subsequent wave? I mean, that, I think, is what you were talking about, this --

On 24 February, Professor Ferguson sent to you and 209
that, on account of their relatively aggressive nature, they were more stringent than what had come before, that pushing the epidemic to the autumn or winter might worsen the consequences, so the notion that if you apply countermeasures, the wave is delayed, or suppressed, there is a risk that a second wave may come back or maybe that wave may come back in a winter season and the consequences may be worse.

Can you please tell the Inquiry to what extent you were concerned about the potential consequences in of course February about the introduction of more aggressive countermeasures?
A. So I think Professor Ferguson and actually some of the others misremember a very strong view of mine, but they misremember the reasons for it, which was that a wave in the winter was going to be very problematic, this is the following winter. But my view was that -- and remember this was my view based in large part on what had happened to previous flu pandemics, accepting all the differences, where the second wave, in the winter, was, from memory, in all three of the major ones in the 20th century, worse than the first and was in the winter.

My view was not based on their models, and I think this is where the misunderstanding came from, was they 210
Q. It is these words:
"... very stringent social and behavioural inventions (such as those in China) have the potential to prevent a major epidemic establishing but risks a large epidemic re-establishing when lifted ..."

Putting aside the accuracy or not of the green line, that sentence is reflective, is it not, of the uncoiled spring debate?
A. Yes, and this is, in a sense, just a statement of fact, which is if you go for a suppression strategy, for however long you do it -- and China has demonstrated this pretty clearly in the last year -- at a certain point you will have to release it, and then the pandemic is still with you and then you will have what is called in epidemiology an exit wave. There's no -- you know, you can hold -- if you've managed to suppress it this far, you may lose control over winter because of epidemiological reasons, but let's say you manage to hold it for two years. The same still applies. So essentially the wave comes at the point you choose to release the measures and, as I say, I think what happened in China is a really clear epidemiological outplaying of that fact. So this is trying to make clear to people: if you go for suppression, don't think that that's your problem done, you just have to suppress
for a bit and you're done. At some point you're going to have to face this, and the question is: at what point do you want to?
Q. Did you prepare this or contribute to this presentation?
A. No. I mean, I may well have seen it, but this is -these are modelling things. But what I'm talking about here is really trying to talk through what the logic of this in reality is. I think it's -- in a sense, I think it's misleading, the way that it's presented, but it does make the point that if you suppress, at some point you will get an exit wave. It doesn't say where.
Q. Professor, did your concern about the relatively severe consequences of a virus re-establishing itself in a subsequent winter, or of a virus recoiling like an uncoiled spring, or however you wish to describe it, did your concern influence in any way your willingness to countenance the more stringent interventions which were being recommended at the time and which, as we now know, of course ultimately came to be imposed?
No, and, you know, you should recall that in the three flu pandemics I was talking about, they didn't do any of these, and they still got a bigger winter wave. So this idea that this only happens if you do suppression in my view flies in the face of our last three experiences of major respiratory pandemics. So, in my view, my 213
But, again, you cannot -- I cannot see a situationwhere anybody with what I will bluntly call an ounce ofcommon sense would suppress a virus until the winter andthen deliberately release it, which is, in a sense, ifyou were taking an absolutely literal interpretation ofa logical thing to do, and I don't think anybody, as faras I'm aware, ever suggested that.
you were taking an absolutely literal interpretation of
MR KEITH: My Lady
LADY HALLETT: Certainly. 10
Thank you very much indeed. It's 9.30 tomorrow. 11
MR KEITH: Yes, please. 12
( 4.30 pm ) 13
(The hearing adjourned until 9.30 am 14 on Wednesday, 22 November 2023)15
position was based on history. The modelling wasn't actually the basis on which I had that view.
Q. Well, then, either the suggestion that you did allow -you held those concerns and you allowed them to influence your willingness to engage these and support these more stringent interventions is correct, or this important Cabinet secretariat presentation is materially misleading insofar as it suggests that a large epidemic will be re-established when measures are lifted. Which is it?
A. It's a statement of fact that if you have a circulating pandemic for which there is zero immunity, so assuming we haven't yet got a vaccine, and potentially even if you have got a vaccine, as China demonstrated, if you suppress for a long period of time, at some point you will have to have an exit wave.

Now, if you have a completely effective vaccine, that may be eliminated. If you have extraordinarily effective treatment, it may be you get an exit wave with no deaths. There are a lot of scenarios. That's a perfectly logical thing to do. But the idea that you can, absent an extremely effective vaccine, suppress and then not have an exit wave, is not realistic, and that's really what this point makes -- this slide makes. It may make the point rather badly. 214

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| 143/2 154/11 | 67/15 69/3 71/14 | 97/12 97/16 100/6 |  |  |
| Wuhan [5] 15/14 77/3 | 71/20 73/13 73/14 | 100/22 106/7 106/8 |  |  |

