your involvement in the various scientific advisory bodies at that stage, you were a participant in SAGE?

Q. That run from 11 February 2020 all the way through to 10 February 2022?

A. Yes.

Q. In conjunction with that, were you also the co-chair of SPI-M-O?

A. That's right, I was the co-chair from 27 March 2020.

Q. And that, again, ran throughout that period until the conclusion of the committee in spring of 2022?

A. Yes.

Q. You were also involved in some task and finish groups.

A. Yes, there were three of those. So the first one was on mass testing, we did that in August of 2020. The second one we always called the "four nations task and finish group"; that was looking at what happened before and after the tiers were put in. And then there was one on -- about the science of vaccination, although of course most of the advice, the great majority of the advice about vaccination was handled separately by JCVI.

Q. Indeed, and we will return to the second of those, the impact of interventions, the four nations --
but subsequently as a consequence of your role as co-chair, is that right, of SPI-M-O?

Q. What was your role within SAGE at that time?

A. So my role in SAGE at that time was like other people, it was to listen to other people's evidence, so evidence that was being brought to SAGE by attendees that day, and challenge it like any scientist would challenge other scientists. Once I was the co-chair of SPI-M-O, it was also to support my co-chair, Graham Medley; sometimes if he wasn't there I would present the SPI-M-O consensus. And then an important part of the work would be to listen very carefully because straight after SAGE we co-chairs and the SPI-M-O secretariat would sit down and think through: right, what's the new commissions that come out of that? What questions arose in SAGE this week that we think SPI-M-O should be -- start working on and thinking about?

Q. Do you consider that to be a strength of the SAGE system, that the co-chairs of the various committees sat on it and then had these follow-up sessions?

A. I would say that was a strength, yes.

Q. In terms of SPI-M-O, again a large number of meetings, 81 during that period as the co-chair, alongside Professor Graham Medley, who we've also heard from, as well, I was always there, when I was available, for the main meeting -- so SPI-M-O had a main meeting, ended up being on a Wednesday -- to support Graham to be listening very carefully to make sure our consensus statement did reflect the discussion.

Yeah, quite often I would be the one who said, "Listen guys, you think that's interesting but I can tell you that is not interesting with respect to this particular policy question". They're academics, my -- I mean, friends of mine, they would get very interested in some particular detail and I would sometimes say, "Sorry, but move on". And on the other side quite often they would say "Oh, but that's obvious" about something that they felt was very obvious, just from what they knew about epidemiology, and I would have to say, "Well, that's obvious to you but actually it's not obvious to lots of extremely well-important -- well-informed people who are absolutely involved in managing this pandemic".

Q. With regard -- sorry, if I may just pause you there, just to pick up on that -- with regard to your input from that perspective, was that very much based upon your role and interaction within government as a chief scientific adviser?

A. Very much. Very much so. I mean, I'd been in the civil service since that September, but I had also done quite a lot of work over the years as an academic advising into government, because there are lots of mechanisms where government reaches out for academic advice, so it wasn't just those six months, I had also done quite a lot of advisory work beforehand. So I think I probably had more experience, particularly perhaps with civil servants who weren't completely steeped in public health, than some of my colleagues on SPI-M-O did.

Q. And with that role in terms of policy development and having that understanding, did you find that you were predominantly therefore involved in commissioning exercises and being that bridge between government and SPI-M-O?

A. I did have a lot to do with commissioning exercises, particularly early on. I mean, I think -- well, actually, I thought Graham put it very well when he said that I was able to talk about things that modelling could do and things that modelling could not do. So quite -- I remember many discussions where I said, "That's just not a good question to bring to SPI-M-O, don't ask them that". And then quite often -- you can imagine we would have a conversation where I would say, "Well, why are you asking that question? What is the policy decision you've got to make here? Is there another way we can frame that question into something that epidemiology analysis and modelling can help with?"

Q. Can I ask you just to slow down slightly --

A. Yes.

Q. -- Professor McLean.

LADY HALLETT: I think we had three minds all the same.

MS CECIL: Indeed. Just because, as I say, there is a note being taken and, as I say, it will be my fault rather than yours.

So just picking up on that, what were the initial problems that you saw with commissioning?
Q. Did that process, firstly, improve as the pandemic progressed?
A. It got much better. So SAGE secretariat basically built a commissioning system, which -- one of the things it did was to stop just sort of commissions just arriving just sort of from left field, from department X or ministry Y, so they really helped us a lot by effectively making some rules of the road about how commissioning would work. And then, yes, I think --

Q. Did you see the fruit of that effectively?
A. Yes. We put lots of work into that.

Q. Very short, pithy documents explaining things such as the reproduction number, the R, the R number as it's been referred to, general principles and assumptions on transmission, introduction to epidemiological modelling, which we've all had sight of, and indeed an FAQ on epi modelling to try to imbue some further understanding effectively within the civil service and indeed those decision-makers?
A. So, my Lady, I've heard you don't like graphs, but this is a beautiful --

LADY HALLETT: Well, it depends on the graph.
A. A very beautiful graph.

I think the way to look at this graph is to think about what can this remind us about how things felt on three different dates.

So before, let's say, mid-March, in 2020, we would have been on the right-hand end of -- I'm looking at the left-hand graph, okay? So the bottom axis says how much active work and leisure contact are people having. So 100 is normal everyday life and the Y axis, the up-down axis, is -- what is this -- here is our R number, and we would like --

MS CECIL: If I could just pause you just very briefly with the R number for the moment.

That's INQ000216286.

If we can go over the page, please, what we see here are a sequence of graphs that deal with issues in terms of schools and the mixing outside of home, degrees of school opening, the efficacy or otherwise of contact tracing, and then NPIs that are in place.

Perhaps if you could, just because -- very quickly or very gen -- I say in high level through the first of those graphs.

A. Yes, we put lots of work into that.

Q. Just to give a few examples of those very briefly, you were responsible for producing explainer documents?
A. Yes.

Q. And sometimes we would get commissions that would string several sort of, "*Please tell us about option A and/or option B, that's three possibilities, and then string those together for sort of three or four different things*, and quite soon we'd get to sort of 100 or so possibilities. And it was my job to say, "I'm really sorry, but in a week we can't do that. What do you really care about? How will you prioritise these questions? Let's turn this into something where we can actually help you."
A. Yes. Yes.

Q. Based on the R number, was that because decision-makers had become familiar with that concept?

A. Yes. Yes.

Q. It was a shorthand, effectively?

A. Exactly, it had turned into a shorthand for: have we got this infection under control, is R at 1 or below 1? Or have we not got this infection under control? Which was the case when R was above 1.

So when R is a long way above 1, you really are in trouble.

Q. And that’s why we have the R number along the one axis --

A. That’s right.

Q. -- and the active work and leisure contacts on the other.

A. That’s right.

Q. And I interrupted you, so please go ahead.

A. Fine, thank you.

So remember this is very early on, nobody vaccinated, the entire population susceptible to infection with bad consequences, particularly for elderly people and also for lots of other people too.

So, there we are, living our normal lives in late February, early March 2020, so we’re at -- we’re far

over on the right-hand side of the X axis, all the schools are open, so the R number is somewhere between 2.5 and 3, we’re in the middle of that -- we’re somewhere in that red band up there on the right-hand side. And that was what was driving the rapid exponential growth that we eventually saw in the very rapid rise in hospitalisations that we saw a few weeks later.

I’m going to come on later -- I hope we’ll come later to where we were in the middle of the week just after the Prime Minister stood up on 16 March and said “Please stay home”.

Q. We will be dealing with that in due course.

A. So under voluntary restrictions, we’ll talk about -- obviously it’s very important where we were, but from the data we had at the time we were probably at about 60 on the X axis, most children still in school, still R way above 1. Then on March 23, when lockdown came in, we were more like at about -- and all schools were closed, we were more like round about 20 on that X axis.

A. Yes.

Q. -- and so on and so forth?

A. Yes. And if I could add one further thing: this is actually based on data from I think it -- well, I think it is tens of thousands of people in something that -- a study that the BBC ran, long before the pandemic, on what kind of contacts people have with other people of what age in what context.

Q. And this was a graph, as we will come to later, that was being dealt with at a very early point in time, in fact, in the pandemic, pre-lockdown, but post voluntary measures being announced?

A. I’m not sure we had this particular graph, because actually if you look at the date that these emails were written, I think this is -- no, I think we actually got this representation in more like May. This idea that we needed to be down round about 75% of contacts outside
the home, so the idea that we needed to be way, way down
on -- back to the top left graph -- only requires
a pretty straightforward calculation.
Q. We're going to move to exactly what that required, as
I say, when we start to look perhaps slightly more
chronologically --
A. Yeah.
Q. -- at the response, as opposed to these topics.
And perhaps we can take that down now.
LADY HALLETT: Just before you do, and now I'm going to show
just how bad I am with graphs. Could we have it back up
again? Sorry.
The left-hand graph, you've got -- bottom axis
you've got up to 100% contact --
A. Yeah.
LADY HALLETT: -- yet we're looking at the grey line, if
schools are closed.
A. Yes.
LADY HALLETT: Well, if schools are closed you haven't got
100% contact, have you?
A. So this is active work and leisure contacts beyond -- so
work, adults; leisure, everybody (apart from school).
So, yes, you're quite right, this is apart from school.
What's everybody doing apart from the children's school
contacts. Thank you for reminding me to clarify that.

LADY HALLETT: I was just thinking that obviously when
schools are open --
A. Yeah.
LADY HALLETT: -- or schools are closed, there's an awful
lot of contact --
A. Yes.
LADY HALLETT: -- that is reduced --
A. When schools are --
LADY HALLETT: -- when they're closed.
A. Absolutely. And I don't think that's in here. So the
fact that when schools are closed parents can't go to
work, I don't think that was captured in here.
LADY HALLETT: The other thing, can I just ask before -- I'm
sorry to interrupt, Ms Cecil.
MS CECIL: No, not at all.
LADY HALLETT: Looking again at the left-hand graph, and
remembering that one of the problems I have with graphs
is it all depends on how big a gap you give between
different measurements --
A. Yeah.
LADY HALLETT: -- when we look at school closures and school
openings, the difference isn't perhaps as great as some
of us might have expected. So if you've got -- well,
let's go for the 100%, just because it's easier -- 100%
of other contacts, but you close schools --

big no-no to mark --
A. Yes.
Q. -- the gap between them or indeed to take a specific
point on many of the graphs that were produced by SAGE
or SPI-M-O as being a critical accurate point?
A. I think that was reflected in Graham's comment about
knowing what you can't do with these things. I mean,
my -- I was showing you earlier, my version of these
graphs, that I'm extremely fond of and often carry
around with me, actually has little -- I drew myself
a little picture of a ruler with a "Don't go there" sign
on it. You know, we shouldn't use these things to say,
"Oh, well, if we had, you know, 45% active work and
leisure rather than 40% and -- we could do precisely
this or precisely that". That's not the point. The
kind of lesson to learn from graphs like this is: look
just how much -- look how good your contact tracing
needs to be before it gives you lots and lots of space
to have fewer interventions in terms of how much people
can be out and about.
Q. Indeed. And was that one of the challenges you and your
colleagues faced during the pandemic in relation to the
understanding of graphs, and indeed numbers, statistics
and other scientific data and outputs?
A. Yes, I think -- I think I would say it's an issue all
your life, as a sort of rather technical person, is difficult. It's their job -- I think it's scientists' job to explain what it is that they've done. The understanding of two key concepts, the first being exponential growth.

So exponential growth arises when you have a process where what's fixed is not the slope of the line but the time it takes to double whatever the quantity you see. So exponential growth and fixed doubling times go together. When we say the doubling time is a week, we instantly know: oh, we're talking about exponential growth.

Indeed, you give some examples within your witness statement of the director general for analysis in the Covid-19 Taskforce. Indeed, the failure to take a decision or to wait is a positive decision in itself when it comes to issues of exponential growth?

Indeed. And from your perspective, that is perhaps one of the most important lessons for the future in terms of developing that understanding -- a lead from the decision-makers in government?

Yes. -- is that right? I think so. And as we will see as we move chronologically through that period, that informs what you consider to be one of the most significant shortcomings in relation to decision-making in both -- well, to some extent in the early part of the pandemic but certainly in the autumn period of 2020?

Yes, I agree, I think we made the same mistake three times. Thank you.

Now, with regard to that understanding, do you consider that that requires a scientific mindset?

No, I don't think it requires a scientific mindset. I think if you -- you can draw it out in a picture in a way that anybody who's prepared to listen and think about it ought to be able to grasp.

Indeed, you give some examples within your witness statement of the director general for analysis in the Covid-19 Taskforce.

Yes. Somebody with an entirely non-scientific background, but able to pick up those concepts and work with those.

Yeah. Now, just picking up on the scientific mindset aspects, there are also differences that you identify in culture and approach between civil servants and indeed scientists. Perhaps if I can just break it down a little bit further into three categories. You have your scientific advisers, you then have your civil servants and policy-makers, operational and taking a lead from the decision-makers in government?

Yes.
Q. So those three categories. And in respect to that can I please bring up paragraph 22 on page 7 of your witness statement, because you describe there two very different cultures. So perhaps turning firstly to academics and scientists, and that culture, you explain that academics tend to focus on points of disagreement, speak pointedly, directly about their views. What was the difference, as you saw it, in terms of your interactions during this period?

A. So really the nicest thing that an academic can do for a colleague is point out why they're wrong before it goes out into the world and somebody unfriendly points out why they're wrong. So that was why under Graham's leadership on SPI-M-O our mantra became "Tell me why I'm wrong", and -- whereas it is very frequent in a civil service meeting that as somebody stands up the very first thing they will say is "I agree with everything that's been said", and you're sat there thinking, "Well, you can't have been listening then". And it's -- I don't think they really mean it, actually, I think it's a sort of a saying that means "I'm here to work with you, we've got things we've got to deliver, I might disagree with some of the details of what you've said, but let's work together". And, I mean, I always found it -- do I still? It's always quite difficult for them to cheer [Name Redacted] up a bit".

Q. Did that cause any difficulties during the pandemic?

A. Yes, there were several occasions when I had to paper over the cracks, I would say, because it was usually -- was it usually this way? -- yes, I think it was mostly that an academic on SPI-M-O had told a civil servant why they were wrong in some way that the civil servant felt was rude. And so, yeah, there were occasions when -- when I -- and I felt it was my job, I was very happy to do it -- was in contact with people to say, "I'm sorry that was upsetting for you, that was -- they didn't mean to be rude to you personally, what they -- you know, to cheer [Name Redacted] up a bit".

Q. And, indeed, different ways of communicating.

A. Absolutely.

Q. So is that an example of what you have been --

A. Indeed.

Q. -- referring to?

A. Indeed. And, I mean, what you can see here is the wonderful Clare Gardiner was able to ring me up and say "Angela, that went a bit far on Wednesday, can you try..."
parameterised model with lots of the complexities about
how different parts of society mixed together. So we
were very clear that this was a pedagogical tool.

Q. Indeed, within the toy model documentation itself, it
makes clear that it's a teaching tool.

A. Yeah.

Q. It's not designed to give accurate forecasts; it is so
that people can play around with it to see what the
potential impacts of different interventions could be,
but in a very general way.

A. That's right. So going back to this issue that we
talked about right at the moment, right early on, that
if something is growing very fast and the control lever
that you have only acts with a bit of delay, you're
going to get this big overshoot after you've made things
better, that sort of thing. And when I say "we built",
was built by a team in JBC, a very able team led by
Fergus Cumming.

Q. And then quality assured and then sent out to various
government departments.

A. That's right. So my role -- so I was incredibly keen
that they should have something that was internally
correct. I mean, it wasn't a great model but it didn't
have mistakes in it, so that it could be relied on in
that sense. So yes, sent it out to be basically peer
reviewed by some academics and it was also very
carefully reviewed by some modellers at the Defence
Science and Technology Laboratory.

Q. We've heard a little bit of evidence already in respect
of Clare Lombardelli from the Treasury with regard to
an email chain that you were involved in, along with
Philip Duffy and Ben Warner, relating to Treasury
playing around with and changing that toy model, and
what you say there, in relation to that, is:
"Given their inability to spot egregious errors in
other things they were sent I do not have any confidence
in their ability to hack a simple, sensible model."

As a consequence, anything they have to say about
infectious modelling is very much on them, as opposed to
quality assured or endorsed by you or SPI-M-O.

A. It was me, this was -- SPI-M-O were actually quite clear
that they felt it was not their job to quality assure
government work, and I think that was right, they were
already doing enough, so it was me as -- really, it was
me as CSA MoD, I would say, who took this, found some --
actually, some of them were SPI-M-O members. But -- so
that was done outside SPI-M-O, and I think rightly.

But, yeah.

Q. But to go back to the -- in the documentation,
I think you'll -- there are things saying, "Please don't
change it", because once you've changed it, it is no
longer quality assured. You know, we had gone to a lot
of trouble to make sure it was correct, and so we said
to people, "Please don't change it, please feel free to
use it however you like". It had been made into this
beautiful, rather easy-to-use thing, I believe, although
I never got to play with it myself.

And, I mean, that is a source of some regret to me,
because if Treasury had come to us and said, "Oh, this
is quite interesting, it doesn't quite do what we need,
would you -- if we make some changes to it, properly
document and explain to you what we've changed, would
you re-quality assure it for us?" And I think I would
have sighed because it was a lot of work, but I would
have done it. And actually that could have formed the
basis for quite an interesting -- a strong interaction.

Q. Indeed. And one of the themes that you do refer to
within your witness statement more generally in relation
to HMT and Treasury is a lack of transparency over the
economic modelling or advice?

A. Yes. I mean, I think there was an issue that the
scientific advice that came through SAGE was completely
transparent, everything was in the public domain, on the
day that a decision was announced, and whatever
modelling Treasury was doing to consider the economic
getting better as the pandemic progressed. Would that
be a fair summary?

A. Yes, that's a fair summary.

Q. If I can just pull up, please, INQ000213194 and go to
page 2, what we have here -- it's the bottom of an email
from you that I'm interested in. It's halfway down the
page:

"That does bring me to the elephant in the room
Mike."

This is an email exchange that's taking place
towards the end of March --

A. Yeah.

Q. -- of 2020, 28 March:

"You are going to be horrified when you find out
what the data flows coming out of the NHS are like.
I just want to warn you. I actually choked when
Peter Bruce said SPI-M must be drowning in data."

So we are obviously at this point in lockdown.
We're there. We still have, on your view, significant
issues with the data flows coming out of the NHS. Is
that right?

A. Yes, that's right.

Q. How did that impact upon your work at that stage?

A. There was -- there was real trouble with doing the sorts
of analysis that we needed because the data weren't
available. It's that straightforward.

Q. Thank you.

A. It did get much better later, so I ... I can't remember
the exact dates, but around this time -- I think it --
I never really knew what happened, it was a bit -- it
was quite sort of elves and the shoemaker. I came down
one day and DSTL had sorted it all. I think what
happened was that my very able private secretary in the
Ministry of Defence, who came from the defence science
labs, what they did was they set themselves up as what
I would call a data haven. Anybody would look at them
and say: well, surely these people know how to keep very
sensitive data secret. So they could be trusted by the
NHS to take the data, clean it, make sure that nothing
was identifiable to an individual, on the one hand; and
on the other hand, they could handle all the
non-disclosure agreements that were absolutely necessary
from people who were going to access that data.

So they set themselves up that way and they became
the people -- a main conduit -- not the only conduit,
but the main conduit -- for data, particularly out of
the NHS, into idea -- into the modelling groups.

Q. So, essentially, a trusted broker?

A. Exactly.

Q. Something of that nature?

A. Yes. And, actually, I mean, I would like to sing their
praises, because I think that act of looking after data,
cleaning data, making sure that only people who should
access it do access it, is often -- they are unsusing
heroes, those people. They weren't the modellers; the
modellers could not have done their work without them.

Q. And just picking up on two other aspects, if I may, of
data. If I can call up, please, an email at
INQ000061765. It's an email, again around the same time
period, 30 March of 2020 through to the 31st, between
you, Sir Patrick Vallance and Professor Medley.

Here, what's being flagged again is, we see from the
second email down from Graham Medley:

"... the lack of data from devolved administrations
should be highlighted."

If we go over the page, please, what we have at the
end of that email, the penultimate line before the
sign-off:

"A key political issue is that we still have no
real-time data from outside England."

So what we're seeing here are significant issues in
relation potentially to Scotland, Wales and
Northern Ireland.

A. That is correct.

Q. Again, what impact did that have on the early stages and
Q. Of course. No, thank you, Professor.

2. Another area of data, just briefly on ethnicity, if I may, you make it plain within your witness statement that with regard to ethnicity there was insufficient data to account for intersectional disparities, so ethnicity and indeed other aspects; is that right?

3. That -- particularly in these main flows of data that were driving parameter estimation for the big models, yes. There were sometimes other particular questions that we could address with particular datasets but yes, I would say in the main data streams there wasn’t enough data, and for the kinds of policy questions we were addressing I don’t really -- I can’t think of policy questions that really would have driven that kind of modelling. Because there’s no point in us making a model more complicated if it isn’t necessary to address a particular policy question.

4. Indeed. And similarly there was an absence of data on wider societal outcomes which feeds into those intersectional issues also?

5. A. Yes.

6. Q. We --

7. A. Sorry, can I just --

8. Q. Of course.

9. A. I don’t think we’re going to visit it here, but there

10. was work done by a different group, not by SPI-M-O, on what Chris Whitty refers to as -- what we always thought of as the CMO’s four harms. So because -- so that was handled by Ian Diamond and John Aston.

11. Q. Yes.

12. A. So that the -- ways of accounting for the harms wider than Covid hospitalisations and deaths.

13. Q. And we have heard some evidence in relation to that at the outset of this module as well from Professor Sir Ian Diamond.

14. A. Good.

15. Q. Similarly, if I may, data and care homes, just touch on that briefly here. With respect to care homes and data, were you also experiencing problems in accessing data flows and data streams?

16. A. We had very little data about outbreaks inside care homes, so for a long time the data we tended to see was: yes, this care home is affected, no, this care home is not affected. But that made it very difficult to say anything helpful about what was happening inside care homes.

17. We did set up a separate care homes group and had modellers specifically on there, so in a sense the care home modelling was -- was delegated to a different group.

18. Indeed, and really I’m just dealing with the data aspect --

19. A. Yes.

20. Q. -- at this moment with you. Perhaps just to round off that topic in terms of your evidence, because we’ve heard evidence obviously from other individuals too, Professor, but from the outset did you expect that there would be problems arising in relation to care homes and outbreaks?

21. A. Yes. I think that was -- you only have to look at historical big epidemics, particularly of respiratory infections, that you would have expected that.

22. Q. Just again briefly, because there will be a module dealing with this in greater detail in due course, was outbreaks, the incidence of outbreaks and problems within care homes, was that something that was a foreseeable issue from the outset of the pandemic?

23. A. Yes.

24. Q. Indeed, within both SAGE and the subgroup, we see that testing is --

25. A. Yes.

26. Q. -- one of the --

27. A. That’s true.

28. Q. -- tools that is repeatedly referred to respect to care homes?
understanding of science event actually in Oxford, so there were sort of lots of us together, and somebody asking me about it, and I remember saying, "Well, John's worried, and that makes me worry". Because, I mean, you know, we've lived through all of -- you know, umpteen times that there has been a pandemic and so we know how different people react; the fact that John found it worrying was a pretty strong signal, I would say, even mid-January.

Q. Is he normally somebody that is cautious then, and so a concern in that respect would be a very significant concern?

A. Yes.

Q. Now, if I may take you then to the first few weeks of March, and if I can take you to paragraph 116 of your statement, you explain that you: "...began to feel that there did not seem to be a plan within government, or a clear sense of how many people were going to die."

A. Why was that?

A. Where are we ... I'm just trying to look -- "first few weeks" ... it seemed incredible, and from what I've heard now it was incredible, that there could possibly be a strategy of -- of a -- even a slightly mitigated epidemic, that the kinds -- I mean, you've talked quite a lot about other people's calculations. We might look at some I have made. If everybody could catch it and it spreads quite well, so that you might expect something like three-quarters of the population to get it, even if the infection fatality rate is only 1%, that's just an unbelievably large number of people. And that was what led me to say to Ben on that -- one of those days, the 10 March day, have decision-takers really understood what they're confronting here.

Q. And 10 March that you're referring to is a SAGE meeting?

A. Yeah.

Q. And Ben is Ben Warner --

A. Yes.

Q. -- who was also in attendance. We also know that Professor Riley was there, Professor Ferguson.

A. I think Professor Riley was not there but we spoke about an important paper of Professor Riley's.

Q. Yes, and it was his paper that was being discussed in any event at that meeting?

A. The point about that paper was, remember, Professor Riley had lived and worked in Hong Kong, so he had experience that was lacking for many of us. And, you know, he expressed this very strong view: we're going to have to go into lockdown and stay there. And so that was 10 March.

And, I mean, I actually hadn't heard about Exercise Nimbus until I heard Ben Warner giving evidence to you, and, I mean, actually -- so if I'd known about Exercise Nimbus on that day I would have thought, "Oh, well, they've had an exercise on it". It was a flu pandemic exercise, but it's still a very, very large number of deaths. So if I'd just known that Exercise Nimbus had happened, I might have been encouraged; actually, if I had known who went to Exercise Nimbus, I might have been a bit discouraged.

Q. If I can just pick up on that, please, with Exercise Nimbus, and certainly it was not the case that all of the CSAs from the various departments were present?

A. No.

Q. Certainly you weren't aware of it?

A. No.

Q. So there was no opportunity to feed in from that scientific perspective?

A. I think GCSA was there. I'm not -- I think at least one of the DCMOs were there.

Q. I mean from the CSA -- I mean from the broader CSA community within government.

A. Yes, absolutely. Yes, that's true. I would also -- the people who were present at Exercise Nimbus were not the secretaries of state who would be sat round the Cabinet table making these decisions.

Q. So at that point did you -- were you concerned that government had not got a grip on the situation?

A. I was concerned that the people who were being asked to make these very consequential decisions that were coming our way very fast may not have got their heads round what it would feel like to have three-quarters of the population infected and 1% of them die. I mean, that's -- it's clearly unconscionable -- whatever the word is -- not something any politician can conceivably agree to. So I wasn't clear what it was they'd agreed to on that -- on that day, on the 10th.

Q. Indeed. And as you say, that's what prompted you to speak to Ben Warner --

A. Yes.

Q. -- about whether or not those decision-makers in government --

A. Yes.

Q. -- ie the politicians --

A. Yes.

Q. -- the Prime Minister and members of the Cabinet --

A. Yeah.

Q. -- secretaries of state had understood the consequences?

A. Yes.
Q. The overwhelming of the NHS --
A. Yes.
Q. -- and the tsunami of deaths that would potentially be coming --
A. Yes.
Q. -- the -- in the way?
A. So this was the first time I saw a picture that compared potential pandemic and ICU capacity, and it was really shocking. Because -- I mean, you've all seen it now, but it is this line right down at the bottom, not so many at the top. And I did also -- a relative of mine was working in a London ICU then, and from what she described and from what I knew about exponential growth -- you know, they didn't have many people but if the doubling time was less than a week, it was just very obvious that they would be in big, big trouble in a few weeks' time.

Q. Indeed. And that prompted you to send Professor Sir Patrick Vallance an email.
A. That was my interpretation of what we seemed to be saying, that the situation was going to be something that we make it a little bit better and then we'd stay within capacity --

A. LADY HALLETT:
A. If capacity is nearer the low line ...
Q. "Intermittent lockdown"?
A. Yeah.
Q. "... what other combinations of options are there?"
A. Yeah.
Q. This is on 15 March. And we see, at the top: "Lockdown"?
A. Yeah.
Q. You don't need a model?
A. No.
Q. You don't need modellers?
A. No.

MS CECIL: And the NHS would cope, effectively?
A. Yeah.
Q. But actually capacity seemed to be at quite a distance from that?
A. Yeah.
Q. And as a consequence would be overwhelmed and swamped very quickly?
A. But other people who were having conversations --
Q. I mean, this is me at home in Oxford, you know, doing little drawings. Other people who were in London that week were in the process of finding out how far along -- or, in real life, how far along those lines we were, which was actually, as you heard earlier this week, the much more compelling piece of evidence.
Q. Indeed. If I can just then take you down slightly further on your page, this is where you set out what you consider to be the combinations of options: "If capacity is nearer the low line ..."
A. Yeah.
Q. "... what other combinations of options are there?"
A. Yeah.
Q. "Intermittent lockdown"?
A. Yeah.

Q. Presumably coming into lockdown, coming out, going back into lockdown?

A. Yeah.

Q. "Spread out [over] time to achieve immunity". What does that mean?

A. Other ways of -- intermittent lockdown is one way to spread out when your infections happen. We could have thought -- I'm sure if we'd applied brain we could have thought of others.

Q. And "Continue contact tracing". We'll come to that a little bit later.

And then:

Q. "Others"?

A. Yeah.

Q. So we see that you are flagging here to Professor Sir Patrick Vallance those options, if this is where we are?

A. Yeah.

Q. You raise herd immunity effectively to demonstrate the numbers that it would take to reach a level of population immunity?

A. Well, actually, if you look at what is happening here, I'm not actually doing any kind of herd immunity calculation. There's no 1 minus 1 over R here, it's just if you wanted to end up with half the population immune what would happen. And so that's that first row.

Q. And that's the sort of numbers that would have been looked at in Exercise Nimbus. It's not exactly those ones but it would have been something like that.

A. Yeah.

Q. Indeed.

A. So a sense that -- I guess what I'm saying at this stage is what Chris said two days ago: nobody was ever considering this. And I guess I was getting up to speed with this was not something that could be considered.

Q. Indeed. And then you send this document the same day to Professor Medley?

A. Yes, because that, I did not want to be -- remember I'm not on SPI-M at this stage, so I didn't want to be treading on his toes, just making sure he sees it.

Q. Indeed.

Now, just going back to the NHS data point that we discussed earlier, would you have expected better quality data at this stage to inform these sorts of calculations in terms of ICU capacity bed space?

A. Yes, I think it would have been very useful if, in one of the SAGE -- as I say at the beginning, there's a discussion that I missed that SAGE -- if it has occurred. So, I mean, that -- I think that's a sort of polite way of saying: why on earth have we not had a discussion in which we look at some of these potential waves we're thinking about and plot them against our known capacity?

I think there's con -- I mean, from other things I've seen you look at, perhaps those conversations were happening somewhere else.

Q. If I can just also just pick up on one further point before leaving the document, you also raised nosocomial infections, so infections take place when an individual is admitted to hospital, and certainly that was also a concern of yours at this stage; is that fair to say?

A. Yes.

Q. We then move through the pandemic in terms of -- in terms of announcements. On 16 March, just so that you're aware, that's when the Prime Minister says "Now is the time for everyone to stop non-essential contact and travel", and by 18 March you, within SAGE, and indeed SPI-M-O as a consequence, had some data in respect to what -- how people's behaviours had changed; is that right?

A. That's right, there was, this was paper -- sorry, this was data that we looked at at SAGE on 18 March. So this is two days after voluntary stay at home.

Q. What we see from that is that they had achieved around a sort of 40% reduction --

A. Yeah.

Q. -- in social contacts, but was that sufficient?

A. No, we knew that we needed about 75% reduction in contact. So I think -- look, this is something I think is quite important to remember, that we did actually data that very day that said that voluntary reductions were not enough.

Q. We see quite significant -- in fairness, we see quite significant voluntary behavioural change in reality. We see that "16% of those with school age children have already stopped their children going to school". We see the public reacting to that announcement?

A. Already.

Q. But as you say, it simply was not enough in terms of --

A. No.

Q. -- what you considered was necessary to prevent the tsunami of potential infection?

A. Indeed.

LADY HALLETT: Did you have enough data? You said you had some data, but I think I have heard other people say that it would take more than just two days to get sufficient data as to --

A. Yes.
LADY HALLETT: -- whether or not it was working. So what conclusions can we get after two days?
A. What conclusions we get after two days is that after two days we haven’t got enough. I think there are other -- I mean, that’s all we had and a decision had to be made.
So I think there are other data streams that tell us that the voluntary measures weren’t enough, and in particular the fact that hospital admissions peaked on April 2nd, and that’s ten days after March 23rd. If 16 January had been enough -- sorry, if 16 March had been enough to get R below 1, we would have expected hospital admissions to peak ten days after that.
MS CECIL: And that’s your lag point as well?
A. That’s the ten-day line.
Q. Indeed.
A. Yeah.
Q. So broadly accurate but insufficient?
A. A big -- I mean, I think all of us who were there -- I mean, actually I have a photograph on my phone of an empty train as I went into London that week. It felt enormous. But actually, I think, if we remember, it was not as enormous as the next week. I mean, the next week it was really sort of wind down an empty street, wasn’t it?

enough information on that date to say "We need to stop all non-essential contact".
MS CECIL: My Lady, I’m going to turn to another topic. It’s slightly earlier than would ordinarily be the break but it may be that now is an appropriate moment.
LADY HALLETT: Thank you, I shall return at 10.50.
(10.37 am)
(A short break)
(10.50 am)
LADY HALLETT: Ms Cecil.
MS CECIL: My Lady.
Professor, if I may just pick up very briefly on lockdown. We’d just got to the point of the first lockdown and the stay at home guidance. You were expressing your views on the timeliness of that lockdown.
Can I just be clear, is that from a public health perspective?
A. Yes. I’m not entirely sure it’s sensible to completely separate out the public health perspective and all the other costs. I think, actually, you had strong evidence from my colleague Tom Hale in Oxford that the countries that did best were countries that kept incidence low, and they had both better health outcomes and better economic outcomes. So the idea that it was this pure trade-off, one thing or the other, I don’t think is a helpful mindset.
Q. Indeed. But, of course, when considering lockdown --
A. Yeah.
Q. -- there are other factors and there are other broader considerations alongside the public health considerations, as you have identified, economics, which may go one way or the other.
A. Yes.
Q. Indeed.
Then just dealing with your point about lagged delays. So we have the announcement of the lockdown on 23 March and stay at home, and we see -- and you’ve set it out within your witness statement -- that, again, peak hospital admissions then subsequently fell ten days later on 2 April.
A. Yes.
Q. What does that mean in terms of the R number, from your perspective?
A. From my perspective, that tells us that the R number fell below 1 for the first time about ten days earlier, namely on 23 March.
Q. So we’re seeing those correlations, and you’ve given two examples now --
A. Yes.
Q. -- in your evidence so far.
  In terms of support for that view, what you also set out is the alternative, if the R number had been higher during that second half of March.
  What implications would that have had in relation to the first wave?

A. Well, let's -- there are various possibilities. If it had been higher and above 1, hospital admissions would have continued rising, I think. I mean, that would have been intolerable. We were -- everybody was very, very worried those days in early April. Was it going to peak? Would the stay at home law -- so would the imposed lockdown be enough to bring R below 1? That was the first thing. So that's -- a terrible outcome would have been if hospital admissions had carried on rising.

But even if it had fallen a little bit below 1, say -- we think now it fell to about 0.7. If it had fallen but not that much, that first wave would have been bigger. It would have -- so we'd have had a peak, but it wouldn't have come down so fast.

I think most people feel that the first wave was bad enough.

Q. I suspect that's a view that's broadly shared --

A. Yeah.

Q. -- and uncontroversial.

Q. -- in relation to low incidence --

A. Yes.

Q. -- and the role that that may have played in relation to pandemic response and outcomes.

Now, in April, on 10 April, you attended a working group on the science of exit from lockdown, and at that meeting, there were two scenarios that were being discussed, weren't there: a low incidence scenario and a high incidence scenario.

Can you just explain for us in simple terms what a low incidence scenario is, and then we'll move in a moment to the high incidence.

A. So I think a good way of labelling those -- we ended up labelling them "hospitals empty" or "hospitals full". So high incidence actually wasn't all that full. And the question -- actually, what we wanted to do was start to have strategic think-through about: what are we going to do? You know, we're in a deep hole here. We've got a nasty infectious disease circulating that is -- makes many people very ill, and sadly kills quite a lot too.

Q. So if I can ask you questions then about your involvement in the exit from lockdown. You've already touched upon one aspect of that by reference to your colleague, Professor Thomas Hale --

A. Yeah.

Q. -- and that role that that may have played in relation to pandemic response and outcomes.

And so in some ways I would say the low incidence and the high incidence comparison that we ended up making was an attempt to start a conversation, both with policy-makers and decision-takers, along the lines of: well, what is your strategy? What's the plan?

Q. Indeed, and a lack of strategy or clear plan or strategic aim is one of the primary themes that's contained within your witness statement.

A. Yes.

Q. If I can deal with that briefly with you now.

You explain that the primary strategy that evolved or the closest thing you got to was the focus on the R number.

A. That's right.

Q. What impact did that have in terms of strategic thinking and your ability within SAGE and indeed SPI-M-O --

A. Yeah.

Q. -- to model interventions and to provide, effectively, options that could be developed to policy?
that's breached --

A. No.

Q. -- potentially, and effectively a trigger -- or for use of a shorthand, to trigger other interventions or to bring in further aspects of a plan.

A. There were some levels, weren't there? There were those five levels I expect other people have talked to you about. But I don't think we ever had from central government: we want R slightly less than 1 and the number of new infections per day less than, let's say, some thousands of numbers.

Q. And did you request further guidance or a clear strategic aim?

A. I certainly requested them of my civil service contacts, and, I mean, they got to a stage where they knew what I was going to say, you know, because the plans would come back that it was, you know, sort of a tolerable number or something, and they knew I was going to say, "Well, what is a tolerable number? What number is that?" But, I mean, I think it's very clear that that was a choice, not to articulate a number on what was tolerable.

Q. Indeed. So that in itself was a positive decision.

A. Indeed.

Q. The consequence from your perspective -- and you could imagine a world where we had said -- well, where decision-takers had said, "Oh, gosh, we've breached the target, let's get a grip", and that is not what happened.

Q. We're going to move to that in due course.

A. Yeah.

Q. -- running a pandemic, also you've put it, in hot or cold terms --

A. Yes.

Q. -- to engage or get decision-makers and policy-makers to engage with what it was that they saw as a clear strategy.

A. Yes, and the point of that document was to lay out how different things would be with respect to a whole lot of different factors. For example, contact tracing is only really going to be able to make a huge difference if you're running a cold epidemic, if you've got low incidence, because once incidence is really high, it becomes very difficult to do contact tracing well enough to find everybody who's got infected and get them into isolation. So there is quite a long table in that document of sort of careful thinking about what would be the difference between these two.

Q. Thank you.

A. If I may, there is -- I think really the closing paragraph of that document finished the question for us, in which somebody makes the point or the point is made: well, let's just imagine that low incidence is about one-fifth of high incidence, that means we're accruing immunity five times more slowly, that means -- if we think roughly speaking -- we did think roughly speaking we'd get to a useful amount of immunity in one year with high incidence.

Q. With high incidence?

A. With high incidence. That means if we think we might get a vaccine or a really good pharmaceutical, a really good drug, in anything less than five years, then we should go for low.

LADY HALLETT: Can I --

A. And that was sort of the killer for us. That was the end of the question for us.

LADY HALLETT: Sorry to interrupt.

A. Can I just go back to the point about not having a plan.

LADY HALLETT: I appreciate having a plan or a strategy
would make your life and the lives of your colleagues a great deal easier to provide what you considered to be more accurate and sensible advice, but provided the experts advising decision-makers were getting the message across that this was going to be a nightmare, the NHS would be overwhelmed, do you have to have a target that gets breached?

No. No, we don't. We might come to that at the end, because there was never any target expressed in the 2021 spring documents. There's no numerical target.

I would say it's probably more to do with politics and values and acting fast. I mean, I think the fact that fast action was required, I think that is a scientific issue, because it's to do with the system science of -- it's basically to do with fast exponential growth and fast talking. Fast exponential growth and lag delays, those are scientific issues. I think articulated targets might have driven faster action, and in that case would have been good from the point of view of pandemic control.

Thank you.

We'll touch upon that as we come into the autumn period in due course, and then indeed we will turn to the roadmap and the targets and objectives that were outlined there and the policy objectives.

As a simple way of explaining to those decision-makers what the consequences of either hot or cold, low or high incidence, would be. Now, in terms of SAGE and your colleagues, the general consensus was that the low incidence approach was the preferable one.

Correct.

And that was communicated upwards.

I assume so. Yes, I think -- so I'm pretty sure that what happened is that Chris and Patrick wrote their own version of this document, which they, I assume, then took to Cabinet.

We touched upon that already in terms of some of the evidence that we've heard. Now, just if I may now turn to another aspect, that alongside all of this, while you're running through those scenarios, you're also considering the possibility, at least, of elimination.

Discussing, yeah.

Indeed, and you raised that --

Yeah.

-- on 18 April and indeed on 19 April, firstly in an email to Professor Medley on the 18th, and then secondly in a conversation with Professor Sir Patrick Vallance. In respect of that, you're perhaps just to round off this, if I can just bring up INQ000212100. This is an email from you. It's the one that attaches your paper that we've just been discussing. But you boil it down to Sir Patrick Vallance within this email -- if I can just go down slightly further -- into a very simply dichotomy, in many respects --

Yeah.

-- for politicians, so decision-makers:

"Do you want to keep COVID deaths as low as possible until pharmaceuticals produce a solution [that's your vaccine or your medicine]"

"Or "Are you prepared to define a tolerable level of COVID deaths that would allow us to start moving towards an immune population whilst we wait."

And of course, as you say:

"The devil then is how small can 'tolerable' be and still move us towards an immune population at some meaningful rate."

And then you explain further, as you've just touched upon:

"... if you want to be at population immunity within a year, we cannot imagine getting there with any fewer than N deaths ..."

As I say, you're essentially saying: have we properly considered it? Have we ruled this out as a potential option?

You also address within that the potential for the health and social care infections to be driving the community epidemic as opposed to the other way round, with the community epidemic driving the health and social care infections.

We've not seen any further material in relation to pursuing elimination as a strategy, but what were your views at that time, and was it a possible strategy to be pursued?

So quite quickly, because the infection was so widely seeded across the population, and as we were finding out more about asymptomatic infections, it was very clear that it was not feasible. At that point, I -- we probably had a discussion in which we said: well, we could do a bunch of calculations, we could make a model, we could, you know, do some squiggly Greek letters, but at the end of the day we're just going to say exactly those words. So this was a place where doing some modelling simply doesn't add anything, so let's not do it. So that was elimination.

I think I did feel then: let's challenge that a bit, let's make absolutely clear, because Australia and New Zealand were aiming for elimination, but -- so let's...
be clear in our heads why we think it's not going to be possible. And for people like us, the way to be clear in your heads is to think it through with a little model. But it clearly wasn't a useful way to spend a lot of time for SPI-M.

Q. Indeed.

A. Was the -- were the hospital and care home epidemics driving the -- did we need a three -- basically, a three-part model, so a model that had community and care homes and hospitals? I think we probably put that to modellers and they said, "No, we don't think so".

One of the big models did end up with care homes in it, but fundamentally I think we ended up with a decision that: no, they weren't driving. They were important in terms of places where large numbers of very vulnerable people gathered together, but they weren't important in terms of driving transmission back into the wider population.

Q. Just touching, if I may, on elimination more generally, this was obviously in April, but looking back now, would elimination have ever been possible on what is known?

A. Certainly not after we'd seeded the epidemic the way we did after half term in February.

Q. Thank you.

Now, as we emerged from lockdown 1, and moving then into the summer months of then May 2020, you took part in -- well, over the course of the pandemic -- a number of Number 10 Downing Street press conferences.

In May 2020, in reference to coming out of lockdown and any changes in relation to lockdown, you explained that the scientific evidence was clear, and that any changes to lockdown were also dependent the track and trace system being in place.

Now, that was obviously your comments then in May 2020. Was that track and trace system ever in place to an adequate level to enable that to actually take place?

A. I think our estimates in the summer of 2020 was that it was probably blocking about one in five, so 20%, of onward infections, and that in order to have a really in order to have so substantial an impact that big changes could be made to how much mixing we could have without driving R above 1, that needed to be more like four out of five.

Q. Thank you.

Further in that press conference, you also said that any lifting of restrictions should be based on observed levels of infection and not on fixed dates.

A. Yeah.

Q. So effectively data not dates, in shorthand. Was that position coming out of that first initial lockdown and, indeed, in April of 2020 through to May. You explain there that -- it's about halfway down:

"I do not know what people in government understood the characteristics of Covid-19 to be, but we were worried that for whatever reasons, decision-makers had not taken on board quite how serious it was."

You explain then by reference to an early meeting that you had in the Ministry of Defence, where your comment that it would take at least 18 months was met with disbelief.

Was that a view that you saw more widely across government?

A. I think if we'd been in the room together -- of course, it was all a Zoom meeting then -- I would have used the phrase "you could have heard a pin drop". Perhaps "disbelief" is a little bit hard. But I think people -- I think -- I mean, it was quite shocking, wasn't it, I think, for all of us, the thought that -- that was quite a hard idea to get your head round, that we were in so much trouble that it might take us more than a year to get out of that trouble. And, as I say, there were midway reviews in April which -- we were certainly not midway in April, were we?

But I think in retrospect, one of the things that
I wish we had done is this sort of -- what I think of as the missing commission. So in that summer of 2020 when, you know, things were under control, I really wish there had been a cross-government commission that recognised all this, that said, "Well, we're in this for the long term, it's going to take until we get a vaccine, and then another year, so what are we going to do? There aren't really good options; are there any less worse options?" And I would have -- in retrospect, I think we should have used the expertise that we had, both inside government and had already gathered from outside government, to pause and think really carefully about a long-term plan.

Q. Thank you. Would you describe that as a missed opportunity?

A. I do think that was a missed opportunity. Again, with the benefit of hindsight. I didn't ever ask for it at the time.

Q. That's the next -- indeed, you've already foreseen my next question.

A. But perhaps then therefore going to the summer of 2020, and you've explained that infections were low, the R rate was around 0.7 or so at that stage in the summer, we then move into the June, July, August period, and of course in July, the Eat Out to Help Out policy was announced.

We know that SAGE were not consulted on that policy; is that right?

A. That is right.

Q. Was SPI-M-O consulted?

A. We were not consulted.

Q. Indeed, you've been through both the SAGE and the SPI-M-O consensus statements and there's no references to it there.

A. Correct.

Q. Do you have any knowledge at all about what, if any, scientific advice informed that scheme?

A. No, I don't know anything about any scientific advice that went into that.

Q. In terms of your view on that scheme, and the advice that you would have given at the time, what would that have been?

A. It would have been along the lines of advice that we were giving routinely, which is that there wasn't much room for increasing mixing, and the kind of mixing that should be avoided is between households indoors. So we would have said, "Could you not find some other way to stimulate the economy?"

Q. If I can just call up, please, a SPI-M-O paper which deals with social distancing measures. It's dated 22 June 2020, and it's INQ000074930, it's page 1, and if I can go to paragraph 4. Here, what we see within SPI-M-O is effectively it's looking at how one goes forward and takes NPIs forwards and relaxation, and what's set out here is that: "Rather than focusing on re-introduction or relaxation of individual measures in isolation, it is necessary to consider a package of interventions as a whole and what implications one measure may have for the choices in [another]."

It's trade-offs, in short; is that right?

A. Yeah. Absolutely.

Q. You explain you could use the ready reckoners that we've already discussed and touched upon to explore the impact on transmission from one intervention to be weighted against other potential relaxations. None of that work, as far as you are aware, was conducted in relation to the Eat Out to Help Out scheme by SPI-M-O or SAGE?

A. Certainly not by SPI-M-O or SAGE, I don't know if by other people.

Q. Then if we go to paragraph 5, you explain here that -- this is SPI-M-O's view.

A. Yeah.

Q. So the committee: "... do not believe it is possible to return to a 'pre-COVID' normality, without levels of contact tracing and COVID security effectiveness that would be difficult to achieve without some sort of additional increase in immunity ..."

Or vaccines, and so on.

A. Covid security is more things like everybody washing their hands very carefully, maybe wearing masks, do you remember there were all those screens that went everywhere, restrictions on how many people were in a room. So it was more the -- yes, those sorts of NPIs, yes.

Q. If we continue at paragraph 5, it states: "In order to be able to re-open schools in September without causing a second wave, it [is] therefore critical that some measures remain in place."

So that the reproduction number (R) remains below 1 at the start of September when they all return to school.

A. Yes.

Q. That's the position in June; would that have still been the position in July?

A. And August.

Q. And August.

A. And September.
Q. Indeed.
A. Yes, that second wave was foreseeable. I mean -- but because -- for the simple reason that virtually nobody had had it.
Q. And, indeed, winter was also coming.
A. Yes.
Q. And we've heard from Professor Sir Chris Whitty that history has taught us that, in pandemics, second winter waves often far exceed the first wave.
A. They do indeed. Actually, I think most parents know that September is a time of year when respiratory infections are often rife.
Q. Indeed, September to December is constant germ after germ.
A. Yeah.
Q. So if I can then move into the September period, so schools returning, and if I could just take you, please, 77

... where more stringent restrictions are put in place for a shorter period could have a significant impact on transmission. Modelling indicates that a 2-week period of restrictions similar to those in force in late May could delay the epidemic by approximately 4 weeks."

A. That was the SAGE advice. So a circuit breaker is...
LADY HALLETT: Why aren't intermittent lockdowns a rollercoaster?
A. Because it's a very boring, little rollercoaster. So, I mean, you're just going like this (indicated).

So, I mean, for example, your contact tracing works better because you've never got very high incidence. Your hospitals work better because they're not completely full. I mean, one of the things that we often -- well, that we saw was that fatality rates in hospital were higher when the hospitals were fuller. There were plenty of good reasons why intermittent, short lockdowns could well have been better than the long, harsh lockdowns that we had to live because we put them off to the last possible moment.

MS CECIL: And that's pulling it back to the low --
A. Yes.
Q. -- incidence rate, as opposed to the high incidence rate, running an epidemic hot or cold?
A. Yeah.
Q. Trying to keep a lower level of infections, albeit they go up and down and rise up and down. They don't meet that peak, effectively.
A. That's right.
Q. Now, you were subsequently invited to a meeting with the Prime Minister on 20 September of 2020, and I just want to deal with something very shortly before that and prior to the meeting on 18 September.

It is some messages with Sir Patrick Vallance. It's on INQ000229601. It's the bit at the bottom that I'm interested in. It says:
"I have an invite to a zoom with the [Prime Minister] at 1730 on Sunday. I'd be honoured to accept that invitation. However I assume this is the meeting you and Stu were organising yesterday [presumably a reference to Stuart Wainwright at GO-Science]. Does it fit your plan if I rock up and say 'RWCS [reasonable worst-case scenario] assumes someone gets a grip at this stage of things and it would be great if that happened'."

Can you explain in your own words what you were trying to impress upon certainly Sir Patrick at that point and your view?
A. I wanted to -- I'm quite a believer in the single voice of consensus science. So what I was checking here was -- basically running past Patrick what I'm planning to say so that he knows in advance of the meeting. And "[Reasonable worst-case scenario] assumes someone gets a grip at this stage", we just talked about that.

We were all invited to write a single-page explanation of -- I think the title of the meeting was something like, "Should the government act now?"
Q. Indeed, I'm going to move to that in just a moment --
A. Okay, fine.
Q. -- and we'll discuss the meeting and what views were put across within that meeting and, indeed, your view at that point.
A. Yeah.
Q. And then what we see here, just to round this off so we can take it away, from Patrick Vallance back is: "This is a meeting where the [Prime Minister] wants to hear from a range of scientists (specifically the Heneghan and Gupta let it rip variety). We have got a rather balanced group to make sure he hears all sides. Message re getting a grip - yes please."

Indeed, I'm going to maybe just deal with that now: do you consider that you got across that message within that meeting?
A. I said those words. I don't know -- I mean, nothing happened, so inadequately at best.
Q. If I can turn to that meeting now, and you were just speaking about speaking with one voice. So Sir Patrick Vallance was on the same page as you, is that fair to say, at that point?
A. I think so, yes.

Q. SAGE and SPI-M-O?
A. Yes.
Q. So all unanimous going into that meeting in terms of that perspective.

Now, if I can just call up the meeting, please. Thank you. This is the "Covid-19 small group scientific discussion", that was the formal name given to it. We see that, indeed, you're right about the question, the essay question, as it may have been posed, or exam question: "Should government intervene now and if so ..."

We see a list there of attendees. We have the names redacted, but the reality is it's all in the public domain in any event and, indeed, we have a statement. The first of those is Professor Gupta and the second of those is Anders Tegnell, the Chief Scientist in Sweden. But we see the Prime Minister, the Cabinet Secretary, who is chairing it, Sir Patrick Vallance, Professor Sir Chris Whitty, Professor John Edmunds -- and we'll move to him in a moment -- Professor Carl Heneghan, who we've also heard from, and then you.

For the purposes of this meeting, as you've just explained, you were asked to set out your views in a one-page document, a very short document.

If I can just deal with the position in relation to
the varying views around the table, or on Zoom, online at that time, but just deal with points of similarity. Was it the case that at any point anyone in that meeting was expressing a view that the government ought not to do anything at that time?

A. My memory is there were some people who felt more studies were necessary, which was pretty close to nothing, in my view.

Q. Indeed.

Then we have Anders Tegnell. Just pull up his document for one moment. That's INQ000137281, page 11, please. Chief Scientist in Sweden. He set out a short note, as requested, for the benefit of the meeting. He explains in the second paragraph down that his answer to the question, "Should government intervene now and if so ...": 

"... in my opinion yes. The myth that Sweden did nothing during the pandemic is false."

He talks about a wide range of activities that were initiated there. He speaks about the public health community. He continues to go down and says: 

"I believe there is a strong consensus that with a pandemic a government needs to be active even if we know that most of the non-medical measures have comparatively little effect and the evidence for how and where we were afraid they would be, and then -- and when they work is limited. But even so there is a possibility to make a difference."

So that's Professor Tegnell's view. If I can now take you to your view, that's at page 13 of this document. I don't know if we can rotate it. Is this the paper that you prepared?

A. Yes.

Q. We've heard reference already to the reasonable worst-case scenario.

A. Yes.

Q. And you explain that's a Covid-S --

A. That's right. So that little picture at the top left was given to SPI-M-O by Covid-S saying, "Do something a bit like the top -- the red line here", so a difficult autumn followed by a large winter peak. So that red arrow, I think, that I've put on there says: this is roughly where we are towards the end of September. Things were okay in July, they've been getting a bit worse. There it is, with the -- so can you see the dotted red line being flat for a while through October.

So that wasn't going to happen without some substantial intervention.

Q. So this is your, as you say, reasonable worst-case scenario.

A. Yeah.

Q. You then go on to set out in the middle, "How do numbers compare today?"

A. Yes.

Q. Can you just run us through that very briefly?

A. Very good. So this is sort of the second bit of the argument: where are we? The reasonable worst-case scenario says, roughly speaking -- prevalence is how many people out there are infected. Reasonable worst-case scenario thinks about 78,000, now it happened to be 71,000. The fact that these are pretty close in agreement is kind of irrelevant; the point is that we had made this plan, the first column, that things would get a little bit worse in September and then we'd do something about it, and this is me saying: that has happened, things have got a bit worse, they are about where we were afraid they would be, and then -- and they're getting worse.

I think the point I was trying to make with these numbers was: you are about to exceed your own reasonable worst-case scenario, and that means all the plans that you have made are going to fail because they were made against the reasonable worst-case scenario. If it has any purpose, the purpose for reasonable worst-case scenario is that it lets government make plans in which the -- and assume that -- on the assumption that the situation here, the disease, the level of infection, won't be so bad as to break those plans. So we're about to break -- things are getting so bad that they're worse than the RWCS. When you specified what you were going to do, you said you would do something now.

Q. This was an internal target, effectively, set by Covid-S, or objective.

A. Up to a point, except -- well, except that there's no numbers on the Y axis in the Covid-S graph.

Q. And you set out below it a short graph which effectively illustrates the fact that hospital admissions --

A. Yeah.

Q. -- are really following the first wave pattern in terms of regions.

A. Yes.

Q. So those that were most badly hit in the first wave are
also being most badly hit in the second wave.

Then finally, in part 3 of your paper --

A. Yeah.

Q. -- you explain what happens next, where does this end up --

A. Yeah.

Q. -- the trajectory.

A. Yeah.

Q. And what you explain here is that under the current trajectory, hospitalisations will increase exponentially, surpassing the first wave by early November.

A. That's right.

Q. Then you go on to explain about the governmental planning, you explain that epidemiology is in line with the reasonable worst-case scenario but infections are still rising, and you explain that you expect that reasonable worst-case scenario to be breached.

A. In days.

Q. In days.

A. And I think that closing sentence is worth noticing: "[Test and trace] will not function effectively in a large second wave."

Q. And, of course, that's one of the tools in the pandemic toolbox.

because he has explained his views earlier in the evidence, but I certainly can. If I can just call it back, they're in the pages that precede this one.

I believe they're on pages 10 and 11, from recollection, I'm afraid, if I can just go to those, but we can certainly have a look at them. (Pause)

Back one further page, in that case. Start on page 9.

This is Professor Heneghan's views. We see here that, halfway down the first paragraph, he takes the view that:

"Recent responses are out of proportion to the threat. They are underpinned by a lack of understanding of the data, the role of community pathogens and an overreliance on predictive modelling."

He very strongly bases that on the fact that it has effectively been influenza preparedness, and that that has had a significant impact upon the advice that's been provided, and effectively that advice is wrong.

What are your views in relation to that?

A. I think that we were expecting a large autumn wave and that something needed to be done to prevent it. Sadly, that large autumn wave did happen. I don't really think that's to do with was this influenza or was it a different respiratory infection; it was a respiratory infection to which there was very, very little immunity in the population at that time because, dreadful though the first wave felt, it actually infected rather a small proportion of the population.

Q. If we can just look a little bit further down this page, please. I touched upon it earlier in relation to the control strategies that they were -- collectively, there are differences between their papers, but one aspect of it was about those targeted measures and segmentation, and there has been a criticism levelled that segmentation was never considered properly by SPI-M-O or SAGE.

What do you have to say about that?

A. It was quite carefully considered. Segmentation can be used in several different ways. One way of thinking about it would be simply on age. Should we have let the over 40s -- sorry, the under 40s or the under 45s live a normal life whilst everybody else was in lockdown?

I would say it's very clear. You don't need modelling. You can just look at the data that we have about household composition, so what age of people live with other people, or we have beautiful data about who mixes with whom. I talked a bit about that with the BBC data. It was very, very clear that there was far too much mixing between different age groups for that sort of...
segmentation plan to work, because even a little bit of
leakage from -- if you had half the population leading
a normal life, back into the segmented, is enough to be
very, very damaging at this point in time, when immunity
in the population was so very low. So that's age
segmentation.

Then other ideas about protecting the vulnerable by
making sure the people who come into contact with them
are doing, say, lots of testing, always seemed to me
intuitively appealing, but probably needed to work in
a context of very low infection in the community,
because they weren't going to be perfect, so if -- they
would work best if there was not much infection in the
wider community. And, of course, there are the points
that have been made to you earlier this week by
Professor Whitty and Professor Vallance that those put
a huge, huge burden on more vulnerable people.

Q. Just dealing, if I may, then with segmentation. Indeed,
there's various different ways of referring to it; we
have heard about shielding, we've heard about
super-shielding and we've heard some evidence on
cocooning as well. But in terms of SAGE, SAGE had
indeed sought earlier advice and notes on
segmentation --
A. Yeah.
to herd immunity and that we were a very long way from it, and could therefore expect a large autumn wave, which indeed did then happen.

Q. At the very end of her document she posits two scenarios, ultimately. The first is to bring in population-wide restrictions to keep infection levels down until the vaccine becomes available. The downside to that for her is that it comes at huge social and economic cost. Not clear that such a policy is sustainable until that development of that vaccine.

The second solution, which is -- and I'm assuming it's the one that was posited within the meeting -- is to:

"...take steps to protect the vulnerable..." while allowing those that are at low risk to accumulate immunity [which is going back to that herd immunity point that you've already addressed] such that the risk to the former is reduced as rapidly as possible to levels that [are acceptable] for other respiratory pathogens."

LADY HALLETT: Looking at your paper, Professor, I heard the expression this week that the advice had to be electrifying if you wanted to trigger the action. Could I confess that I don't find your paper electrifying?

A. Yeah, but you don't like graphs.

LADY HALLETT: No, but your audience may not have liked graphs either.

A. No, that's a very good point. I think it's better than all this text, myself.

Actually, you know, I think you raise a really important issue, which is: how are scientific advisers going to get a whole lot better at communicating what we think? Because, I agree with you. I thought that was a pretty electrifying page, and it's very interesting for me to hear that you don't find it electrifying, and I certainly -- I mean, I ran the experiment and they didn't do what we said, did they?

So I think -- so, for me, pictures are better than text. I think you're right; one has to remember that there are many people that -- that might be a cultural thing, and there might be people -- there are lots of people for whom text is better than pictures.

Indeed, in your witness statement, just picking up on that point, one of the lessons to be learned, as you identify it, is that science advisers -- SAGE, whoever it may be -- need to be more unequivocal in their advice; more forceful, effectively, in their advice; is that right?

A. Yes.

Q. And what you say in that is that, as advisers, you should have thought more critically about the state of mind of those who you were advising and -- and this is in the context of delay -- the reasons for that delay, not least because you needed to assume that elected officials do not want to make unpopular decisions, extremely difficult for them to do so.

A. Yes.

Q. And you're talking here about lockdown, and: "If we had a better sense of how unpalatable lockdown was to decision-makers, if anything this would have expedited strong advice to lock down, rather than give us cause to delay providing the advice or to weaken its terms."

And you make it very plain that, looking to the future, advisers should err on the side of giving unequivocal advice earlier in the context of advising on time-sensitive matters.

A. Yes, and --

Q. Here specifically about pandemics.

A. Yes, I agree, and clearly more electrifyingly.

LADY HALLETT: I do apologise.

A. No, it's fine.

MS CECIL: In terms of how those views were expressed, obviously that's how they were expressed on paper; you've already explained that you did say to those in the meeting, which of course included the Prime Minister and other senior members of the government, that they needed to get -- that somebody needed to get a grip.

A. Yes.

Q. How was that received?

A. In silence. I mean, they just sat there in silence and listened to us. I don't remember there being many questions, except -- I mean, a few -- except towards the end, where I think somebody said, "What do you think we should do?" They just went round the four of us and said, "What do you" -- well, five of us, sorry, "What do
you think we should do?"
2  No, there wasn’t a lot of discussion, that’s what
3  I remember.
4 Q. When asked, “What do you think we should do?”, what was
5  your response?
6 A. So I actually gave my own personal response, which
7  I realise perhaps I shouldn’t have, anyway, I said
8  I think we should go into lockdown with schools open.
9 Q. With schools open?
10 A. Yeah. And I think that was an honest reflection that
11  I didn’t really think two weeks was going to be enough.
12 Q. And in terms of the others in the meeting at that point,
13  so Professor Gupta, do you recall what she said?
14 A. I don’t recall.
15 Q. No.  Professor Heneghan?
16 A. I’m sorry, I don’t remember.
17 Q. Not at all.
18 You may not recall in relation to Dr Tegnell, Anders Tegnell?
19 A. No.
20 Q. Or indeed --
21 A. John I do remember, because John said we need to be in
22  lockdown now, and it was unusual -- and I remember
23  thinking: oh, well, gosh, is he right and I’m wrong?
24 Can we sort of afford -- you know, have we got enough --
25
1 combined reduced the R number to about 0.7. Indeed, that’s what we were looking at, if you recall, earlier --
2 A. Yeah.
3 Q. -- when we looked at what the R number was in the
4  summer, June, when SAGE and SPI-M-O met.
5  So what he then says is:
6  "... to meet [Her Majesty’s Government’s] aim [as it was then] of keeping R below 1 a large package of
7  interventions will have to be implemented, not just one
8  or two."
9  It talks about educational institutions; if they are
10  to remain open, a very wide package of other
11  interventions will be essential. And then what he talks
12  about is the imperative for speed of action. Response
13  "needs to be fast and large. The harder the measures,
14  the less time they need to be in place for."
15 A. Yeah.
16 Q. It then continues to explain that the UK responded
17  slowly in March and paid a heavy price for this in terms
18  of deaths.
19  "This shows - unambiguously - that the key factor
20  for the large number of deaths in the UK was the
21  lateness of our response. We should not make the same
22  mistake again."
23
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4 summer, June, when SAGE and SPI-M-O met.
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7 was then] of keeping R below 1 a large package of
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11 to remain open, a very wide package of other
12 interventions will be essential. And then what he talks
13 about is the imperative for speed of action. Response
14 "needs to be fast and large. The harder the measures,
15 the less time they need to be in place for."
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18 slowly in March and paid a heavy price for this in terms
19 of deaths.
20 "This shows - unambiguously - that the key factor
21 for the large number of deaths in the UK was the
22 lateness of our response. We should not make the same
23 mistake again."
A. I felt we were at that stage at risk of making the same mistake again. If we had acted decisively then, we would have learnt from March, but we didn't; implication: we had not learnt from March.

Q. We know that there was no circuit breaker in September at this stage.

A. No.

Q. Was that in your view, from your public health perspective and epidemiological perspective, a mistake?

A. Yes, I believe that was a mistake. I think if we'd had a circuit breaker in September, we could have kept cases -- cases would have dropped a little bit and then we would have bought some time.

Q. In the absence of a circuit breaker at that stage, again, what were the consequences, from your perspective?

A. The number of infections kept rising through September and October with attendant hospitalisations and, sadly, deaths.

Q. Had there been a circuit breaker, therefore, again, in your view, would the number of deaths have been lower?

A. Yes.

Q. Now, in terms of the remainder of that meeting, were any views expressed by the Prime Minister that you can recall?

A. That's correct.

Q. The Cabinet Secretary?

A. I'm sorry, I can't remember.

Q. Then we also understand that the Chancellor was present.

A. Well, I think perhaps he called in. I'm not certain.

Q. Did he make any contribution?

A. Well, you see, I think it was him who asked, "What should we do?", but perhaps that's just an incorrect memory.

Q. Now, after that meeting, the following day, there was a further SAGE meeting on 21 September, and if I can just pull that up, it's INQ000061566, page 2, please.

It's paragraph 2. It starts by setting out that Covid-19 instances increasing across the country; talks about the effect on schools, colleges and universities; doubling time could currently be as short as seven days.

Then it goes on to make recommendations at this point:

A package of interventions will need to be adopted to reverse this exponential rise in cases.

And it then goes on to talk about single interventions, coming back to the single or package of interventions that we've discussed:

Single interventions by themselves are unlikely to be able to bring R below 1 ...

And we see the confidence intervals. We've discussed those previously in evidence.

Q. High confidence in that assertion.

A. Yeah.

Q. The shortlist of ... (NPIs) that should be considered for immediate introduction includes ...

A. And that's where we see: * a circuit-breaker ... to return incidence to low levels.

Q. And that's were we see: * advice to work from home ...

A. * banning all contact within the home with members of other households ...

Q. * closure of all [retail and hospitality, and so on] ...

A. * all university and college teaching to be online ...

Q. So at this point, these are recommendations with schools staying open.
Q. You’ve described a period of frustration; how were you feeling at this stage?
A. Very worried, because having lived through the first wave with its horrible consequences, I couldn’t understand why we weren’t doing things to try hard to avoid a second autumn wave. We’d been telling them since we started that there will be an autumn wave, and I suppose I’d thought in the summer, with the Covid-S scenario, that that had been brought on board, that we would try to do things, inasmuch as we could, to prevent an autumn wave, and nothing was happening.
Q. We subsequently had the tier system that was introduced in October of 2020, 14 October. You described that as being suggestive of a lack of caution on the part of decision-makers. Why is that?
A. Because of the way it was introduced. So if what you do is you introduce a set of tiers where in places where incidence is low, you put in controls that are insufficient to stop incidence from growing, all that will happen is that in all those places, incidence will grow. We sometimes referred to it as the levelling-up scheme. It was a scheme that would allow incidence of infection to rise in many, many parts of the country.
Q. Now, on 23 October of 2020, you emailed Sir Chris Whitty and Professor Sir Patrick Vallance. It’s at INQ000062800. What you ask here -- it is the SPI-M-O and Professor Sir Patrick Vallance. It’s at
A. Can I just add, I didn’t -- there’s nothing wrong with geographically targeted measures, it’s just this business of starting off with something very low, letting it grow, putting in something that barely keeps it stable, so that it grows in most places.
Q. Thank you.
A. I’m going to deal with the report --
Q. -- that was subsequently written in due course, but if I can just keep to the chronology --

Q. What you explain here, as we go on down, is that you were projected to hit the level of admissions -- and let’s just deal with this, this is about the assumption of avoiding the first wave of peak hospital admissions.
A. Yeah.
Q. To stop that, you need to reduce the R to less than 1 by 28 October, so five days’ time.
A. That’s right.
Q. And you’ve done some calculations and you explain that you will exceed that on 21 November.
A. Yeah.
Q. To stop that, you need to reduce the R to less than 1 by 10 November.
A. Yeah.
Q. And if you want to do better than the first wave peak, for example 2,000 hospital admissions a day, you have to get the R below 1 by 28 October, so five days’ time.
A. Yes. I think this was an attempt for us to arm Chris and Patrick with some numerical reasoning to say: we are running out of time.
Q. So was this an intervention, effectively, by SPI-M, the secretariat?
A. The four of us, yeah.
Q. The four of you.
A. I mean, I don’t think we thought Chris and Patrick didn’t agree, we were just trying to -- we were
searching for evidence that we could give to them to take to decision-takers.

Q. Were you trying to prompt some level of action at this stage?
A. Oh, yes.

Q. Now, on 24 October, the following day, Wales instigated their firebreaker. Do you consider that that was a success, first of all?
A. It was probably better than nothing. It didn't bring -- if I remember rightly, we might be able to look at it, actually, because there will be a graph of it. I don't think it had a huge -- it didn't cause a great decrease in cases, is my memory. On the other hand, what's the counterfactual? What would have happened if they hadn't done it?
Q. I've been asked to ask: do you consider that that was early enough, the firebreaker in Wales, or should that have been earlier?
A. I think all of these things should have been done in September, so that whilst incidence was low, we could have kept it low and given ourselves time to come to terms with the fact that: yes, we are having an autumn wave, we don't know when we're getting vaccines, what are we going to do about it?
Q. Indeed, you're subsequently tasked with the task and

introduce measures (such as Tier 2) that can be hoped to retard the growth everywhere and maintain low prevalence."

A. Yes.
Q. And that's a reference back to what you've discussed in terms of how to implement it.
"As soon as rising prevalence is detected, measures should escalate to interventions that are associated with negative growth rates (such as Tier 3)."
A. Yes.
Q. So looking back in terms of an evaluation of those autumn interventions, were they successful, in your mind?
A. They were successful in some places.
Q. And what places were they?
A. Tier 3 -- if you look at the places that were put into Tier 3 and look at the epidemic growth rate the week before they were put in Tier 3 and the week after, what you see is that the growth rate is always lower, and usually negative, in places that were under Tier 3.
We do have to be really, really careful because these weren't experiments. Places that were in Tier 3, there was probably something pretty special about them that they needed to go into Tier 3, but this is what we had. So we need to be very careful to say: this was the pattern we saw, and not -- try really hard not to use words that implies causality. But you can look at the -- you can look at the patterns of growth rate before and after a tier was introduced.
Q. Then we come to the second national lockdown.
A. Yeah.
Q. You described that in your witness statement as a "terrible moment". Why was that?
A. Well, because the thing that we had been trying to avoid by having smaller interventions at lower prevalence had had to be done, and in the same -- it felt like March all over again: we wait till the last possible moment, we delay and delay a decision, and then we have to slam the brakes on as hard as possible with the attendant social costs and economic costs.
Q. At that stage schools were also closed.
A. Is that right? I thought schools were open already.
Q. Have I got that wrong? It may be that I have got that wrong and it's schools were closed in -- schools were certainly closed in the third lockdown. It may be me.
A. Yes, I think that's right.
Q. I'm turning to that now, if I may.
Before we get to the third lockdown after that, we then have the Alpha wave that comes through in December --
And there’s quite a lot of thinking that is done then in
that, with the Covid Taskforce.

Now, as we come out of the third national lockdown,
that’s when you begin working, certainly just before
that, with the Covid Taskforce.

As you know, but others may not, I have to
finish at the very latest at 3.45 this afternoon, and
we’ve got another witness. So I’m going to break now
for five minutes to give the stenographer a rest, and
please can people discuss how we ensure that I leave
here at the very latest by 3.45.

Indeed, throughout this period you had been armed with
much, much greater levels of data.

We not only observed right from the early days the Alpha
wave, we also knew why we had it.

We have this document, Professor, so please don’t
think that we won’t be looking at it. And indeed you
make various of these points in your witness statement,
and so even if we don’t go into detail now, please be
assured that that evidence will be taken into
consideration in due course.

If I can go to page 4, please, and for the first
time we see, in terms of the roadmap, that coming out of
-- I say coming out of lockdown or easing
restrictions, there is a roadmap with a test. And
that’s about a third of the way down, it says:
“This assessment will be based on four tests.”

And we see (a) to (d): vaccine deployment, that the
vaccine separately sufficiently effective in reducing
hospitalisations and deaths, and that those infection

Was that a view that you shared?

MS CECIL: Thank you.

Picking it up in May to December of 2020, again SAGE
meets. 17 December, says additional interventions may
need to be considered, and that's two and a half weeks
before the eventual lockdown that takes place on
5 January. Then on 6 January, that's when we enter the
third national lockdown, that's when schools are also
closed.

Now, in respect of that, there is a communication
between you and I believe it's
Professor John Medley(sic) on 17 December in which he
expresses the view that you had missed the timing of
lockdown with half term -- this is, as I say,
17 December:
“... and today the politicians just went ahead and
made policy anyway, without any guidance from SAGE, so
it is finally a victory for common sense but actually we
have failed to inform policy over the last few months.”

Was that a view that you shared?

MS CECIL: Yes.

Q. Now, as we come out of the third national lockdown,
that's when you begin working, certainly just before
that, with the Covid Taskforce.

A. Yes.
rates do not risk a surge in hospitalisations placing unsustainable pressure on the NHS, and that the assessment is not changed by variants.

To be clear, in relation to that, one of the priorities that is then set out later in the document, on page 10, there are various objectives that also inform this roadmap out. Again, we see (a), (b), (c) and (d). We see again the issue in terms of pressure on the NHS, deployment, protection of the public. But one of the aspects that is a priority is the resumption of face-to-face teaching in schools?

Q. The priority.

Firstly, it's a more transparent document, but secondly when we were talking earlier about the lack of strategy and aims in terms of — from a SPI-M-O/SAGE perspective, with respect to modelling and providing that advice, does this accord with something that you were really looking for, something more like this, with objectives and policy aims?

A. Objectives, things we're going to measure, things that we are actually able to measure, and actually we haven't found it, but the bit that says "and we're going to space these things out, we're going to space these decisions out in a way that is consistent with being able to measure how much difference did the last set of measures that we lifted make".

Q. Indeed.

A. So I view that as a document that's paid proper attention, and I mean that quite carefully, actually, not too much but proper attention to what can be done with all kinds of scientific evidence, including modelling.

Q. It's a fairly lengthy document, and as you say at the outset it does say that it's based on data not dates. Dates are wholly contingent on data and are subject to change if the four tests are not met.

So what we then have is the deployment of this roadmap, and indeed later, I think it's stage 4, it gets delayed because of concerns about a new variant?

A. That's right.

Q. And so you have those triggers.

As I say, we've heard some evidence already in relation to the roadmap out, but I just wanted to use this as an example of how you say policy objectives and advice can be aligned in a much better way in terms of —

A. That's right.

Q. Deliverability?

A. Yes. Can I just say, so I think some of why this was also subsequently, both in relation to surveillance but also in relation to it being a tool in the arsenal.

In terms of testing in the early stages in March of 2020, and the decision to stop community testing at that stage, SAGE was not — am I correct that SAGE and SPI-M-O did not advise in relation to that?

A. That is correct.

Q. And your understanding is that it was not a clinical decision, it was a resource-based decision?

A. That is my understanding.

Q. Limited tests and therefore a need to prioritise to those areas which were most in need, effectively?

A. Yes.

Q. Thank you.

Just in relation to that World Health Organisation advice and developing and less developed -- more developed and less developed countries, is it as applicable to a state such as -- a western country such as the UK as it is to a developing country?

A. Yes, I would say at least as applicable, in that with our age distribution, where we had many, many more elderly people than many less developed countries would have, testing was even more important for us.

Q. In fact within your statement, I don't need to take you through it now in detail because you set it out there,
you refer to the experiences of both South Korea and
Germany as inspiring and examples that the UK should
look to?

A. Yes.

Q. Thank you. And indeed that there are lessons to be
learnt there in terms of their experiences and the use
of that technology and testing, surveillance and
tracing?

A. That's still my view, yes.

MS CECIL: Thank you very much.

Q. Does my Lady have any questions?

THE WITNESS: Thank you.

LADY HALLETT: Even if I didn't find the graphs
electricifying. Thank you very much.

THE WITNESS: Thank you.

(The witness withdrew)

MR KEATING: Do sit down, please. Thank you.

MS KEMI BADENOCH (sworn)

Questions from COUNSEL TO THE INQUIRY

MR KEATING: Do sit down, please. Thank you.

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So you are elected as Member of Parliament for
Saffron Walden since June 2017?

A. Yes.

Q. You were Parliamentary Undersecretary of State (Minister
for Children and Families) July 2019 to February 2020,
and from February 2020 to September 2021 you were
Exchequer Secretary to the Treasury and Minister for
Equalities?

A. Yes.

Q. And you were on maternity leave for a short period at
the beginning of that time period, so it's from
February 2020 to April 2020 --

A. Yes.

Q. -- you were on maternity leave, which is relevant
because that's at the outset of the Inquiry.

Later on, in 2021, you became minister of state at
the Department for Levelling Up, and you held that role
until July 2022, and you currently -- outside
the Inquiry's time periods, but you currently are
Secretary of State for International Trade and president
of the Board of Trade, and also in October 2022 you were
appointed as Minister for Women and Equalities?

A. Yes, business and trade, not international trade.

Q. Business and trade?

A. More has been added to the role, yes.

Q. Yes.

So thank you so much for attending. And in terms of
the role of Minister for Equalities, and that's what
we're dealing with, so back during the pandemic, how
would you describe the responsibilities for the Minister
for Equalities?

A. So I would say that until I took on the role, returning
in April 2020 and I'd say in particular June 2020, the
role for a Minister for Equalities was actually quite
different. It was very much limited to looking at
LGBT-related issues and women's issues, in particular
around women's economic issues, gender pay gap and so
on.

Q. Okay, so your previous responsibilities changed
significantly, and you set out what those workstreams
are in your statement at paragraph 9. And as
an overview of the work you did, we can see that at
paragraph 9 of your statement, one of the main areas was
quarterly reports on progress to address Covid-19 health
inequalities?

A. Yes.

Q. And we will go through those reports, not each report in
detail, but we'll touch upon key features of those.

You refer to ad hoc attendance at Covid-O meetings
in your capacity as Minister for Equalities, and that

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in your capacity as Minister for Equalities, and that
Q. Public health communications, a key feature also. And lastly, one of the significant features, it appears from your evidence, written evidence, is increasing vaccine uptake within ethnic minority groups.

A. In relation to that, there is a module later on in this Inquiry which is going to deal with vaccines.

Q. Which was Liz Truss at that time?

A. At the time, yes. So strictly speaking we were in DIT, that was the Department for International Trade, but as it was, the Department for International Trade, but there were recommendations made by the Commission on Race and Ethnic Disparities that the unit should stay in the Cabinet Office for consistency and continuity.

Q. So the Equality Hub was formed later in 2020, that was based in the Cabinet Office, we’ve heard about that, and in terms of the senior minister in this directorate, to use your phrase, that would have been Liz Truss, who was the Secretary of State at that time?

A. Yes.

Q. The quarterly reports on inequalities and how that work was brought about, just a little bit of context. In terms of when you returned -- when you were appointed as minister in February 2020, joining effectively in April 2020, it was around the time of the Marmot Review. Is that something that -- The Marmot Review 10 Years On, was that a review that you had been aware of in your capacity as Minister for Equalities?

A. Not initially. I did become aware of it later on in 2020, but I think it’s probably worthwhile giving some context as to why that would be the case. The Equality Hub operates a hub and spoke model, even before it was the Equality Hub, it became a bit more broad based, but every department is responsible for managing its own equality work. So we would do perhaps first principles research primarily in the LGBT and women’s space. We did not cover equality across the board. What we looked at was the Equality Act specifications, which is around protected characteristics, and preventing discrimination, rather than inequality that might arise from other areas.

So this -- this work that we started to do was basically expanding what we would normally do in order to provide support to departments like DHSC who were completely swamped at the time. So the Marmot report is not something that would naturally have come to me anyway, but I did become aware of it, at some point, I can’t remember exactly when.

Q. The last bit, just by way of context, so The Marmot Review 10 Years On, the message around February 2020 was that life expectancy in England had stalled since 2010, and this had not happened since at least the 1900s, and there was concern regarding the health of the nation, and that was one of the features which was touched upon in that review, Ten Years On.

Let’s move on to the next report which is of relevance, direct relevance, to your involvement. So as you were about to take up your post, you became aware that there had been requests made of the Secretary of State, Matt Hancock, in relation to...
significant disparities in both risk and outcomes from COVID-19."

Can you assist me just with the first part, the word "apparently", which on one basis may be seen as -- may be a caveat. What did you mean by that?

A. What do I mean by "apparently"?

Q. In that context.

A. It was -- this was something that had not been known or verified, and there was anecdotal information, which was the reason why DHSC commissioned the report. But whether the disparities were real or not we didn't know, what was causing them we certainly didn't know, and that first PHE report did not explain why, but also it's about the significance of the disparities, that you can have disparities and they're not significant, so the "apparently" is referring to both the fact that there were disparities not just -- but that they were significant, and it wasn't just in outcomes but in risk as well.

So the outcome you might be aware of, but also the fact that it was a risk situation was something that became apparent because of the PHE report.

Q. As a result of the report, you were tasked by the Prime Minister at the time to investigate this, and carry out work which we'll touch upon.

So from your perspective, this report had been -- had highlighted significant concerns regarding a disproportionate impact --

A. Yes.

Q. -- particularly in relation to ethnic groups?

A. Yes.

Q. I've emphasised groups as in plural. Shall we deal with terminology now because it's a feature of your work, your concern regarding the terminology?

A. Yes.

Q. What was the feedback that you gleaned from your work over report 1 and report 2 about the use of the term "BAME" to -- as an umbrella term for ethnic groups?

A. It's -- using the term "BAME" masked what was actually happening within different ethnicities. By lumping people who are black with people who are Asian, very, very different -- very, very different groups of people, it was -- it made it harder to actually look at the underlying factors. So what the PHE report did was tell us what was -- what we're seeing, it didn't tell us why, and lumping people into one group completely obscures different bits of information, which we were then able to single out once we started splitting -- once we started splitting groups apart.

What BAME basically does is summarise anyone who is not white from a health perspective or even just from any sort of analysis perspective. That's not particularly helpful. It is a phrase that is used if you're starting from the perspective of there is some discrimination taking place, and that is not the perspective that I wanted us to start from if we were to understand exactly what was going on.

Q. So we recognise the terminology and it being inappropriate in that context, and that is a feature of your work. I think we will see the "BAME" term being used throughout.

A. Yes.

Q. With that context very much in mind, I want to deal with one other matter regarding this publication, this
Beyond the Data: Understanding the impact of COVID-19 on BAME groups, and case, because the assumption was that this was being
hidden from people for deliberate reasons rather than
additional information which we hadn't commissioned
which we were taking longer to respond to.
Q. So in relation to the messaging, using the sort of
political terminology, perhaps, the messaging of the two
reports, is it fair to say that the PHE report doesn't
message that there's going to be another document which
is going to run --
A. No.
Q. -- thereafter?
A. No, it did not.
Q. Was it the case that the second report, which we're
going to touch upon in a moment, the Beyond the Data
report --
A. Yes.
Q. -- was that something which was really disclosed
thereafter because of this outcry regarding --
A. No, no, that's not true. First of all, this was
a report that was written by an independent body, so,
irrespective of whether we published it or not, it could
always have been published. So it wasn't because of
an outcry. It was more the fact that it was being
presented as missing data when actually stakeholder
analysis and responses, especially the way that those
responses had been captured, I felt was not how it
should have been done.
If you go out and ask people who are unhappy "Why
are you unhappy?" you can get a totally skewed view,
rather than asking everyone how they feel. And as
I read that report I could see that the people who
already believed that the system was set against them
were the ones that were more likely to reply.
I recognised many tropes in the documents and in the
responses which were coming from a place -- not from
a clinical or medical analysis, but more general social
commentary, probably even more political, and I felt
that we needed to make sure that we separated the two
things.
I'm very keen that we have as much rigour as
possible when we analyse data, and we should separate
quantitative from qualitative, and the way that it had
been published meant that it wasn't easy to do so.
Publishing them in stages meant that we could look at
what was happening and deal with that and then talk
about the stakeholder responses after.
Q. Thank you for that answer.
Let's look at the report very briefly, and I'm just
going to follow up on your answer in a moment. So if we
could turn to INQ000176354, and that's Beyond the data:
I have extracted two parts to it, not controversial, you would agree --

A. Well, I don't disagree with some of the explanations and assessments, and certainly in terms of what stakeholder groups would have been feeling. That's something that I very much recognise.

Q. Were you listening to these concerns which were being expressed about how certain groups felt that they were being treated and felt that they were exposed to Covid-19?

A. Absolutely. So if you -- if we go back to the first clip, I think you said it was page 6 or paragraph 6, I can't remember.

Q. That's correct, it was, I believe --

A. Many of the recommendations in that report were what informed our decision to publish the four quarterly reports. It was quite clear to me that the recommendations were things that would be needed in order to provide assurance the government was taking this seriously. But one of the reasons why I was quite keen to do the work -- so I wasn't just asked to do it, I did speak to other ministers and let it be known that I would be happy to take on some of this work to help with capacity, because these were concerns that I was having as well. I am a black woman. I was reading that this was something that was impacting black people.

Yes.

Q. And at that stage, so we're June 2020, we're in the stage that we're still in lockdown number 1?

A. Very much so.

Q. In your view, it was an area that still required work to improve public communications?

A. Yes. And in coming up with these terms of reference, I was very keen -- this is probably my engineering, project management, et cetera, background -- that we don't try to duplicate work that other people are already doing, that we provide support and assistance, we don't -- we are ambitious but not so ambitious that it is not feasible for us to deliver, and look for where there are gaps that we can add -- we can add value.

And by the time this report -- pardon me, this terms of reference was being drafted, I could already see the comments about people not understanding -- if you remember, we had those sort of daily 5 pm announcements and who could shield and who didn't need to, and so on, and I knew that communications was an area where there was lot of talk about people not necessarily understanding or not watching the same channels. And making sure that we were able to be as inclusive as possible, I wanted to review how we were communicating, not just what we were doing on the BBC, and that's why I added 7 to it. What I did not want to do was try and
be the Department of Health. That's not what the
Equality Hub does.

Q. No. At paragraph 76 of your statement, you touch upon
that your work on Covid-19 disparities was "primarily
limited to England only", and you referenced that, as we
know, health is a devolved matter in Northern Ireland,
Scotland and Wales.

A. Yes.

Q. It's a question I have been asked to clarify, is the use
of the word "primarily". Was any of your work not
exclusive to England, in other words that it would have
involved the devolved administrations?

A. Well, the -- if you think about the agencies that we
work with, it's NHS England, at that time it's Public
Health England, that's -- that was where we had levers.
What we did was communicate to the devolved
administrations, "Here's what we're doing if you would
like to replicate".

As much as I would have liked to get into every
corner, actually there is often resistance to that from
devolved administrations, they don't want UK Government
telling them exactly what to do or sticking their
fingers into every pie. So it was about providing the
transparency and, where we could get data from devolved
administrations, doing so and sharing, sharing the

devolved administrations were doing?

A. Yes, but I don't think that -- I don't think that this
was work that was being done in isolation. A lot of the
government communications work was spread out, it was
shared, they were attending the Covid-Os, they were
getting updates at the same time. And I think that
those fora were probably sufficient for the kind of
thing that we were doing.

Q. Still on scope, we've dealt with devolved
administrations, we've dealt with your terms of
reference, two important groups, children, number one.
How did work on children, how was that weaved into the
work on disparities over those four quarterly reports?

A. So if we take a step back and look at the framework of
the Equality Act, it's in terms of protected
characteristics, age is one of them. But our purpose is
primarily to prevent discrimination and, in some cases,
disproportionate impact if we think we have a lever into
that.

The disproportionate impact was very much on the
elderly, not on children. That's something that came
across very quickly and very early. So there was
limited -- there was a limited need to look at how the
disease itself was impacting children. There would have
been indirect impacts such as schooling, for example,
Q. Yes.
A. As I said earlier, making sure that we weren't duplicating efforts was quite important, and he already covered that part of the brief quite well. Where I did look into disability was where disability interacts more on the health -- much more on the health side. So where we discovered that diabetes, for example, was a significant risk factor in terms of whether people died from the disease or not, those sorts of things we looked at. But disability generally, across the board, no, that would not have been within my remit.

Q. What sort of interaction would you have with Justin Tomlinson, the Minister for Disabled Persons around that time?
A. Update meetings and we had Equalities ministers meetings where we gave updates on our work across the board. The senior Minister for Women and Equalities as well as myself, Minister for Women, and the Minister for Disabled People would have been present in those meetings.

Q. Yes.
A. And at official level all of that information of course would have been shared.

Q. Yes, and in relation to those meetings which were -- were they regular or irregular, these meetings, Equality

1. 60 per cent of those who had died from coronavirus identified as disabled and, even once socioeconomic factors had been removed, with black men twice as likely to die as their white counterparts. It talks about: “The increased death rate of BAME communities was linked to the fact that these ethnicities were over-represented in eight of the twelve most high-risk coronavirus occupations.”

But if we could go to page 5, please. In terms of context at page 5 of this document, we see that the first and second paragraphs, it's discussing that the first wave of the pandemic, BAME communities had seen higher case rates than their white counterparts. This was being repeated in the second wave of the Covid pandemic. “There’s reference to data being perhaps skewed as a result of testing, but reference still that a BAME person -- that's their terminology -- was still more likely to die from coronavirus, even once the socioeconomic factors had been removed, with black men twice as likely to die as their white counterparts. It talks about: “The increased death rate of BAME communities was linked to the fact that these ethnicities were over-represented in eight of the twelve most high-risk coronavirus occupations.”

If we could just scroll out, please, and look at the third paragraph.

So against that context, this Covid-O meeting then refers to disabled persons, and it says this: “... 60 per cent of those who had died from coronavirus identified as disabled and, even once accounting for other risk factors, disabled people were 1.6 times more likely to die from coronavirus.”
And that spikes considerably when one considers age, and it talks about the difference in relation to gender.

So, Ms Badenoch, just ploughing on from your work in terms of looking at the disproportionate impact on ethnic minority groups and disabled people, that huge group as well, was this not an opportunity for your work to align with the work which was going on in relation to disabled persons, bearing in mind the high death rate which has just been highlighted there?

Q. Correct.

A. I don't think so. I mean, if I understand your question, what you're asking -- correct me if I'm wrong -- is that given that there were bad statistics on the disabled side as well as on the equalities side, why didn't we encapsulate it all together.

Q. It's an obvious point, but of course disabled persons will fall within ethnic minority groups as well.

A. Yes. Yes.

Let's move on to your first quarterly report, which is dated 22 October 2020, and that's INQ000089742 -- thank you, right in front of us.

So published on 22 October, and you touch upon in your statement how you wrote a letter to the Prime Minister setting out the work you were doing.
recommendations.

Q. So you describe this as an evidence-checking process, because one would expect that these are matters which would be in place in any event.

A. Yeah.

Q. Or should be in place in any event.

Let's turn overleaf, please, and look at recommendation 4:

"Departments should continue to work at pace to develop new policy interventions to mitigate COVID-19 disparities, informed by the latest evidence."

You touch upon that in your statement, that this was -- paraphrasing -- a personal issue to you, and your view -- and perhaps you could paraphrase it or say it yourself -- was that you considered more needed to be done; is that correct?

A. Yes, certainly so.

Q. So in relation to work to mitigate Covid-19 disparities, as of October 2020, your view was that more needed to be done and government needed to work at pace?

A. Yes, and I think that what's also -- it may not be obvious, but what's also being emphasised there is that departments should continue to work at pace, and I think that sometimes in government there is an assumption that "Well, somebody else is looking after this, so we"

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"For some policies [this being October 2020, as we're in the tier system], departments have yet to establish effective metrics and monitoring arrangements. While this is understandable with more recent initiatives, this must be a priority for departments over the coming months. This will enable the [Race Disparity Unit] to monitor and assess short and longer term impacts and to assess which interventions are most effective."

So the work you had done had revealed that there was an absence in certain quarters of effective metrics and monitoring; is that correct?

A. Yes. We -- and -- but this was part of what we were looking to identify. Where there were gaps, where some departments weren't doing as well as they could or should we wanted to highlight that. And I imagine the way we write these documents might seem odd, but there is a lot of reading between the lines. We don't want to
demoralise or over criticise the people that we're working with, but effectively what this paragraph is saying is that some people haven't yet done what they should be doing, and in the context of everything that was going on at the time -- many departments overwhelmed, lots of officials being pulled from their day-to-day work to support in the pandemic -- I don't think it was surprising, which is why we said: well, this is understandable. But there was more that we wanted to see and we knew that people weren't moving as quickly as we would have liked.

Q. That last part of your sentence, "We knew that people weren't moving as quickly as we would have liked", just keeping that in mind for a moment, because the question was going to be this: bearing in mind the concerns regarding certain groups being disproportionately impacted, May 2020, it raised -- and a report ordered by the Department of Health and Social Care, PHE reporting back in June 2020, we're in October 2020, in the grip of a moving second wave, and you're concerned here that people weren't doing -- moving as quickly as we would have liked.

A. Yes, there would have been more detail -- I can't recall off the top of my head, but there would have been more detail in the report about what specifically -- there would have been specifics. So this -- I can't remember, I'd need to read the report again to remember exactly, but we commissioned this in June. I think we took about a month just to get everything together, get the right people into the RDU to carry out the work, put the terms of reference, so first report comes out in October. This is after there has been a lull. If you remember,
we had a summer where there was a lull in terms of
infections and there was some easing generally.
So this was just the assessment that was being made
in terms of: if there's a new spike, have we got
everybody ready, I think perhaps to do risk assessments
and so on. And departments need to answer for
themselves specifically why that was the case, but we
had looked at what they were doing and we felt that, by
the metrics we were measuring, not everything was being
met.
Q. Was there, in your view, sufficient capacity to deal
with these matters during summer 2020 so that we were
prepared for the second wave?
A. I don’t think so. I think that -- it’s -- a pandemic
like that, and the amount that we were doing, I’m not
sure there would ever have been enough capacity.
Because on the one hand, government is doing everything
it can to support those who were dealing with the
disease. But even we, whether it’s the officials, the
civil servants, we’re also being impacted ourselves.
Within the cohort of people working in the civil service
were people who were shielding or who had family members
who were dying and so on.
So I don’t think that this was a case of people
slacking off or people not doing as much as they could

Thank you.
This relates to this point, is that:
"There is a significant amount of work being carried
out at the local authority level and by Directors of
Public Health which is not currently being captured
centrally. Capturing this will be a focus in the coming
months."
So, again, drawing that together, your work revealed
that there was a lack of visibility in central
government about what local government colleagues were
doing in relation to these areas?
A. I’m not sure whether that was about the central
government visibility. I think it might have been the
RDU’s visibility into -- being a separate department,
to what was going on. I suspect that DHSC would have
known what directors of local -- local directors of
public health were doing, and probably in MHCLG, as it
was at the time, there would have been some insight.
But making sure that we had that information and we were
able to capture that in our work I suspect is part of
what we were looking at.
I can’t remember exactly, but that -- reading that
now, I think that that is what we were saying. I don’t
think what we were saying was that nobody knows what
anyone is doing.

Q. We’ll read in context, but you don’t like duplicating
other people’s work, but one of your recommendations is:
we need to do a review, we need to know more.
A. Yes.
Q. Dealing with the last themes very briefly, but they’re
important points, data, data remained an issue, which --
A. And -- sorry to interrupt -- if I was to refer to --
that’s point 5. If I was to refer to point 3 on that
page, we document what we did, asking for a set of
returns, and it could also have been that departments
sent us some but not all of what they had, and making
sure that we’re reviewing what information they had as
opposed to what they were sending was also part of it.
Sometimes they just didn’t send us everything. They
might have thought it wasn’t relevant. Sometimes
a particular team may not even know what another
department -- what another part of the department has.
Government is very big, and the bigger it is, the harder
it is to find information.
Q. That goes back to the question before lunch about your
role as Minister for Equalities and whether that had
a sufficient seniority and importance to get a response
from other departments. Was that an issue?
A. I think that was not an issue because this was a report
commissioned by the Prime Minister, so it had his
authority behind it, and remember I was not the only
Equalities Minister; there was a more senior Equalities
Minister as well.
I never felt that they did not take this work
seriously, but I did feel that they were very much at
capacity.

Q. Okay.
Data, and I'm going to summarise. Data was a real
issue. There was:
"... no single dataset [which held] all the
variables needed to gain a full understanding, different
organisations have been linking datasets over the last
4 months ...
We don't need to turn to that, it's page 14.
It says later on at page 20:
"... the emerging picture points to areas of general
concern about data quality ...
So a real feature was: we don't have one dataset,
we're merging a number of datasets; secondly is that
there's issues regarding data quality, data collection,
and the need for harmonisation of data standards.

A. Absolutely.

Q. And that's a feature of the work through the quarterly
reports thereafter; is that right?

A. Yes. I remember that.

Q. We touched upon already that the 13 recommendations in
this first quarterly report in October 2020 were
accepted in full by the Prime Minister, and that this
formed the framework going forward for your work, is how
you said in your statement.
I want to fast forward now to the second quarterly
report --

A. Right.

Q. -- which is in February 2021, so we're now in the third
lockdown in terms of the narrative, and if we could open
up, please, INQ000089744. We have it there, thank you
so much.
This was published on 26 February and, as you
summarise in your statements, looked at causes of higher
infection and mortality rates for ethnic minority groups
in greater detail, and the work undertaken to mitigate
risks. You explain that the impact on ethnic groups had
changed between the first and second waves.
Did you want to, rather than me summarising
everything, explain your assessment at that stage? That
was quite a significant part of your work.

A. Yes. I don't have the exact page in front of me, but
I do recall that there had been a change between what we
saw for black males and -- or at least the black cohort
and whites, there was an equalisation in terms of risk,
whereas on the side of Pakistani and Bangladeshi groups,
I think -- I can't remember whether it stayed the same
or it had got worse, but suddenly black African and
white British men, there was no disparity, but it
continued within the Asian groups.

Q. Yes. That's a fair summary. We have it in front of us
there.
Perhaps, in fact, if we pull out for a moment,
I think page 6, paragraph 3 is probably a better
reference. I may be wrong. Okay. Let’s go with this
reference.
It says overall the direct impacts of Covid-19
improved for ethnic minorities as a whole during the
early second wave, and it describes the difference in
the first wave, and how in the early part of the second
wave the risk of death was the same for black African
and white British men, what you’ve just said to us.

A. Yes.

Q. To underline the second part:
"At the same time, however, the second wave has had
a much greater impact on some South Asian groups. Work
is underway to consider why the second wave to date has
had such a disproportionate impact on Pakistani and
Bangladeshi groups. Relevant considerations include
regional patterns in first and second waves ...
1 household occupancy and multigenerational households, 
2 deprivation, and occupational exposure."
3 It says later on in the report, at page 23, that the 
4 continued higher rate of mortality in people from 
5 Bangladeshi and Pakistani backgrounds was alarming and 
6 required focused public health campaigns and policy 
7 response. Can you help us in relation to that?
8 So we see an increase in mortality in relation to 
9 the British Pakistani/British Bangladeshi groups. What 
10 was done to require focused public health campaigns?
11 A. The -- if we go back to what the information was telling 
12 us, up until really that second quarterly report, the 
13 why of -- why people were disproportionately impacted 
14 was not clear, and if you look at the PHE report, 
15 especially the stakeholder analysis, much of the belief 
16 was that this was due to prejudice, discrimination, 
17 racism. What we were finding there was that something 
18 different is going on because we're seeing improvements 
19 in some groups and worsening in other groups. 
20 So a lot of focus was around compliance with social 
21 distancing, whether people understood a lot of the 
22 advice that government was giving, and at that point we 
23 were spotting the correlation, which we think was quite 
24 a huge causation, about multigenerational families. The 
25 big difference between those two racial groups which 

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1 impacted, we can see certain areas in the country having 
2 a higher rate of incidence, and we decided to target the 
3 problem and be as focused as possible. Given the terms 
4 of reference that I had, a lot of that was to do with 
5 communications. 
6 The community champions programme was one which 
7 identified that, even with the best will in the world, 
8 government can't get everywhere. There are some places 
9 that you need other people to do the communicating. So 
10 the community champions programme was to find people who 
11 were trusted in their communities who could help seed 
12 information around looking after yourself and, in 
13 particular, your family. 
14 A. So in relation to that -- 
15 Q. -- the community champions was something which was 
16 an important part of your work. You mentioned in your 
17 reports that funding was granted in January 2021, so 
18 just at the beginning of the third lockdown. 
19 A. Yes. 
20 Q. This is your report in February 2021. Community 
21 champions and that trusted voice for different 
22 communities, was that something which perhaps should 
23 have been done at an earlier stage? 
24 A. I don't see how we would have done that. If you 

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1 remember, the Equality Hub doesn't have delivery levers. 
2 It's almost, effectively, a research ad policy 
3 recommendation unit. So community champions was 
4 delivered by the communities department. Finding out 
5 which communities are impacted -- this is by the second 
6 report -- looking for who the right community champions 
7 will be, they're not just waiting -- you know, it's not 
8 a set of people waiting, getting people to do the work, 
9 making sure there's the data on where to go, where the 
10 incidence is, looking at places where there's high 
11 morbidity data, high incidence of death, low levels of 
12 English speaking, all of that needs to be captured as 
13 well. 
14 So you can't just press go and start a project. The 
15 departmental co-ordination needs to be there, Treasury 
16 funding needs to -- you need to go through the right 
17 process. Treasury needs to look at the proposal. You 
18 can't -- 
19 Q. Just to pause there, because I'm just going to follow 
20 up, if that's all right. 
21 A. Yes, fine, okay. 
22 Q. I understand the mechanics -- 
23 A. Yes. 
24 Q. -- that these things -- to use your phrase, "pressing 
25 go". 

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What would you say to the challenge to that, which would be: we're a country rich in diversity, and there always would be a need to have different communication channels to reach different parts and different communities, and that should be something which should be in place already?

A. I think it is something that should always be considered, but I don't think that even government can create a system that would be in place already to deal with that.

If I give you an example, I -- and this is where my own personal experience was feeding into this, and I know this was something that was very common. I'm in a family WhatsApp group with family members across the world, from Africa to the US, all of us experiencing the pandemic, different bits of information being shared, clips of people saying, "This isn't real, it's a government -- this is a government agenda", lots of conspiracy theory, having to rebut very well educated people who are bringing in arguments that they're seeing on the internet.

The government can't get into my family WhatsApp group. It's just -- there are some channels which you cannot break into in the information age that we live in. What we can do is try and make sure that as many address that.

I'm going to move on, if I may.

In terms of areas in which positive measures were implemented as a result of the second quarterly report, we mentioned community champions, community testing, which was taking place, piloted at places of worship in ethnically diverse areas, and trying to enable more identification of higher numbers of cases.

I want to turn to page 11, if I may, of this report. I've highlighted the progress which has been made and the efforts which were being implemented, and we see at paragraph 7 -- thank you again for the references, which are correct -- it says this:

"While good progress has been made to address COVID-19 disparities, government departments must redouble their efforts, taking account of the latest available data and evidence. In particular, departments must consider measures that will benefit those most affected by the second wave of the virus, and in particular those from the Bangladeshi and Pakistani ethnic groups."

So, again, this report recognises and identifies that more needs to be done; is that right?

A. Yes.

Q. We talked about metrics, and one of those, if you fast forward to page 49, was your recommendation 10 from the first report. There was an update in relation to recommendation 10 which you wrote to colleagues in December 2020, encouraging departments to establish metrics for assessing the impact of their policies, accompanied by a technical annex, and you also met the minister for Covid-19 vaccinations.

There isn't anything exciting, I don't believe, overleaf. Yes, as I recollected, nothing really more to add in relation to that.

Where were we with metrics? You sent the information out. Were metrics established to gauge what different departments were doing to address these issues?

A. I believe they were, although I can't recall exactly what they would have been, certainly not off the top of my head. By this point, metrics -- a lot of intra-departmental metrics were not necessarily things that we would have been looking at, it was making sure that they were monitoring and checking that what they were doing would have been effective, and a lot of what we were focused on by this point was: what is the data telling us about who is impacted? What can we do in order to make sure that they're protecting themselves?

I seem to recall by this point we were heading into...
periods where religious festivals were taking place. We knew that large gatherings of people were occurring, especially in certain minority communities; how to make sure that people protected themselves and did not — you know, did not end up in a situation where large non-compliance activities were taking place.

But in terms of metrics, not off the top of my head, no. I’m sure they are there, but I can’t recall at the moment.

**Q.** Let’s hope that confidence is borne out, but in relation to the time period where we are, we are in lockdown 3, it’s February 2021, and next steps -- I can outline them rather than invite you to turn to it -- was: more recommendations on engagement, more recommendations on data and evidence, more recommendations on engagement, more recommendations on tailored communications.

**A.** Yes.

**Q.** Why was that?

**A.** Because many of the non-pharmaceutical interventions -- I think that's what NPI stood for.

**Q.** Yes, it does.

**A.** Yes. Many of the NPIs were things that we were trying to do to help prevent, but in terms of efficacy, we couldn’t control a lot of it. You can’t control how people behave. In some cases, it’s impossible for them to shield, depending on their living circumstances.

Vaccines, on the other hand, were proven, and looking at some of the things that I felt would have been contributing to ethnic minority disproportionate impact, fear -- not participating in clinical trials would mean that: what if people were getting the vaccine and then it wasn’t working because of genetics or something else? So increasing vaccine uptake, but also encouraging people to understand what vaccines are about, that they’re safe, taking part in clinical trials was really important to me. I took part in clinical trials myself. I trialled -- I went on the Novavax vaccine trial, publicised that, to let people know that this wasn’t something that they should be afraid of.

There was a lot of fear by this point that the government wants to -- or the -- how can I put this?

**Q.** You recognised that there was mistrust in the communities, not one community, and there were efforts which are set out in this report to address that and improve communication and improve vaccine uptake.

**A.** I disagree, and I think that we would need to be very careful in this -- at this point about stigmatisation, which is something that I had very much at the back of my mind.

Vaccines worked. This was a fact, this was proven, and to spend time away from what we knew worked to do things which were less viable, less effective, in order to deal with the emotional feelings of people who didn’t -- either didn’t like vaccines or wanted other levels of support I think would have been wrong.

But I also think that -- I remember reading lots of recommendations and lots of reports at the time. What people were suggesting was racial segregation: let’s treat black people differently because they’re disproportionately impacted, let’s give them the vaccine first -- something that we didn’t do, for example -- or let’s target support packages for ethnic minority communities, and I think that a lot of this -- it goes...
back to the point I was making about use of the word "BAME". Ethnic minorities don't just exist as communities of segregated people. We are part and parcel of this country. We are related to people who don't come from our ethnic background. My husband is white, my children are mixed race; there are families like ours all across the country. Targeting ethnic minorities in this way rather than targeting households and families would have been the completely wrong thing to do, and that applies to both the clinical interventions, as well as things like economic packages and so on.

Q. Let's pause there for a second, because it's just -- we're on points.
A. Yes, okay.
Q. And you're talking about support packages for ethnic minority groups.
A. Yeah.
Q. -- British Pakistani, British Bangladeshi, and in the type of occupations they work more in, and we talked about key workers as well.
A. Yeah.

So, against that background, was it not the case that earlier in the pandemic, perhaps before vaccines, there should have been greater financial support to help people in areas, such as in the north of England?

A. So I would say no, and I say this -- at the time I was a Treasury minister as well as an equalities minister, so it was quite a useful intersection, and I would say one of the advantages of having equalities ministers sit in other departments. What the evidence has shown is that being an ethnic minority was not the cause of being disproportionately impacted; it correlated with what the causes were, the comorbidities. So you have to tackle the actual cause, not the thing that comes in common with it. If you provided support packages to particular minority groups, you would have left quite a lot of people out who desperately needed similar support, rather than targeting the people who were most affected.

So, for instance, you could argue that: let's give extra money to all Pakistani men, they're disproportionately impacted. I think that would have been a terrible waste of money. There would have been a lot of --

Q. I don't think that was the suggestion, in fairness.
A. I'm giving examples, I'm not saying that's what you are suggesting.

You could have said: let's give money to the taxi drivers, who are particularly exposed, who are from that background. But they are no more exposed than taxi drivers of another background. You could say: well, let's give extra money to all taxi drivers. But then there are other groups of people, not least of all health workers, who are also similarly exposed. There is no perfect way of finding a particular group to give extra cash to, and extra cash in and of itself would not have solved the problem which we were trying to resolve of making sure people were protected and away from the virus.

Q. Just --
A. If I may, there is one extra point. What this highlights is the trade-off, that is the trade-off that we, as government ministers, have to balance. Deprivation is one of the reasons why people say that there is inequality. Making sure that people can stay economically active -- it's not just about the earning of the money but also the things that come with it. If you reduce that, you also create factors that can lead to inequalities later. So we have to look at all of those things in the round and find the right balance and --
Q. Can I ask you a question in relation to this, because I'm conscious that there was a long answer and I don't want to lose it all.
A. Right.
Q. So one of the areas which is an alternative was whether there should have been more financial support in relation to those occupations, or people generally -- putting ethnicity to one side -- who may have been self-employed or working in low paid areas which, if they were sick, they would get sufficient financial support so they could self-isolate. That's the vehicle for this sort of support, which I'm sure you're familiar with. Was that not something that your work should have included or at least explored?
A. That was work that was taking place in the Treasury. I wasn't the minister responsible for that, but that was looked at in the Treasury. I'm afraid I only have the Equality Hub notes for this module, but that definitely was done, and I remember standing at the despatch box and explaining how we came to devise the packages which we did. There always has to be a cut-off, and there is a cost to everything.

So the package -- the furlough and a lot of the quantitative easing and money printing which we did then is directly related to some of the issues that we're seeing now with high interest rates, with inflation. So more interventions are not without cost or consequences,
1 and there needs to be at some point a line that was
2 drawn.
3 Q. Yes.
4 A. Even where we drew the line, people asked that it should
5 have been for people earning slightly more. They felt
6 that the £50,000 cut-off which we had was too low.
7 There's always -- no matter where you draw the boundary,
8 there will always be people who feel that they're on the
9 wrong side of the boundary and should be included, and
10 if you take that to its logical conclusion, we should do
11 it for everybody.
12 Q. Well, let's draw a metaphorical line under this for the
13 moment. We're still on your third report, and I want to
14 move on to page 5, if I may, which is the third line,
15 and just draw out what we're discussing. We're
16 discussing British Pakistani/British Bangladeshi and
17 what the data was showing here, and by this stage --
18 I think it's the third line: "This third report summarises the data for deaths in
19 the second wave up to 31 January ... which was not
20 available ... The latest data confirms the finding from
21 the second report that people from South Asian ethnic
22 groups, particularly the Pakistani and Bangladeshi and
23 groups, were at the greatest risk of death from COVID-19
24 during the second wave."
25
26 In terms of those numbers, I would summarise it, at
27 page 22, is that compared to white British men and
28 women, Bangladeshi men and women were 6.1 and 6.3 times
29 more likely to die from Covid, Pakistani men and women
30 were 4.4 and 3.8 times as likely to die from Covid, and
31 that they adjusted -- they reduce, but not
32 significantly, for other factors as well.
33 In relation to one other feature which arises in
34 this report for the first time -- and it's an interest
35 to groups which are core participants -- is at page 29,
36 Long Covid. That's something which is raised for the
37 first time in this third report. I'm just going to
38 touch upon it briefly, if I may, and ask you what work,
39 if any, was done.
40 It describes Long Covid as "an emerging phenomenon
41 that is not yet fully understood", and describes the
42 impact of that, which I can summarise. The prevalence
43 rates for self-reported Long Covid were highest for (a)
44 people with a pre-existing activity-limiting health
45 condition and (b) health and social care workers, and we
46 see that in the middle of the page. In very simple
47 terms, those in the white ethnic groups had the highest
48 prevalence rates of Long Covid compared to the Asian
49 ethnic groups.
50 Quick question on an important topic, but in
51 relation to your work -- this was the third report --
52 was there any work done to explore Long Covid in terms
53 of its impacts on ethnic minority groups?
54 A. No, I think for several reasons. One, it would have
55 been outside our immediate terms of reference. This is
56 very much health work, and by that I would say sort of
57 frontline research analysis, whereas the analysis that's
58 done within my unit is more statistical. But it was
59 something that we thought was worth highlighting,
60 especially -- certainly in my personal opinion, the
61 health and social care workers was emphasising that this
62 is something to do with exposure, you know, being
63 exposed is likely to -- or the frequency of exposure is
64 likely to trigger Long Covid. But we would not have
65 been the right place for that kind of work to have taken
66 place, but it was something that we thought was worth
67 referencing in this report.
68 Q. Thank you.
69 We fast forward to the final report, which is the
70 fourth quarterly report, which is dated 3 December 2021.
71 So just as we are -- Omicron is around at that time,
72 December 2021. This was a long report, even for the
73 report you undertook on our behalf, 133 pages.
74 We see, if we could turn to page 5, please, the
75 understanding is much clearer, in your view, and the
76 work that was undertaken on your behalf.
77 "The main factors behind the higher risk of COVID-19
78 infection for ethnic minority groups include occupation,
79 (particularly for those in frontline roles, such as NHS
80 workers), living in children in multigenerational
81 households, and living in densely-populated urban areas
82 with poor air quality and higher levels of deprivation."
83 So occupation, deprivation, and household make-up,
84 significant factors:
85 "Once a person is infected, factors such as older
86 age, male sex, having a disability ..."
87 And we touched a lot on disability:
88 "... or a pre-existing health condition (such as
89 diabetes) ..."
90 And you've touched upon that:
91 "... are likely to increase the risk of dying from
92 COVID-19."
93 And in relation to the work you've done, your
94 summary was, in the statement, that vaccination was the
95 most significant measure, in your view, to protect
96 ethnic minorities.
97 A. [Witness nods].
98 Q. Was that the position?
99 A. Sorry, vaccination was taken in a sufficient enough ...
100 Q. No, I'll say it again, it's my fault if it's lost.
What you say in your statement is that vaccination was the most significant measure to protect ethnic minorities.

A. Yes, yes.

Q. And your point, if we perhaps could turn to page 6, please, is that the conclusions in this report really form your recommendations going forward.

A. Yes.

Q. And you describe how there's a number of wider public health lessons to be learned in relation to ethnic minorities, including: talking about vaccination deployments in other public health programmes -- in other words, the lessons we've learned in relation to Covid vaccinations can be used for other work -- reference to using community champions or respected local voices to build trust and tackle misinformation; a point you've made, and we recognise at the outset: not to treat ethnic minority groups as a homogeneous group, and there is not a one-size-fits-all approach.

A. Yes.

Q. Not controversial.

A. No. I hope not.

Q. No, not that aspect. Recognising that there is more than one community.

In relation to -- thank you for turning overleaf -- everyone being treated regardless of their ethnicity.

And the Equality Act states very explicitly that positive discrimination is illegal.

And many people don't understand that lots of these ideas, well intentioned as they are, are positive discrimination and they don't help in the long run. And certainly, given the way that we were lumping together lots of groups, they didn't help in the short run as well. When you mixed all the different ethnicities you lost the insight about multigenerational households and you ended up spending time looking at problems like who was being racist or if there was a racist that was causing those problems. We would not have fixed the problem by focusing on the wrong issue.

So stigmatising is something that I am very concerned about. I believe that it is my job to make sure that people treat ethnic minorities in a colour blind way, you look at the individual, you look at their circumstances, not start off with their skin colour and start to make deductions based on that.

Q. And a final point here is in relation to a feature which is about data, improving the quality of health ethnicity data so that patterns and trends can be spotted quicker in the future.

A. Yes, and one of the recommendations -- I think that avoiding stigmatising ethnic minority groups by singling them out for special treatment.

We've mentioned it a couple of times. Perhaps this is the opportunity to deal with that and stigmatisation.

What were the concerns regarding stigmatisation during your work in relation to the impact on ethnic minority groups?

A. So one of my duties as the guardian of the Equality Act is looking at social cohesion, and it is important that we don't let the good intentions take us to -- down a path that's actually counterproductive to what we're trying to do. And quite often very well meaning people think, "We need to do this for this group so that they can see that we care".

But that often has other unintended consequences, and one of them, I remember, was -- for a certain period, there was a large belief -- or a significant number of people believing that it was ethnic minorities who were spreading the virus. Because they were talking about so much, they're the ones catching it, and if they're disproportionately impacted, they must be disproportionately spreading it as well.

Anything that looks like certain groups are being treated better than others does not work because it goes against the principle of equality before the law, and would have come in an earlier report -- was even about recording ethnicity on death certificates, which was something that we discovered was not being done, and was a big issue. So --

Q. Just in relation to that, because that's one matter that I would like your assistance on --

A. All right.

Q. -- because this was something which was around -- just to help you in timings, it was one of your recommendations in the first quarterly report.

A. Yes, I think so, first or second, yes.

Q. I believe it was the first, but we can --

A. Okay.

Q. If we're wrong, it's my fault but it's the first quarterly report. Why was that something which you were of the view needed to be recognised and ethnicity would be noted on death certificates?

A. Because I felt that if we had had that -- and I don't know why it wasn't recorded, I don't know if there was ever a reason, it was just something that wasn't recorded -- if we had had that, we might, not certainly, but we might have been able to spot the disproportionate impact a little bit earlier. But this -- this was certainly speculation, reasonable speculation on that basis for that problem. But it seemed an odd place to
A. Yes, I think we had a -- I think we had a lot of successes actually. I'm very proud of the work that my team -- my team did. I think under a lot of pressure and with very high expectations, I think that they delivered. I think the work that they did was rigorous, it was very carefully done, it was very sensitive. They won an award, in fact. They won an ONS award in research excellence for the analysis that they did, and that was in competition -- the other shortlisted people were universities, so the quality of the work they produced was very high.

And it was -- and it was a very painful process because I went through all of these reports line by line making sure that they were written in a way that people would understand. You quite often get a lot of documents in what I call officialese, where the information is obscured, and I hope that that has been helpful, actually, to the Inquiry, the way that the documents were presented.

I think we saw things like greater vaccine uptake...
pick up on something you said to Counsel to the Inquiry just a moment ago, you were talking about tackling the cause as opposed to just looking at the issue, why certain groups were affected disproportionately. One of the reasons for that surely would be structural inequalities, would you agree?

A. I'm not sure that I do agree because it depends on what you mean by structural inequalities --

Q. Poverty --

A. Yes.

Q. -- for example --

A. Yes, but we don't -- we don't have a cure for poverty. If we did, we would have done it.

Q. I hadn't finished.

A. Okay.

Q. Poverty, for example, discrimination based on race, perhaps gender, perhaps other factors such as, you know, we know that some people suffer from disability suffer from discrimination, so factors such as that, that's what I mean by structural inequalities.

A. Okay, so you mentioned discrimination as an example. That was not something that was found in any of the evidence that we carried out. And these are things which there are processes in place to address, but in terms of the issues around deprivation, poverty, health

So, for example, when we looked at the intersectionality of age and gender, we found that being male was a bigger issue than being female in terms of catching the disease and in fact dying from it. We looked at the intersectionality of things like age and disability. So that was all taken into account. We may not have called it "intersectionality", but there were lots of multivariable analyses that took place, including things like geography which don't always get taken into account.

Q. Let me cut to the chase. If you took into account the intersections between certain factors and you've outlined some of them, did you have, in government, targeted strategies to address those disparities comprehensively and if not why not?

A. The strategies we had would have dealt with intersectionality in and of themselves, there was no reason to believe that there was something -- that there was a gap. Unless you can give me an example of a gap that you have identified. I would be quite keen to hear it.

Q. I'm going to ask you this: do you accept that gathering and understanding the data was important?

A. Yes.

Q. So we can agree on that. Can we also agree that because comorbidities, a lot of work was done to look at things that we could do to tackle that. But we can't cure diabetes, we can't remove poverty. So saying that structural inequalities had an impact on incidence, yes, that is true, but that doesn't mean that there is a silver bullet to resolve them.

Q. Do you remember in your evidence this morning, I think we can agree on this, you said that the label "BAME" is unhelpful because it is kind of like a one size fits all and you need to look at the situation and the impact and it's much more nuanced. We can agree on that, yes, that "BAME" is an unhelpful term?

A. That is what I said.

Q. Yes. So with that in mind, and I'm referring -- I'm not going to call up the documents unless you want to go to them, but I'm referring to your witness statement, and just for the record paragraphs 44, 47, 48, where you discuss disparities and they're highlighted. My question is this: how were the intersection of ethnicity with other factors such as gender, disability, socioeconomic status, dealt with?

A. So if by intersectionality you're talking about a coincidence of protected characteristics, that would have been taken into account just by looking at the cohort of people that were being sampled.
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1. commissioned by PHE to check what was going on. That was one of the anecdotal pieces of information that alarmed me. But knowing that the first set of doctors who died were from an ethnic minority background doesn't tell you why they are dying, it just tells you that is happening. So finding out the "why" is important to address the issue. And as we've seen from all the research that has been carried out, if we had simply made an assumption that being an ethnic minority in itself was the risk factor -- it wasn't, this was not a disease that targeted people on that basis -- then we would have carried out the wrong interventions.

13. Q. On 4 June 2020, following the publication of the Public Health England's review on the Covid-19 disparities, it was put to government by Gill Furniss that the report simply confirmed what was already known and failed to make any recommendations. She asked government whether government were listening to the calls for employees to risk assess black, Asian and minority ethnic workforce, and in response you said, on behalf of government, that you needed to wait to ensure that "we do not take action that is not warranted by the evidence". "we must widely disseminate and discuss the report before deciding what needs to be done".

Question: in the light of the substantial and severe disparities in the infection and mortality rates, which was evident from the widely publicised datasets and statistics from late March 2020 onwards, why did the government feel the need to wait before taking any action in response?

6. A. I'm sorry, I lost the thread of the question.

7. Q. Let me break it down.

8. A. Thank you, yes.

9. Q. All right.

10. So we've got the report in June, 4 June 2020, highlighting the disparities. It was put to the government by Gill Furniss that the report was --

13. A. Was that when it was published or at what point?

14. Q. It was published on 4 June 2020.

15. A. And when did Gill Furniss --

16. Q. Shortly afterwards. I can't give you the exact date, but shortly afterwards what Gill Furniss is putting to you and government is: well, the report is simply confirming what's already known. Okay?

22. And the response was -- she was suggesting it was important for the government to risk assess, to urge -- call on employers to risk assess black, Asian and minority ethnic workforce. And in response you said on behalf of government that you need to wait to "ensure that we do not take action that is not warranted by the evidence", "we must widely disseminate and discuss the report before deciding what needs to be done".  

25. A. Gill Furniss I believe is an MP, a Labour MP, am I correct?

27. PROFESSOR THOMAS: Yeah?


30. So, first of all, the point of the report which she was referring to was about understanding whether what was suspected was actually the case. So her saying these were things that were already known, they were not known, they were suspected, they were assumptions, there was no data. And so the report had to be done.

33. In terms of the point I was making, it wasn't specifically to risk assessments. The risk assessments -- we didn't wait to start the risk assessments, they were already in train and they went on for an extended period of time. So that was not a problem.

34. What I was referring to was not knowing why something is happening means that you don't know how to fix it. And that means looking at a report and getting the data out. And as it happened, I didn't think that the report that PHE published answered the question why, which is why we carried out our piece of work.

23. PROFESSOR THOMAS: My Lady, those are the questions that --

24. LADY HALLETT: I'm very -- and I'm sorry to interrupt you,

25. Mr Thomas, you know the concern about we're not allowed...
to trespass --

PROFESSOR THOMAS: I understand, I was just surprised at the intervention bearing in mind that it was clearly within the document.

LADY HALLETT: Indeed. I apologise.

THE WITNESS: She asked me the question in parliament, I believe. I don't think there would have been any other place that she would have asked it.

LADY HALLETT: Right, anyway, it's done now, Mr Thomas.

Anyway I apologise for interrupting if you had permission. By the sounds of it, it probably shouldn't have been given permission, and that's my fault.

Mr Stanton's over there. Don't worry, all the advocates that sit over there understand they're going to get a back to them every so often, but can you please make sure that we still record -- you still use the microphone. Thank you.

Questions from MR STANTON

MR STANTON: Thank you, my Lady.

Ms Badenoch, please don't feel any need to turn to face me, if it's slightly awkward. I think it's more important that you're able to speak into the microphone.

A. All right.

Q. I'd like to briefly revisit an issue that Mr Keating addressed with you earlier in your evidence in connection with the Public Health England report of 2 June, and the concerns that you made reference to, or of a number of organisations, about the possibility that information had been withheld from that report.

I'm asking questions on behalf of the British Medical Association, the BMA, and you may be aware that the BMA was one of the organisations that made representations to you. You may recall -- maybe not the dates -- it was on 5 and 7 June.

Q. On 12 June, the matter was escalated to Matt Hancock in the Department of Health, and I'd just like to bring up for you that letter on screen, which is INQ000097872, and just to draw your attention to the first paragraph, which states:

"I am writing to express our serious concern at reports that 69 pages covering seven recommendations for change were removed from last week's PHE's report on inequalities and disparities in the impact of COVID-19 on certain groups. A clear response is needed as to why these pages and important recommendations were omitted from publication, especially when it is so critical that action is taken to save lives now and reduce race inequalities."

A. Absolutely not, and I'm actually grateful for the opportunity to set the record straight, because this was something that caused an immense amount of frustration, and when I referred to personal abuse in the earlier session, this is what it was about.

The health department commissioned a report, but two reports were received, it was not one report. However, people who were contributing were not aware of that, so they assumed that their contributions had been withheld.

What we did was we published the first report immediately, what we'd asked for, and taking away the second one, which had recommendations which were actually not that easy to understand -- things like cultural competency, there's no clear definition of what that means -- meant that it took some time for us to look at what our response to it would need to be, and that was one of the reasons why, in addition to the first report being a "what is going on" rather than how

we fix it. That's one of the reasons why we carried out the second piece of work.

But I would like to state on the record that it is absolutely not the case that anything was withheld and only published because we were concerned about complaints. The fact of the matter is this report was not written by government. It could not have suppressed it anyway. PHE could have released it if it wanted to, it could have been leaked. So it would not have been a sensible thing to even have tried to suppress it in the first place.

Sometimes things don't happen quickly. It doesn't mean that there is a conspiracy to hide information, and that's the response that I gave to the BMA at the time and which I would like to put on record.

Q. Thank you.

A. Thank you.

Q. The 69 pages deal exclusively with the issue of disproportionate impact on ethnic minority groups and, as you will know, the BMA became very concerned from an early stage, from April 2020, about this issue, particularly as early data had shown that, among the doctors who had died in the early months from Covid-19, 94% were from a BAME background.

Given the seriousness of this issue and the
Q. One of the, perhaps, areas in which misunderstanding has been allowed to creep in is because the original terms of reference of the review included a requirement to make recommendations --

A. Yes.

Q. -- and recommendations only appeared in the second report.

A. Yes.

Q. Was that part of the problem, do you think?

A. No. No, and in fact I did get an apology from PHE for doing that, because they mixed the two things together.

They didn't provide -- and that for me was actually highlighting the fact that they didn't know what to do on the substance of the findings which they had. They didn't make recommendations as we had commissioned; instead, they did a separate piece of work that was different and made recommendations there.

Q. Thank you very much for clearing those matters up.

A. Thank you.

Q. I just want to move to a separate topic, very quickly.

Recommendation 4 of the second report concerned the need to accelerate the development of culturally competent occupational risk assessments. I'd just like to ask: in the work that you undertook following the report, what progress were you able to make in this regard, particularly having regard to the impact that disability as a matter of generality was not in your remit and you not wanting to duplicate, but you've said that you were interested in how disabilities, in your words, interact with health outcomes, and you gave the example of diabetes.

A. Yes.

Q. My questions are about how government struck the balance between non-duplication and the important matters of interaction that, as it may be, needed joined up thinking.

A. Right.

Q. Firstly, when Justin Tomlinson gave evidence to the Chair, we asked him what he understood the reason at the time was for why disabled people were not included in Minister Badenoch's investigation and the published reports across 2020 and 2021, and his answer was "I don't know". That's Day 20, pages 223 to 224, for the record.

"So was he consulted on that matter?"

A. I don't remember whether he was consulted on that matter. However, the Minister for Women and Equalities, I was senior minister, who had overall responsibility for this area, would have known about it. I can't recall. However, if we look again at the genesis of how this report came to be, and it relates to the previous...
question on intersectionality which was asked by the
previous counsel, you need to be able to disaggregate
data before you can look at them in the multivariant
analysis, you can look at the way that they interact.
So whether or not we took this work into account, the
data -- within our workstream or they looked at it
separately, the data would still have been there. So if
the question --
Q. Well, I just -- I'm going to come on to it, I'm only
interrupting you just because I'll come on to that. But
I think the answer you've given is that you don't know
about Justin Tomlinson but you think maybe Liz Truss, in
her position --
A. I don't recall whether or not Justin Tomlinson was but
Liz Truss would have been.
Q. Right, because I'm going to ask a second question
following that, if I may, which is that we have seen
none but was there a documented decision along those
lines around disabled people in relation to your
investigation or is it a more informal consultation that
you're recalling?
A. I don't think it is either. If we look at the -- one of the
quarterly reports where we talk about a separate
workstream --
Q. It's the final one.
A. I would not have needed to have those conversations
because that happens anyway. If you are disabled and
work is being done around disability, ethnic minorities
who are disabled will be captured and vice versa. So we
don't need to have a discussion to make sure that this
happens. This will simply be the case.
Q. Well, we don't need to study all your published reports,
but you don't deal with it in any way at all in your
reports?
A. We don't reference it because we are speaking
specifically -- the report is about ethnic minorities,
so we are talking specifically about that.
Q. Then lastly this, you have been asked about
intersectionality and perhaps the difference between how
much it was considered in substance as opposed to
definitional form, but the Oxford English Dictionary
defines intersectionality as:
"The interconnected nature of social categorisations
such as race, class and gender..."
We would add disability.
A. Yes.
Q. December 2021, in a footnote.
A. Yes, where we talk about a separate workstream. This is
a directorate that has all these units working together,
but the knowledge of disability as having such a severe
impact meant that it didn't need to be in -- it didn't
need to be within my bit of work.
Q. Okay.
A. If I may?
Q. Yes.
A. With the bit of work that I was doing, my workstream,
we're trying to understand why ethnicity would've had an
impact. For disability it's a lot more obvious. There
were fewer questions to be asked about why disability is
having an impact. It's clear to see. So there was no
need to mix those two workstreams together and in fact
I would not -- knowing what I know now, I would not
recommend it.
Q. Well, I understand that. How much discussion, though,
did you have with Minister Tomlinson or indeed the
Disability Unit about how disability or disabilities
interact with health and, in your work, how the various
ethnic minority groups could also be parts of disabled
groups and vice versa when it comes to risk and
outcomes?
to find out exactly what the answer is.

What we are doing in government is trying to use our resources as effectively as possible. So we start out with the measures that will help the largest number of people, not the measures that will tackle the most niche groups, whose intersectionality of race, of gender, of sex, of class and so on. That is very complicated data that actually -- an analysis that actually requires a lot of work. If you are dealing with a pandemic and there is a lot going on, you need to be able to manage resources effectively, and starting off with work that is the most complex means that you will help the least number of people. And that is why I would not recommend that.

Q. I think you've taken my question as: always do it first.
A. Right.

Q. I think your answer is "I never recommend doing it first", for the reasons you've just given, but you don't seem to be excluding its relevance once you have done, as it were, the more disaggregated work?
A. Yes, but you use the term "intersectionality", epidemiologists would talk about multivariable analysis -- multivariate analysis. They are not different things.

Q. Yes, but am I right: never first, but a formula of that kind relevant to all work within the scheme of things?
A. I think -- I think it's probably safe to say that that is something that is routine, I don't think it's something that is neglected.

MR FRIEDMAN: Thank you, madam.

LADY HALLETT: Thank you, Mr Friedman.

I think there was a matter that wasn't covered by Counsel to the Inquiry's questions and therefore, Ms Sergides, I think you're going to ask a question. Can you see the questioner?

THE WITNESS: Yes.

Questions from MS SERGIDES

MS SERGIDES: Can you see me?
A. Yes, I can.

MS SERGIDES: I'm grateful, my Lady.

Secretary of State, I appear on behalf of Southall Black Sisters and Solace Women’s Aid. I only have one question for you, relating to the overall responsibility for victims of domestic abuse in government.

Can you see me?
A. Yes, I can.

Q. Your role as Women and Equalities Minister is not a Cabinet position, but looking at the wider needs of victims of domestic abuse during lockdown and their children, including for example housing, just one of many examples affecting domestic abuse victims, is it correct that these issues are spread across various departments without there being ultimate responsibility in one minister or department?
A. I don't think that is true. We have a Minister for Safeguarding who put through domestic abuse legislation, and that would -- what you have described would primarily sit with that minister, but there was a Minister for Women, the ministers -- and there was a Minister for Women and Equalities as well, separate to me as Minister for Equalities, so actually I think that this is something which is covered by one minister but loads of others actually provide support in that space.

MS SERGIDES: I'm grateful, my Lady.

LADY HALLETT: Thank you very much indeed.

I think that completes the questions.

MR KEATING: Sounds good.

LADY HALLETT: I'm losing track of the days and months.

MR KEATING: Next Monday.

LADY HALLETT: 27 November at 10.30.

Thank you, everybody.

(3.20 pm) (The hearing adjourned until 10.30 am on Monday, 27 November 2023)
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