

Thursday, 23 November 2023

1
2 (9.30 am)
3 **LADY HALLETT:** Ms Cecil.
4 **MS CECIL:** Indeed, good morning, my Lady, may I call
5 Professor Dame Angela McLean, please.
6 **PROFESSOR DAME ANGELA McLEAN (affirmed)**
7 **Questions from COUNSEL TO THE INQUIRY**
8 **MS CECIL:** Indeed, Professor, thank you for your assistance
9 this morning, and indeed you have provided a witness
10 statement to the Inquiry as well. That's dated
11 19 October 2023, so earlier this year. It runs to some
12 51 pages, at the conclusion of which is there's
13 a statement of truth and your signature. Can I just ask
14 you to confirm that the contents are true?
15 **A.** Yes, the contents are true.
16 **Q.** Now, if you can keep your voice up, not least because we
17 have a transcript being made at the same time, and so it
18 may be that at points we need to take things more
19 slowly, so we will try to maintain a reasonable speed
20 and pace. If I ask you to slow down it will be my
21 fault. Similarly we'll take a break at some point this
22 morning.
23 So, Professor McLean, you are currently the UK's
24 Government Chief Scientific Adviser; is that right?
25 **A.** Yes.

1

1 your involvement in the various scientific advisory
2 bodies at that stage, you were a participant in SAGE?
3 **A.** I was.
4 **Q.** That run from 11 February 2020 all the way through to
5 10 February 2022?
6 **A.** Yes.
7 **Q.** In conjunction with that, were you also the co-chair of
8 SPI-M-O?
9 **A.** That's right, I was the co-chair from 27 March 2020.
10 **Q.** And that, again, ran throughout that period until the
11 conclusion of the committee in spring of 2022?
12 **A.** Yes.
13 **Q.** You were also involved in some task and finish groups.
14 Can you just give a very brief outline as to what those
15 were?
16 **A.** Yes, there were three of those. So the first one was on
17 mass testing, we did that in August of 2020. The second
18 one we always called the "four nations task and finish
19 group"; that was looking at what happened before and
20 after the tiers were put in. And then there was one
21 on -- about the science of vaccination, although
22 of course most of the advice, the great majority of the
23 advice about vaccination was handled separately by JCVI.
24 **Q.** Indeed, and we will return to the second of those, the
25 impact of interventions, the four nations --

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1 **Q.** That's a position you have held since 3 April of this
2 year; you succeeded Professor Sir Patrick Vallance?
3 **A.** Yes.
4 **Q.** Previously you've occupied a number of roles both within
5 government but also within academia?
6 **A.** Yes.
7 **Q.** You were formerly the Chief Scientific Adviser for the
8 Ministry of Defence?
9 **A.** Yes.
10 **Q.** And indeed you were at the time and the period with
11 which the Inquiry is concerned with regard to the
12 Covid-19 response?
13 **A.** Yes, that's right.
14 **Q.** At that point you also acted as a Deputy Chief
15 Scientific Adviser from spring of 2020?
16 **A.** That's correct, yes.
17 **Q.** Thank you.
18 In terms of your professional background, you were
19 also a professor of mathematical biology and that's
20 where your expertise lies; is that right?
21 **A.** Yes.
22 **Q.** At Oxford University, and you hold a number of
23 fellowships in that regard?
24 **A.** Yes.
25 **Q.** If I may now turn to the pandemic response itself and

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1 **A.** Yeah.
2 **Q.** -- task and finish group in due course, but you cover
3 the other two within your statement so I don't propose
4 to take you to those today.
5 With regard to providing scientific advice to
6 government, did you at any point attend COBR, Cabinet,
7 Covid-O or Covid-S?
8 **A.** I think I went to a small number of Covid-O meetings,
9 none of the others.
10 **Q.** With regard to the later stages of the pandemic, was
11 your involvement with the Covid-19 Taskforce?
12 **A.** So later on in the pandemic, towards the end of that
13 first year, Covid-19 Taskforce Analytics became a really
14 important part of our lives as advisers, because it
15 formed a really fantastic sort of network for
16 collaborators. So that was headed up by a man called
17 Rob Harrison, and so I think sort of from about
18 December, maybe, 2020, I started going to their morning
19 meeting every day.
20 **Q.** Again, we will turn to that in a little more detail when
21 we come to discuss the roadmap out of lockdown in 2021.
22 So just very briefly with respect to SAGE, you
23 attended a significant number, some 89 of those SAGE
24 meetings, throughout that period. Initially that was as
25 the chief scientific adviser for the Ministry of Defence

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1 but subsequently as a consequence of your role as
 2 co-chair, is that right, of SPI-M-O?
 3 **A.** That's correct.
 4 **Q.** What was your role within SAGE at that time?
 5 **A.** So my role in SAGE at that time was like other people,
 6 it was to listen to other people's evidence, so evidence
 7 that was being brought to SAGE by attendees that day,
 8 and challenge it like any scientist would challenge
 9 other scientists. Once I was the co-chair of SPI-M-O,
 10 it was also to support my co-chair, Graham Medley;
 11 sometimes if he wasn't there I would present the SPI-M-O
 12 consensus. And then an important part of the work would
 13 be to listen very carefully because straight after SAGE
 14 we co-chairs and the SPI-M-O secretariat would sit down
 15 and think through: right, what's the new commissions
 16 that come out of that? What questions arose in SAGE
 17 this week that we think SPI-M-O should be -- start
 18 working on and thinking about?
 19 **Q.** Do you consider that to be a strength of the SAGE
 20 system, that the co-chairs of the various committees sat
 21 on it and then had these follow-up sessions?
 22 **A.** I would say that was a strength, yes.
 23 **Q.** In terms of SPI-M-O, again a large number of meetings,
 24 81 during that period as the co-chair, alongside
 25 Professor Graham Medley, who we've also heard from, as
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1 they would say "Oh, but that's obvious" about something
 2 that they felt was very obvious, just from what they
 3 knew about epidemiology, and I would have to say, "Well,
 4 that's obvious to you but actually it's not obvious to
 5 lots of extremely well-important -- well-informed people
 6 who are absolutely involved in managing this pandemic".
 7 **Q.** With regard -- sorry, if I may just pause you there,
 8 just to pick up on that -- with regard to your input
 9 from that perspective, was that very much based upon
 10 your role and interaction within government as a chief
 11 scientific adviser?
 12 **A.** Very much. Very much so. I mean, I'd been in the civil
 13 service since that September, but I had also done quite
 14 a lot of work over the years as an academic advising
 15 into government, because there are lots of mechanisms
 16 where government reaches out for academic advice, so it
 17 wasn't just those six months, I had also done quite
 18 a lot of advisory work beforehand. So I think
 19 I probably had more experience, particularly perhaps
 20 with civil servants who weren't completely steeped in
 21 public health, than some of my colleagues on SPI-M-O
 22 did.
 23 **Q.** And with that role in terms of policy development and
 24 having that understanding, did you find that you were
 25 predominantly therefore involved in commissioning
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1 you will know, earlier in the Inquiry.
 2 What was your -- as co-chair of SPI-M-O, what was
 3 your role as distinct from that of Professor Medley?
 4 **A.** So I think my main role was really to be the go-between.
 5 I was the person who was at SPI-M-O meetings, very
 6 involved in the work they had done and were going to do,
 7 but also with lots of access to the relevant civil
 8 servants, so particularly in CCS -- what does CCS stand
 9 for? -- Civil Contingencies Secretariat to start with,
 10 and then later on in Covid-19 Taskforce and then
 11 particularly in Covid-19 Taskforce Analytics. So lots
 12 of that. But then also supporting Graham in devising
 13 workflow, like I just described. I was often there --
 14 well, I was always there, when I was available, for the
 15 main meeting -- so SPI-M-O had a main meeting, ended up
 16 being on a Wednesday -- to support Graham to be
 17 listening very carefully to make sure our consensus
 18 statement did reflect the discussion.
 19 Yeah, quite often I would be the one who said,
 20 "Listen guys, you think that's interesting but I can
 21 tell you that is not interesting with respect to this
 22 particular policy question". They're academics, my --
 23 I mean, friends of mine, they would get very interested
 24 in some particular detail and I would sometimes say,
 25 "Sorry, but move on". And on the other side quite often
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1 exercises and being that bridge between government and
 2 SPI-M-O?
 3 **A.** I did have a lot to do with commissioning exercises,
 4 particularly early on. I mean, I think -- well,
 5 actually, I thought Graham put it very well when he said
 6 that I was able to talk about things that modelling
 7 could do and things that modelling could not do. So
 8 quite -- I remember many discussions where I said,
 9 "That's just not a good question to bring to SPI-M-O,
 10 don't ask them that". And then quite often -- you can
 11 imagine we would have a conversation where I would say,
 12 "Well, why are you asking that question? What is the
 13 policy decision you've got to make here? Is there
 14 another way we can frame that question into something
 15 that epidemiology analysis and modelling can help with?"
 16 **Q.** Can I ask you just to slow down slightly --
 17 **A.** Yes.
 18 **Q.** -- Professor McLean.
 19 **LADY HALLETT:** I think we had three minds all the same.
 20 **MS CECIL:** Indeed. Just because, as I say, there is a note
 21 being taken and, as I say, it will be my fault rather
 22 than yours.
 23 So just picking up on that, what were the initial
 24 problems that you saw with commissioning?
 25 **A.** So early on with commissioning, so remember this would
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1 be -- when I say early on, this is from 27 March
 2 onwards, so actually after the first lockdown was in
 3 place, commissions arrived from all over the place. So
 4 particularly we would get commissions from Civil
 5 Contingencies Secretariat and Number 10 and we didn't
 6 know how -- and we wouldn't know how to prioritise
 7 those. And sometimes we would get commissions that
 8 would string several sort of, "Please tell us about
 9 option A and/or option B, that's three possibilities,
 10 and then string those together for sort of three or four
 11 different things", and quite soon we'd get to sort of
 12 100 or so possibilities. And it was my job to say, "I'm
 13 really sorry, but in a week we can't do that. What do
 14 you really care about? How will you prioritise these
 15 questions? Let's turn this into something where we can
 16 actually help you."

17 **Q.** Did that process, firstly, improve as the pandemic
 18 progressed?
 19 **A.** It got much better. So SAGE secretariat basically built
 20 a commissioning system, which -- one of the things it
 21 did was to stop just sort of commissions just arriving
 22 just sort of from left field, from department X or
 23 ministry Y, so they really helped us a lot by
 24 effectively making some rules of the road about how
 25 commissioning would work. And then, yes, I think --

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1 **A.** That's right.
 2 **Q.** Did you see the fruit of that effectively?
 3 **A.** I think we did, yes, I think the discourse became much
 4 better informed on both sides.
 5 **Q.** In addition to that, and I appreciate some of us are not
 6 so familiar with graphs and graphical representations,
 7 but one of the other main developments throughout that
 8 period, in terms of communications of the scientific
 9 advice and the outputs of SAGE and SPI-M-O, was the
 10 production of something that became known as "ready
 11 reckoners"?
 12 **A.** **(Witness nods)**
 13 **Q.** Again, that was something initially pulled together by
 14 a Professor Brooks-Pollock --
 15 **A.** That's right.
 16 **Q.** -- within SPI-M-O --
 17 **A.** Yes.
 18 **Q.** -- and taken forward by you, as co-chair?
 19 **A.** Yes, I mean, I think that's a good shorthand way of
 20 putting it. I think generally in SPI-M-O and then in
 21 SAGE it was felt, yes, this is a useful way of making
 22 lots of comparisons all on one page without having to
 23 draw thousands of squiggly lines.
 24 **Q.** Indeed. And perhaps we could have a very quick look at
 25 perhaps one of the earliest iterations of that, and

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1 well, I felt that my growing relationship with CCS meant
 2 that we got better at shared language and me
 3 understanding more why they were asking their questions,
 4 them understanding more what kind of thing we in SPI-M-O
 5 could and could not do.

6 **Q.** Thank you. If I may just pick up, then, in terms of
 7 those difficulties that were initially experienced with
 8 a lack of understanding, you undertook a number of
 9 initiatives, would that be fair to say, to try to assist
 10 civil servants and policy-makers and indeed
 11 decision-makers in their understanding of both
 12 scientific consents but also the outputs of SPI-M-O and
 13 SAGE?

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

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

17 **A.** We did.

18 **Q.** Very short, pithy documents explaining things such as
 19 the reproduction number, the R, the R number as it's
 20 been referred to, general principles and assumptions on
 21 transmission, introduction to epidemiological modelling,
 22 which we've all had sight of, and indeed an FAQ on
 23 epi modelling to try to imbue some further understanding
 24 effectively within the civil service and indeed those
 25 decision-makers?

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1 that's INQ000216286.

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

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

10 **A.** So, my Lady, I've heard you don't like graphs, but this
 11 is a beautiful --

12 **LADY HALLETT:** Well, it depends on the graph.

13 **A.** A very beautiful graph.

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

17 So before, let's say, mid-March, in 2020, we would
 18 have been on the right-hand end of -- I'm looking at the
 19 left-hand graph, okay? So the bottom axis says how much
 20 active work and leisure contact are people having. So
 21 100 is normal everyday life and the Y axis, the up-down
 22 axis, is -- what is this -- here is our R number, and we
 23 would like --

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

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1 A. Yes. Yes.
 2 Q. Based on the R number, was that because decision-makers
 3 had become familiar with that concept?
 4 A. Yes. Yes.
 5 Q. It was a shorthand, effectively?
 6 A. Exactly, it had turned into a shorthand for: have we got
 7 this infection under control, is R at 1 or below 1? Or
 8 have we not got this infection under control? Which was
 9 the case when R was above 1.
 10 So when R is a long way above 1, you really are in
 11 trouble.
 12 Q. And that's why we have the R number along the one
 13 axis --
 14 A. That's right.
 15 Q. -- and the active work and leisure contacts on the
 16 other.
 17 A. That's right.
 18 Q. And I interrupted you, so please go ahead.
 19 A. Fine, thank you.
 20 So remember this is very early on, nobody
 21 vaccinated, the entire population susceptible to
 22 infection with bad consequences, particularly for
 23 elderly people and also for lots of other people too.
 24 So, there we are, living our normal lives in late
 25 February, early March 2020, so we're at -- we're far

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1 these graphs -- I don't know if it's possible to zoom
 2 out a little bit? -- is that -- well, if you compare the
 3 left-hand graph -- on the top row, if you compare the
 4 left-hand graph and the right-hand graph, you can see
 5 that a little bit of contact tracing -- so the
 6 right-hand graph is if contact tracing could prevent one
 7 in five onward transmissions, 20%, well, that doesn't --
 8 there's not a huge difference, is there? Whereas, if
 9 you go to the bottom graph, if contact tracing could
 10 prevent four out of five onward transmissions, then we
 11 start to have quite a lot more room to sort of roam up
 12 and down this bottom axis.
 13 So the bottom axis is sort of how hard you have to
 14 intervene, the different bands are how much the schools
 15 are open, and the different pictures in this particular
 16 representation is how much contact tracing might we be
 17 able to build.
 18 Q. Indeed. And on each of the graphs it sets out what the
 19 parameters are?
 20 A. Yes.
 21 Q. So, taking the top one, we see that the grey band is
 22 "Schools closed".
 23 A. Yes.
 24 Q. Then the blue one, "50% of 5-11 year olds at school" as
 25 an alternate.

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1 over on the right-hand side of the X axis, all the
 2 schools are open, so the R number is somewhere between
 3 2.5 and 3, we're in the middle of that -- we're
 4 somewhere in that red band up there on the right-hand
 5 side. And that was what was driving the rapid
 6 exponential growth that we eventually saw in the very
 7 rapid rise in hospitalisations that we saw a few weeks
 8 later.
 9 I'm going to come on later -- I hope we'll come
 10 later to where were we in the middle of the week just
 11 after the Prime Minister stood up on 16 March and said
 12 "Please stay home".
 13 Q. We will be dealing with that in due course.
 14 A. So under voluntary restrictions, we'll talk about --
 15 obviously it's very important where we were, but from
 16 the data we had at the time we were probably at about 60
 17 on the X axis, most children still in school, still R
 18 way above 1. Then on March 23, when lockdown came in,
 19 we were more like at about -- and all schools were
 20 closed, we were more like round about 20 on that X axis.
 21 All schools closed, so in the middle of the grey band,
 22 the R number round about 0.7.
 23 So this was, this was a very quick and easy way to
 24 see, roughly speaking, if we do the following things
 25 what will happen. And one of the things you see from

14

1 A. Yes.
 2 Q. Yellow, the 5 to 11-year-old category at school.
 3 A. Yes.
 4 Q. And then "Schools open".
 5 A. Yes.
 6 Q. Then, as you say, you see, if we go to the right one, we
 7 then see "Schools closed + 20% [contact tracing]"
 8 reduction --
 9 A. Yes.
 10 Q. -- and so on and so forth?
 11 A. And if I could add one further thing: this is actually
 12 based on data from I think it -- well, I think it is
 13 tens of thousands of people in something that -- a study
 14 that the BBC ran, long before the pandemic, on what kind
 15 of contacts people have with other people of what age in
 16 what context.
 17 Q. And this was a graph, as we will come to later, that was
 18 being dealt with at a very early point in time, in fact,
 19 in the pandemic, pre-lockdown, but post voluntary
 20 measures being announced?
 21 A. I'm not sure we had this particular graph, because
 22 actually if you look at the date that these emails were
 23 written, I think this is -- no, I think we actually got
 24 this representation in more like May. This idea that we
 25 needed to be down round about 75% of contacts outside

16

1 the home, so the idea that we needed to be way, way down
 2 on -- back to the top left graph -- only requires
 3 a pretty straightforward calculation.
 4 **Q.** We're going to move to exactly what that required, as
 5 I say, when we start to look perhaps slightly more
 6 chronologically --
 7 **A.** Yeah.
 8 **Q.** -- at the response, as opposed to these topics.
 9 And perhaps we can take that down now.
 10 **LADY HALLETT:** Just before you do, and now I'm going to show
 11 just how bad I am with graphs. Could we have it back up
 12 again? Sorry.
 13 The left-hand graph, you've got -- bottom axis
 14 you've got up to 100% contact --
 15 **A.** Yeah.
 16 **LADY HALLETT:** -- yet we're looking at the grey line, if
 17 schools are closed.
 18 **A.** Yes.
 19 **LADY HALLETT:** Well, if schools are closed you haven't got
 20 100% contact, have you?
 21 **A.** So this is active work and leisure contacts beyond -- so
 22 work, adults; leisure, everybody (apart from school).
 23 So, yes, you're quite right, this is apart from school.
 24 What's everybody doing apart from the children's school
 25 contacts. Thank you for reminding me to clarify that.

17

1 **A.** Yeah.
 2 **LADY HALLETT:** -- with schools closed, you're still up at
 3 an R number of over 2.
 4 **A.** Yeah, correct.
 5 **LADY HALLETT:** And with schools open, you've got an R number
 6 of 3. Well, you said earlier, anything over 1 we're in
 7 trouble. So is that as great a distinction as laypeople
 8 like me might have expected?
 9 **A.** I would look at that and say only closing of schools
 10 would have been -- wouldn't have helped us -- well,
 11 would have helped us very little, I agree.
 12 **LADY HALLETT:** Thank you.
 13 **MS CECIL:** Perhaps that's the advantage of the ready
 14 reckoners and the visual comparators on the page, in
 15 fact.
 16 But these were incorporated, as a consequence, into
 17 both consensus statements and SAGE minutes?
 18 **A.** They were.
 19 **Q.** Yes. Just to deal, perhaps, and picking up my Lady's
 20 comment in relation to the gaps on graphs, certainly
 21 that is one of your primary issues with how politicians
 22 and -- not just politicians and decision-makers but
 23 policy-makers, individuals that are not acquainted with
 24 graphs, potentially utilise them and certainly when it
 25 comes to getting a ruler out, for example, that's a very

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

18

1 big no-no to mark --
 2 **A.** Yes.
 3 **Q.** -- the gap between them or indeed to take a specific
 4 point on many of the graphs that were produced by SAGE
 5 or SPI-M-O as being a critical accurate point?
 6 **A.** I think that was reflected in Graham's comment about
 7 knowing what you can't do with these things. I mean,
 8 my -- I was showing you earlier, my version of these
 9 graphs, that I'm extremely fond of and often carry
 10 around with me, actually has little -- I drew myself
 11 a little picture of a ruler with a "Don't go there" sign
 12 on it. You know, we shouldn't use these things to say,
 13 "Oh, well, if we had, you know, 45% active work and
 14 leisure rather than 40% and -- we could do precisely
 15 this or precisely that". That's not the point. The
 16 kind of lesson to learn from graphs like this is: look
 17 just how much -- look how good your contact tracing
 18 needs to be before it gives you lots and lots of space
 19 to have fewer interventions in terms of how much people
 20 can be out and about.
 21 **Q.** Indeed. And was that one of the challenges you and your
 22 colleagues faced during the pandemic in relation to the
 23 understanding of graphs, and indeed numbers, statistics
 24 and other scientific data and outputs?
 25 **A.** Yes, I think -- I think I would say it's an issue all

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1 your life, as a sort of rather technical person, is
 2 that -- to find people as interlocutors who will listen,
 3 but also challenge in a really constructive way, is
 4 really important. Because it's just as bad if they
 5 believe everything you say, because that's not very
 6 helpful, if you need somebody -- I mean, most of my
 7 academic life was done in collaboration with people who
 8 were not mathematicians, not modellers, and by far the
 9 best collaborators are -- will listen and criticise and
 10 say, "Well, why did you do that? And should I really
 11 believe, you know, that confidence level? How did you
 12 draw the confidence interval?"

13 So I think one of the things I would always say to
 14 any colleague is if a scientist comes and tells you
 15 something and you don't understand what they say, you
 16 must say to them, "Say it again, I didn't understand".
 17 It's their job -- I think it's scientists' job to
 18 explain what it is that they've done.

19 **Q.** With regard to that point and understanding, perhaps if
 20 I can pick that up here, perhaps if I can take you to
 21 paragraph 57 of your witness statement on page 17, we're
 22 going to turn to decision-making in respect of NPIs, as
 23 I say, in due course, but one of the factors that you
 24 identified as being a difficulty during the pandemic was
 25 the understanding of two key concepts, the first being

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1 until the thing you're worried about is really, really
 2 bad, and growth is exponential and fast, you could very
 3 easily end up with things twice as bad at the hospital
 4 door, even if you put in a brilliant intervention. So
 5 this idea that things where whatever your control
 6 measure is doesn't fix your problem until ten days later
 7 is a really important part of why this was such
 8 a difficult problem, and really, as I point out in this
 9 paragraph, needed to be understood because it made
 10 "watch and wait" tactics very damaging.

11 **Q.** Indeed, the failure to take a decision or to wait is
 12 a positive decision in itself when it comes to issues of
 13 exponential growth?

14 **A.** Indeed.

15 **Q.** And from your perspective, that is perhaps one of the
 16 most important lessons for the future in terms of
 17 developing that understanding --

18 **A.** Yes.

19 **Q.** -- is that right?

20 **A.** I think so.

21 **Q.** And as we will see as we move chronologically through
 22 that period, that informs what you consider to be one of
 23 the most significant shortcomings in relation to
 24 decision-making in both -- well, to some extent in the
 25 early part of the pandemic but certainly in the autumn

23

1 the implications of fast exponential growth and the
 2 second being lagged controls.

3 Can you just explain exponential growth and its
 4 importance in this context for us, please.

5 **A.** So exponential growth arises when you have a process
 6 where what's fixed is not the slope of line but the time
 7 that it takes to double whatever the quantity you see.
 8 So exponential growth and fixed doubling times go
 9 together. So when we say the doubling time is a week,
 10 we instantly know: oh, we're talking about exponential
 11 growth. And I think as you heard very eloquently from
 12 Chris Whitty, you know, exponential growth, once it gets
 13 going, grows really shockingly fast.

14 **Q.** Exponentially.

15 **A.** Exponentially.

16 **Q.** Indeed.

17 **A.** And lagged controls, well, that was particularly
 18 pertinent here because what we were trying to do, we
 19 were trying to stop too many people ending up being
 20 admitted to hospital, and admission to hospital was
 21 something that we expected to happen sort of ten or
 22 eleven days after you got infected, so if we have -- so
 23 the place where you could make an intervention was
 24 people getting infected, whereas the thing that you were
 25 worried about happens ten days later. So if you wait

22

1 period of 2020?

2 **A.** I agree, I think we made the same mistake three times.

3 **Q.** Thank you.

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

6 **A.** No, I don't think it requires a scientific mindset.

7 I think if you -- you can draw it out in a picture in
 8 a way that anybody who's prepared to listen and think
 9 about it ought to be able to grasp.

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

13 **A.** Yes.

14 **Q.** Somebody with an entirely non-scientific background, but
 15 able to pick up those concepts and work with those.

16 **A.** Yeah.

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

25 **A.** Yes.

24

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

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

25

1 they -- what they were talking about was your work", you
 2 know.

3 **Q.** Indeed.

4 If I could just call up INQ000215900, it's an email
 5 with Professor Medley and it relates to perhaps one of
 6 those scenarios that arose during the pandemic with
 7 a member of -- a civil servant.

8 Within this, what we see is in the top part it's
 9 an email from you. Second paragraph down, you explain
 10 that a gentleman was unhappy about SPI-M-O on Wednesday
 11 so you sent him an email, which you copied in to
 12 Professor Medley just so that he was also in the loop,
 13 and you explain:

14 "I think Civil Servants have different ways of being
 15 robust with each other from academics. Perhaps he found
 16 our ways of expressing ourselves more direct than he is
 17 used to. No action required."

18 Then you explain you'll try to find out why he's
 19 uncomfortable and report back.

20 So is that an example of what you have been --

21 **A.** Indeed.

22 **Q.** -- referring to?

23 **A.** Indeed. And, I mean, what you can see here is the
 24 wonderful Clare Gardiner was able to ring me up and say
 25 "Angela, that went a bit far on Wednesday, can you try

27

1 an academic who becomes a civil servant to understand
 2 why people are saying this sort of weirdly emollient
 3 thing, when actually our values are so similar: we are
 4 trying to get at the truth. I think it's a difference
 5 between: are you really trying to get at every detail of
 6 the truth, or are you trying to make something workable
 7 that you can deliver? So I think it's summed up quite
 8 well by "Tell me why I'm wrong" (academics) versus
 9 "I agree with everything that's been said" (civil
 10 servants). I think the values are actually very close,
 11 but they're different ways of approaching working
 12 together.

13 **Q.** And, indeed, different ways of communicating.

14 **A.** Absolutely.

15 **Q.** Did that cause any difficulties during the pandemic?

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

26

1 to cheer [Name Redacted] up a bit".

2 **Q.** And the underlying issue there was a meeting in SPI-M-O
 3 where members were expressing some level of frustration
 4 with the testing and tracing situation?

5 **A.** I believe that -- I believe so. Elsewhere there's
 6 a response from [Name Redacted] saying he's not
 7 surprised people are frustrated with the progress of the
 8 test and trace system.

9 **Q.** Now, if I may turn to separate issue and that's the one
 10 in relation to further attempts to assist policy-makers
 11 and government decision-makers in a slightly different
 12 way, and that was the creation of a toy model. And
 13 we've heard a little bit about that already, but if you
 14 could just explain very shortly in a sentence what a toy
 15 model is, please.

16 **A.** So a toy model -- I think the phrase really comes from
 17 physicists -- is an absolute caricature. It is
 18 something where you keep things as simple as possible,
 19 either perhaps so you can do some analytical
 20 calculations, you know, on a piece of paper, or in this
 21 case we wanted to make something that could be freely
 22 available both to policy-makers and, if they wanted it,
 23 decision-takers, to build their understanding and
 24 intuition about how infectious disease systems work. We
 25 knew that we couldn't build for them a full sort of well

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1 parameterised model with lots of the complexities about
2 how different parts of society mixed together. So we
3 were very clear that this was a pedagogical tool.

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

6 **A.** Yeah.

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

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

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

21 **A.** That's right. So my role -- so I was incredibly keen
22 that they should have something that was internally
23 correct. I mean, it wasn't a great model but it didn't
24 have mistakes in it, so that it could be relied on in
25 that sense. So yes, sent it out to be basically peer

29

1 change it", because once you've changed it, it is no
2 longer quality assured. You know, we had gone to a lot
3 of trouble to make sure it was correct, and so we said
4 to people, "Please don't change it, please feel free to
5 use it however you like". It had been made into this
6 beautiful, rather easy-to-use thing, I believe, although
7 I never got to play with it myself.

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

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

21 **A.** Yes. I mean, I think there was an issue that the
22 scientific advice that came through SAGE was completely
23 transparent, everything was in the public domain, on the
24 day that a decision was announced, and whatever
25 modelling Treasury was doing to consider the economic

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1 reviewed by some academics and it was also very
2 carefully reviewed by some modellers at the Defence
3 Science and Technology Laboratory.

4 **Q.** We've heard a little bit of evidence already in respect
5 of Clare Lombardelli from the Treasury with regard to
6 an email chain that you were involved in, along with
7 Philip Duffy and Ben Warner, relating to Treasury
8 playing around with and changing that toy model, and
9 what you say there, in relation to that, is:

10 "Given their inability to spot egregious errors in
11 other things they were sent I do not have any confidence
12 in their ability to hack a simple, sensible model."

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

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

24 But to go back to the -- in the documentation,
25 I think you'll -- there are things saying, "Please don't

30

1 case, I've still never seen.

2 **Q.** And with regard to, you may have heard that there was
3 some attempt at epi-macro modelling by HMT?

4 **A.** Yeah.

5 **Q.** By Treasury. And what you do refer to in your email are
6 "egregious errors in other things". Did they have
7 adequate or sufficient epidemiological modelling
8 experience in your view to do that?

9 **A.** I think they could have used some more. I mean, in the
10 same way that DHSC looks for outside help via SPI-M,
11 even in peacetime, and there's plenty of good modellers
12 in DHSC, but they have the, I think, very good sense to
13 go to academics who, you know, who are world class
14 leaders in the subject. So I think it would be sensible
15 for Treasury if they wanted epidemic models to have
16 reached out that way.

17 **Q.** Thank you.

18 Then one final topic before we turn to the
19 governmental response and the response to Covid-19,
20 please, and it's that of data and data flows, and we can
21 deal with this relatively briefly.

22 We've heard a lot of evidence so far in relation to
23 data and the absence of data, but that's also something
24 that you experienced, certainly at the very beginning of
25 the pandemic but also throughout the pandemic, albeit

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1 getting better as the pandemic progressed. Would that
2 be a fair summary?

3 **A.** Yes, that's a fair summary.

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

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

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

12 **A.** Yeah.

13 **Q.** -- of 2020, 28 March:

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

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

22 **A.** Yes, that's right.

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

24 **A.** There was -- there was real trouble with doing the sorts
25 of analysis that we needed because the data weren't

33

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

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

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

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

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

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

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

24 **A.** That is correct.

25 **Q.** Again, what impact did that have on the early stages and

35

1 available. It's that straightforward.

2 **Q.** Thank you.

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

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

23 **Q.** So, essentially, a trusted broker?

24 **A.** Exactly.

25 **Q.** Something of that nature?

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1 did that position improve?

2 **A.** That was a -- that was a difficult issue for quite some
3 time and it made it very difficult for SPI-M-O to do
4 work that was specifically relevant to other -- to the
5 devolved administrations. It did get much better over
6 time, and in time particularly Scotland and Wales
7 actually created very good analytic and modelling
8 capability of their own and data flows from other parts
9 of the UK did get better.

10 **Q.** And with respect to that sharing of data and the data
11 flows, at what point in the pandemic did you see
12 a significant improvement? Obviously not necessarily
13 the date, but just broadly.

14 **A.** My sense is that by mid-May it was much better. You
15 have to understand that modellers are a bit like farmers
16 and the weather, you know, there's never enough data.

17 **Q.** Of course. Did you or SAGE or SPI-M-O ever experience
18 any difficulties in obtaining data from Scotland,
19 Northern Ireland or Wales, effectively were there any
20 blocks put in the way by any of those devolved nations
21 or was there a free flow of data, once the capacity was
22 there?

23 **A.** I don't think I can answer that question because that
24 was -- that would have been handled by my co-chair and
25 the secretariat.

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1 Q. Of course. No, thank you, Professor.
 2 Another area of data, just briefly on ethnicity, if
 3 I may, you make it plain within your witness statement
 4 that with regard to ethnicity there was insufficient
 5 data to account for intersectional disparities, so
 6 ethnicity and indeed other aspects; is that right?
 7 A. That -- particularly in these main flows of data that
 8 were driving parameter estimation for the big models,
 9 yes. There were sometimes other particular questions
 10 that we could address with particular datasets but yes
 11 I would say in the main data streams there wasn't enough
 12 data, and for the kinds of policy questions we were
 13 addressing I don't really -- I can't think of policy
 14 questions that really would have driven that kind of
 15 modelling. Because there's no point in us making
 16 a model more complicated if it isn't necessary to
 17 address a particular policy question.
 18 Q. Indeed. And similarly there was an absence of data on
 19 wider societal outcomes which feeds into those
 20 intersectional issues also?
 21 A. Yes.
 22 Q. We --
 23 A. Sorry, can I just --
 24 Q. Of course.
 25 A. I don't think we're going to visit it here, but there

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1 Q. Indeed, and really I'm just dealing with the data
 2 aspect --
 3 A. Yes.
 4 Q. -- at this moment with you. Perhaps just to round off
 5 that topic in terms of your evidence, because we've
 6 heard evidence obviously from other individuals too,
 7 Professor, but from the outset did you expect that there
 8 would be problems arising in relation to care homes and
 9 outbreaks?
 10 A. Yes. I think that was -- you only have to look at
 11 historical big epidemics, particularly of respiratory
 12 infections, that you would have expected that.
 13 Q. Just again briefly, because there will be a module
 14 dealing with this in greater detail in due course, was
 15 outbreaks, the incidence of outbreaks and problems
 16 within care homes, was that something that was
 17 a foreseeable issue from the outset of the pandemic?
 18 A. Yes.
 19 Q. Indeed, within both SAGE and the subgroup, we see that
 20 testing is --
 21 A. Yes.
 22 Q. -- one of the --
 23 A. That's true.
 24 Q. -- tools that is repeatedly referred to respect to
 25 care homes?

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

5 Q. Yes.
 6 A. So that the -- ways of accounting for the harms wider
 7 than Covid hospitalisations and deaths.
 8 Q. And we have heard some evidence in relation to that at
 9 the outset of this module as well from Professor Sir
 10 Ian Diamond.
 11 A. Good.
 12 Q. Similarly, if I may, data and care homes, just touch on
 13 that briefly here. With respect to care homes and data,
 14 were you also experiencing problems in accessing data
 15 flows and data streams?
 16 A. We had very little data about outbreaks inside
 17 care homes, so for a long time the data we tended to see
 18 was: yes, this care home is affected, no, this care home
 19 is not affected. But that made it very difficult to say
 20 anything helpful about what was happening inside
 21 care homes.
 22 We did set up a separate care homes group and had
 23 modellers specifically on there, so in a sense the
 24 care home modelling was -- was delegated to a different
 25 group.

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1 A. Yes.
 2 Q. And that concerns were being raised within SPI-M-O?
 3 A. Yes, that's right. It was clearly going to be an issue.
 4 Of course, at that very early stage we did not have many
 5 tools in our pockets for helping, and testing would have
 6 been one of the few things we could do.
 7 Q. Were you and SPI-M-O concerned that not enough was being
 8 done in relation to care homes?
 9 A. Yes, and I think SAGE too, I think there were SAGE
 10 comments from quite early on about how particular
 11 attention would need to be paid to care homes.
 12 Q. And as you've already referred to, we see that
 13 a separate subgroup, a working group, was set up
 14 specifically to deal with that issue?
 15 A. Yes.
 16 Q. Thank you.
 17 Now, if I may move now to start with the actual
 18 Covid-19 response, and so taking you back, if I may, all
 19 the way to your first interactions in terms of SAGE,
 20 which was on 11 February, I understand that you were
 21 aware of Covid-19 prior to that as a consequence of
 22 interaction with Professor Edmunds and -- were you
 23 concerned at that stage?
 24 A. I think I mention in my statement that on 25 January
 25 I remember being at an infectious disease public

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1 understanding of science event actually in Oxford, so
 2 there were sort of lots of us together, and somebody
 3 asking me about it, and I remember saying, "Well, John's
 4 worried, and that makes me worry". Because, I mean,
 5 you know, we've lived through all of -- you know,
 6 umpteen times that there has been a pandemic and so we
 7 know how different people react; the fact that John
 8 found it worrying was a pretty strong signal, I would
 9 say, even mid-January.

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

13 **A.** Yes.

14 **Q.** Now, if I may take you then to the first few weeks of
 15 March, and if I can take you to paragraph 116 of your
 16 statement, you explain that you:

17 "... began to feel that there did not seem to be
 18 a plan within government, or a clear sense of how many
 19 people were going to die."

20 Why was that?

21 **A.** Where are we ... I'm just trying to look -- "first
 22 few weeks" ... it seemed incredible, and from what I've
 23 heard now it was incredible, that there could possibly
 24 be a strategy of -- of a -- even a slightly mitigated
 25 epidemic, that the kinds -- I mean, you've talked quite

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

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

15 **A.** No.

16 **Q.** Certainly you weren't aware of it?

17 **A.** No.

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

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

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

24 **A.** Yes, absolutely. Yes, that's true. I would also -- the
 25 people who were present at Exercise Nimbus were not the

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1 a lot about other people's calculations. We might look
 2 at some I have made. If everybody could catch it and it
 3 spreads quite well, so that you might expect something
 4 like three-quarters of the population to get it, even if
 5 the infection fatality rate is only 1%, that's just
 6 an unbelievably large number of people. And that was
 7 what led me to say to Ben on that -- one of those days,
 8 the 10 March day, have decision-takers really understood
 9 what they're confronting here.

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

11 **A.** Yeah.

12 **Q.** And Ben is Ben Warner --

13 **A.** Yes.

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

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

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

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

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1 secretaries of state who would be sat round the Cabinet
 2 table making these decisions.

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

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

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

16 **A.** Yes.

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

19 **A.** Yes.

20 **Q.** -- ie the politicians --

21 **A.** Yes.

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

23 **A.** Yeah.

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

25 **A.** Yes.

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1 Q. The overwhelming of the NHS --
 2 A. Yes.
 3 Q. -- and the tsunami of deaths that would potentially be
 4 coming --
 5 A. Yes.
 6 Q. -- the -- in the way?
 7 Your involvement then continued, and indeed you
 8 attended SAGE 15, meeting 15, then on 13 March of 2020,
 9 and at that point ICU hospital capacity was being
 10 discussed by Professor Edmunds. What was your view in
 11 relation to hospital capacity and what you knew about
 12 the potential pandemic?
 13 A. So this was the first time I saw a picture that compared
 14 potential pandemic and ICU capacity, and it was really
 15 shocking. Because -- I mean, you've all seen it now,
 16 but it is this line right down at the bottom, not so
 17 many at the top. And I did also -- a relative of mine
 18 was working in a London ICU then, and from what she
 19 described and from what I knew about exponential
 20 growth -- you know, they didn't have many people but if
 21 the doubling time was less than a week, it was just very
 22 obvious that they would be in big, big trouble in a few
 23 weeks' time.
 24 Q. Indeed. And that prompted you to send Professor Sir
 25 Patrick Vallance an email.

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1 A. No.
 2 Q. You just need to apply basic facts and, to some extent,
 3 that word common sense --
 4 A. I think what modelling might -- would help you with is
 5 this sense of how fast is it growing, how long have
 6 I got.
 7 Q. Indeed. And this document, you explain that you know
 8 there were many uncertainties, you're looking at
 9 realistic current capacity versus reasonable worst case
 10 epidemiology as well within there, but really focusing
 11 in here on just NHS capacity and it being overwhelmed?
 12 A. Yeah.
 13 LADY HALLETT: Sorry just to interrupt again. What made you
 14 pose the question: but what if it's here? To lower the
 15 line.
 16 A. Yes, the meeting that we'd had on that Friday, where
 17 John Edmunds had shown a picture where -- I think he'd
 18 had some real data -- I think it was just from one
 19 county, actually -- and had drawn, effectively, that
 20 picture.
 21 LADY HALLETT: So who had given you the higher dotted line?
 22 A. That was my interpretation of what we seemed to be
 23 saying, that the situation was going to be something
 24 where we make it a little bit better and then we'd stay
 25 within capacity --

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1 And if I can just pull that up, please, that's
 2 INQ000195889.
 3 And this is your own calculation --
 4 A. It's not a calculation, it's just a drawing.
 5 Q. A drawing. I mean, "calculation" places it too high?
 6 It's probably --
 7 A. On purpose actually, because it's -- see, I was worried
 8 that people were looking at models and saying, "Oh, it's
 9 just modelling", and so I wanted to say this isn't
 10 really about modelling, this is about have we somehow
 11 been making the wrong assumption about where capacity
 12 lies relative to what we're going to do.
 13 Because on Friday we'd been shown the picture where
 14 the dotted line is way down the bottom, and if the
 15 dotted line is way, way down there, all this discussion
 16 about are we going to mitigate or are we going to
 17 suppress, well, if you're going to stay below the dotted
 18 line, to mitigate is to suppress. It was -- it was --
 19 once you -- once -- once you see where that lies it's
 20 not a complicated question --
 21 Q. No.
 22 A. -- if you are not going to exceed capacity.
 23 Q. You don't need a model?
 24 A. No.
 25 Q. You don't need modellers?

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1 MS CECIL: And the NHS would cope, effectively?
 2 A. Yeah.
 3 Q. But actually capacity seemed to be at quite a distance
 4 from that?
 5 A. Yeah.
 6 Q. And as a consequence would be overwhelmed and swamped
 7 very quickly?
 8 A. But other people who were having conversations --
 9 I mean, this is me at home in Oxford, you know, doing
 10 little drawings. Other people who were in London that
 11 week were in the process of finding out how far along --
 12 or, in real life, how far along those lines we were,
 13 which was actually, as you heard earlier this week, the
 14 much more compelling piece of evidence.
 15 Q. Indeed. If I can just then take you down slightly
 16 further on your page, this is where you set out what you
 17 consider to be the combinations of options:
 18 "If capacity is nearer the low line ..."
 19 A. Yeah.
 20 Q. "... what other combinations of options are there?"
 21 A. Yeah.
 22 Q. This is on 15 March. And we see, at the
 23 top: "Lockdown"?
 24 A. Yeah.
 25 Q. "Intermittent lockdown"?

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1 A. Yeah.

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

4 A. Yeah.

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

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

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

13 And then:
14 "Others?"

15 A. Yeah.

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

18 A. Yeah.

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

22 A. Well, actually, if you look at what is happening here,
23 I'm not actually doing any kind of herd immunity
24 calculation. There's no $1 - 1/R$ here, it's
25 just if you wanted to end up with half the population

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1 occurred. So, I mean, that -- I think that's a sort of
2 polite way of saying: why on earth have we not had
3 a discussion in which we look at some of these potential
4 waves we're thinking about and plot them against our
5 known capacity?

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

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

14 A. Yes.

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

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

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1 immune what would happen. And so that's that first row.

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

5 And, I mean, you just get to these numbers that
6 clearly no one's going to tolerate. No one is going to
7 tolerate 2,000 deaths each week.

8 Q. Indeed.

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

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

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

18 Q. Indeed.

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

23 A. Yes, I think it would have been very useful if, in one
24 of the SAGE -- as I say at the beginning, there's
25 a discussion that I missed that SAGE -- if it has

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

3 A. Yeah.

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

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

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

15 A. Already.

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

17 A. No.

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

20 A. Indeed.

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

25 A. Yes.

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1 **LADY HALLETT:** -- whether or not it was working. So what
 2 conclusions can we get after two days?
 3 **A.** What conclusions we get after two days is that after
 4 two days we haven't got enough. I think there are
 5 other -- I mean, that's all we had and a decision had to
 6 be made.
 7 So I think there are other data streams that tell us
 8 that the voluntary measures weren't enough, and in
 9 particular the fact that hospital admissions peaked on
 10 April 2nd, and that's ten days after March 23rd. If
 11 16 January had been enough -- sorry, if 16 March had
 12 been enough to get R below 1, we would have expected
 13 hospital admissions to peak ten days after that.
 14 **MS CECIL:** And that's your lag point as well?
 15 **A.** That's the ten-day line.
 16 **Q.** Indeed.
 17 **A.** Yeah.
 18 **Q.** So broadly accurate but insufficient?
 19 **A.** A big -- I mean, I think all of us who were there --
 20 I mean, actually I have a photograph on my phone of
 21 an empty train as I went into London that week. It felt
 22 enormous. But actually, I think, if we remember, it was
 23 not as enormous as the next week. I mean, the next week
 24 it was really sort of wind down an empty street, wasn't
 25 it?

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1 enough information on that date to say "We need to stop
 2 all non-essential contact".
 3 **MS CECIL:** My Lady, I'm going to turn to another topic.
 4 It's slightly earlier than would ordinarily be the break
 5 but it may be that now is an appropriate moment.
 6 **LADY HALLETT:** Thank you, I shall return at 10.50.
 7 (10.37 am)
 8 (A short break)
 9 (10.50 am)
 10 **LADY HALLETT:** Ms Cecil.
 11 **MS CECIL:** My Lady.
 12 Professor, if I may just pick up very briefly on
 13 lockdown. We'd just got to the point of the first
 14 lockdown and the stay at home guidance. You were
 15 expressing your views on the timeliness of that
 16 lockdown.
 17 Can I just be clear, is that from a public health
 18 perspective?
 19 **A.** Yes. I'm not entirely sure it's sensible to completely
 20 separate out the public health perspective and all the
 21 other costs. I think, actually, you had strong evidence
 22 from my colleague Tom Hale in Oxford that the countries
 23 that did best were countries that kept incidence low,
 24 and they had both better health outcomes and better
 25 economic outcomes. So the idea that it was this pure

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1 **Q.** Indeed. And that's when, of course, lockdown was
 2 announced?
 3 **A.** Yes.
 4 **Q.** Now, with respect to the announcement of lockdown in
 5 terms of its timeliness --
 6 **A.** Yeah.
 7 **Q.** -- what is your view on that?
 8 **A.** You've already heard from colleagues that it was too
 9 late. So if we're doing a with benefit of hindsight
 10 exercise here, I would say it should have been two weeks
 11 earlier, you know, that that would have made a really
 12 huge difference. Now, we didn't have the data two weeks
 13 earlier, so ... by the 16th we had -- we had enough
 14 data. In my opinion we should have gone into lockdown
 15 on that Monday the 16th.
 16 **Q.** And that's the critical period from your perspective,
 17 the 16th? The 16th is that critical timing, in terms of
 18 the datasets that you had at the time --
 19 **A.** Yes.
 20 **Q.** -- and the knowledge base that you had at the time?
 21 **A.** I think on the 16th, given what we knew about how fast
 22 this epidemic was spreading, given what we knew and
 23 could surmise about the fact that there seemed -- that
 24 probably everybody could catch it, I mean, probably
 25 everybody was susceptible to catch it, I think there was

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1 trade-off, one thing or the other, I don't think is
 2 a helpful mindset.
 3 **Q.** Indeed. But, of course, when considering lockdown --
 4 **A.** Yeah.
 5 **Q.** -- there are other factors and there are other broader
 6 considerations alongside the public health
 7 considerations, as you have identified, economics, which
 8 may go one way or the other.
 9 **A.** Yes.
 10 **Q.** Indeed.
 11 Then just dealing with your point about lagged
 12 delays. So we have the announcement of the lockdown on
 13 23 March and stay at home, and we see -- and you've set
 14 it out within your witness statement -- that, again,
 15 peak hospital admissions then subsequently fell ten days
 16 later on 2 April.
 17 **A.** Yes.
 18 **Q.** What does that mean in terms of the R number, from your
 19 perspective?
 20 **A.** From my perspective, that tells us that the R number
 21 fell below 1 for the first time about ten days earlier,
 22 namely on 23 March.
 23 **Q.** So we're seeing those correlations, and you've given two
 24 examples now --
 25 **A.** Yes.

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- 1 Q. -- in your evidence so far.
- 2 In terms of support for that view, what you also set
- 3 out is the alternative, if the R number had been higher
- 4 during that second half of March.
- 5 What implications would that have had in relation to
- 6 the first wave?
- 7 A. Well, let's -- there are various possibilities. If it
- 8 had been higher and above 1, hospital admissions would
- 9 have continued rising, I think. I mean, that would have
- 10 been intolerable. We were -- everybody was very, very
- 11 worried those days in early April. Was it going to
- 12 peak? Would the stay at home law -- so would the
- 13 imposed lockdown be enough to bring R below 1? That was
- 14 the first thing. So that's -- a terrible outcome would
- 15 have been if hospital admissions had carried on rising.
- 16 But even if it had fallen a little bit below 1,
- 17 say -- we think now it fell to about 0.7. If it had
- 18 fallen but not that much, that first wave would have
- 19 been bigger. It would have -- so we'd have had a peak,
- 20 but it wouldn't have come down so fast.
- 21 I think most people feel that the first wave was bad
- 22 enough.
- 23 Q. I suspect that's a view that's broadly shared --
- 24 A. Yeah.
- 25 Q. -- and uncontroversial.

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- 1 and most of our population is susceptible to it, and we
- 2 don't know when we might have either drugs that are so
- 3 great that we can treat infections really well, or
- 4 a vaccine. So we don't know how long this is going to
- 5 go on for, let's start to have a think through what we
- 6 can do about it.
- 7 And so in some ways I would say the low incidence
- 8 and the high incidence comparison that we ended up
- 9 making was an attempt to start a conversation, both with
- 10 policy-makers and decision-takers, along the lines of:
- 11 well, what is your strategy? What's the plan?
- 12 Q. Indeed, and a lack of strategy or clear plan or
- 13 strategic aim is one of the primary themes that's
- 14 contained within your witness statement.
- 15 A. Yes.
- 16 Q. If I can deal with that briefly with you now.
- 17 You explain that the primary strategy that evolved
- 18 or the closest thing you got to was the focus on the
- 19 R number.
- 20 A. That's right.
- 21 Q. What impact did that have in terms of strategic thinking
- 22 and your ability within SAGE and indeed SPI-M-O --
- 23 A. Yeah.
- 24 Q. -- to model interventions and to provide, effectively,
- 25 options that could be developed to policy?

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- 1 If I can ask you questions then about your
- 2 involvement in the exit from lockdown. You've already
- 3 touched upon one aspect of that by reference to your
- 4 colleague, Professor Thomas Hale --
- 5 A. Yeah.
- 6 Q. -- in relation to low incidence --
- 7 A. Yes.
- 8 Q. -- and the role that that may have played in relation to
- 9 pandemic response and outcomes.
- 10 Now, in April, on 10 April, you attended a working
- 11 group on the science of exit from lockdown, and at that
- 12 meeting, that working group, there were two scenarios
- 13 that were being discussed, weren't there: a low
- 14 incidence scenario and a high incidence scenario.
- 15 Can you just explain for us in simple terms what
- 16 a low incidence scenario is, and then we'll move in
- 17 a moment to the high incidence.
- 18 A. So I think a good way of labelling those -- we ended up
- 19 labelling them "hospitals empty" or "hospitals full".
- 20 So high incidence actually wasn't all that full. And
- 21 the question -- actually, what we wanted to do was start
- 22 to have strategic think-through about: what are we going
- 23 to do? You know, we're in a deep hole here. We've got
- 24 a nasty infectious disease circulating that is -- makes
- 25 many people very ill, and sadly kills quite a lot too,

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- 1 A. So I think if we were to be very straightforward, we
- 2 could say the ends were: you will not collapse the NHS.
- 3 So that was the strategic aim. The ways were: well,
- 4 we'll control mixing so the R number is slightly less
- 5 than 1. And my feeling was that was only really half of
- 6 an explanation of what we were trying to do, because R
- 7 round about 1 just means that the number of infections
- 8 each day is flat. So you can have R round about 1 with
- 9 hardly any infections each day, or R round about 1 with
- 10 lots and lots of infections each day. So it didn't
- 11 express an opinion about what those in power thought was
- 12 the right way to work our way through this very
- 13 difficult situation, I felt.
- 14 Q. For example, by otherwise considering other targets,
- 15 such as the number of infections each day, or even, as
- 16 unpalatable as it sounds, the maximum tolerable limit in
- 17 terms of deaths.
- 18 A. Yes, or we could perhaps have had -- I think it would
- 19 have been helpful if we had had an expression from the
- 20 NHS of how many people could they manage in hospital at
- 21 any one time with Covid, whilst also doing all the other
- 22 things that we need the NHS to do. But there was no
- 23 appetite ever to express with such clarity what the plan
- 24 was.
- 25 Q. And the consequence of that is that there's no target

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1 that's breached --

2 **A.** No.

3 **Q.** -- potentially, and effectively a trigger -- or for use

4 of a shorthand, to trigger other interventions or to

5 bring in further aspects of a plan.

6 **A.** There were some levels, weren't there? There were those

7 five levels I expect other people have talked to you

8 about. But I don't think we ever had from central

9 government: we want R slightly less than 1 and the

10 number of new infections per day less than, let's say,

11 some thousands of numbers.

12 **Q.** And did you request further guidance or a clear

13 strategic aim?

14 **A.** I certainly requested them of my civil service contacts,

15 and, I mean, they got to a stage where they knew what

16 I was going to say, you know, because the plans would

17 come back that it was, you know, sort of a tolerable

18 number or something, and they knew I was going to say,

19 "Well, what is a tolerable number? What number is

20 that?" But, I mean, I think it's very clear that that

21 was a choice, not to articulate a number on what was

22 tolerable.

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

24 **A.** Indeed.

25 **Q.** The consequence from your perspective -- and

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1 you could imagine a world where we had said -- well,

2 where decision-takers had said, "Oh, gosh, we've

3 breached the target, let's get a grip", and that is not

4 what happened.

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

6 But coming back, then, to 10 April and this working

7 group, this was an effort in terms of low and high

8 incidence --

9 **A.** Yeah.

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

11 cold terms --

12 **A.** Yes.

13 **Q.** -- to engage or get decision-makers and policy-makers to

14 engage with what it was that they saw as a clear

15 strategy.

16 **A.** Yes, and the point of that document was to lay out how

17 different things would be with respect to a whole lot of

18 different factors. For example, contact tracing is only

19 really going to be able to make a huge difference if

20 you're running a cold epidemic, if you've got low

21 incidence, because once incidence is really high, it

22 becomes very difficult to do contact tracing well enough

23 to find everybody who's got infected and get them into

24 isolation. So there is quite a long table in that

25 document of sort of careful thinking about what would be

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1 I appreciate this is from a public health or science

2 advisory perspective that I'm asking you to speak about

3 here -- was that it was very difficult -- well, was it

4 very difficult to therefore model and plan and provide

5 a route through?

6 **A.** So if you're not told what's the objective, it becomes

7 very difficult to say, "Watch out, you're three weeks

8 from breaching your objective", say. So we always had

9 to impose an objective of our own. So somewhere else in

10 these documents you will see a document where we say,

11 "Well, you're a few weeks from having more admissions

12 every day than you had in the peak of the first wave".

13 That wasn't because somebody else had said, "Please do

14 that calculation"; it was because we felt

15 decision-takers needed to see that calculation because

16 things were getting so bad.

17 **Q.** Indeed. So with a clearer goal or level or strategic

18 aim in mind --

19 **A.** Yeah.

20 **Q.** -- would it have been possible, looking back, to have

21 managed the pandemic more effectively?

22 **A.** Looking back, let us imagine that in September 2020 we

23 had breached some then specified level -- actually we

24 did, we breached the reasonable worst-case scenario,

25 which had been specified by Covid-S, not by us -- we --

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1 the difference between these two.

2 **Q.** Thank you.

3 **A.** If I may, there is -- I think really the closing

4 paragraph of that document finished the question for us,

5 in which somebody makes the point or the point is made:

6 well, let's just imagine that low incidence is about

7 one-fifth of high incidence, that means we're accruing

8 immunity five times more slowly, that means -- if we

9 think roughly speaking -- we did think roughly speaking

10 we'd get to a useful amount of immunity in one year with

11 high incidence.

12 **Q.** With high incidence?

13 **A.** With high incidence. That means if we think we might

14 get a vaccine or a really good pharmaceutical, a really

15 good drug, in anything less than five years, then we

16 should go for low.

17 **LADY HALLETT:** Can I --

18 **A.** And that was sort of the killer for us. That was the

19 end of the question for us.

20 Yes.

21 **LADY HALLETT:** Sorry to interrupt.

22 Can I just go back to the point about not having

23 a plan.

24 **A.** Yeah.

25 **LADY HALLETT:** I appreciate having a plan or a strategy

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1 would make your life and the lives of your colleagues
 2 a great deal easier to provide what you considered to be
 3 more accurate and sensible advice, but provided the
 4 experts advising decision-makers were getting the
 5 message across that this was going to be a nightmare,
 6 the NHS would be overwhelmed, do you have to have
 7 a target that gets breached?
 8 **A.** No. No, we don't. We might come to that at the end,
 9 because there was never any target expressed in the 2021
 10 spring documents. There's no numerical target.
 11 I would say it's probably more to do with politics
 12 and values and acting fast. I mean, I think the fact
 13 that fast action was required, I think that is
 14 a scientific issue, because it's to do with the system
 15 science of -- it's basically to do with fast exponential
 16 growth and fast talking. Fast exponential growth and
 17 lag delays, those are scientific issues. I think
 18 articulated targets might have driven faster action, and
 19 in that case would have been good from the point of view
 20 of pandemic control.
 21 **LADY HALLETT:** Thank you.
 22 **MS CECIL:** We'll touch upon that as we come into the autumn
 23 period in due course, and then indeed we will turn to
 24 the roadmap and the targets and objectives that were
 25 outlined there and the policy objectives.

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1 As a simple way of explaining to those
 2 decision-makers what the consequences of either hot or
 3 cold, low or high incidence, would be.
 4 Now, in terms of SAGE and your colleagues, the
 5 general consensus was that the low incidence approach
 6 was the preferable one.
 7 **A.** Correct.
 8 **Q.** And that was communicated upwards.
 9 **A.** I assume so. Yes, I think -- so I'm pretty sure that
 10 what happened is that Chris and Patrick wrote their own
 11 version of this document, which they, I assume, then
 12 took to Cabinet.
 13 **Q.** We touched upon that already in terms of some of the
 14 evidence that we've heard.
 15 Now, just if I may now turn to another aspect, that
 16 alongside all of this, while you're running through
 17 those scenarios, you're also considering the
 18 possibility, at least, of elimination.
 19 **A.** Discussing, yeah.
 20 **Q.** Indeed, and you raised that --
 21 **A.** Yeah.
 22 **Q.** -- on 18 April and indeed on 19 April, firstly in
 23 an email to Professor Medley on the 18th, and then
 24 secondly in a conversation with Professor Sir
 25 Patrick Vallance. In respect of that, you're

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1 Perhaps just to round off this, if I can just bring
 2 up INQ000212100. This is an email from you. It's the
 3 one that attaches your paper that we've just been
 4 discussing. But you boil it down to
 5 Sir Patrick Vallance within this email -- if I can just
 6 go down slightly further -- into a very simply
 7 dichotomy, in many respects --
 8 **A.** Yeah.
 9 **Q.** -- for politicians, so decision-makers:
 10 "Do you want to keep COVID deaths as low as possible
 11 until pharmaceuticals produce a solution [that's your
 12 vaccine or your medicine]
 13 "Or
 14 "Are you prepared to define a tolerable level of
 15 COVID deaths that would allow us to start moving towards
 16 an immune population whilst we wait."
 17 And of course, as you say:
 18 "The devil then is how small can 'tolerable' be and
 19 still move us towards an immune population at some
 20 meaningful rate."
 21 And then you explain further, as you've just touched
 22 upon:
 23 "... if you want to be at population immunity within
 24 a year, we cannot imagine getting there with any fewer
 25 than N deaths ..."

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1 essentially saying: have we properly considered it?
 2 Have we ruled this out as a potential option?
 3 You also address within that the potential for the
 4 health and social care infections to be driving the
 5 community epidemic as opposed to the other way round,
 6 with the community epidemic driving the health and
 7 social care infections.
 8 We've not seen any further material in relation to
 9 pursuing elimination as a strategy, but what were your
 10 views at that time, and was it a possible strategy to be
 11 pursued?
 12 **A.** So quite quickly, because the infection was so widely
 13 seeded across the population, and as we were finding out
 14 more about asymptomatic infections, it was very clear
 15 that it was not feasible. At that point, I -- we
 16 probably had a discussion in which we said: well, we
 17 could do a bunch of calculations, we could make a model,
 18 we could, you know, do some squiggly Greek letters, but
 19 at the end of the day we're just going to say exactly
 20 those words. So this was a place where doing some
 21 modelling simply doesn't add anything, so let's not do
 22 it. So that was elimination.
 23 I think I did feel then: let's challenge that a bit,
 24 let's make absolutely clear, because Australia and
 25 New Zealand were aiming for elimination, but -- so let's

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1 be clear in our heads why we think it's not going to be
2 possible. And for people like us, the way to be clear
3 in your heads is to think it through with a little
4 model. But it clearly wasn't a useful way to spend
5 a lot of time for SPI-M.

6 **Q.** Indeed.

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

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

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

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

24 **Q.** Thank you.

25 Now, as we emerged from lockdown 1, and moving then
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1 observed at that period in the pandemic?

2 **A.** I do not remember exactly what happened with the
3 unlocking of the lockdown through the summer of 2020.
4 I'm sorry, I can't exactly remember.

5 **Q.** Not at all.

6 **A.** Numbers were low then.

7 **Q.** Thank you.

8 In terms of any feedback loop that you had, what did
9 you consider the main drivers within government would
10 have been in relation to exit strategies from lockdown
11 and, more generally, the loosening of restrictions?

12 **A.** There were very clear indications that, quite
13 reasonably, recovery of economic activity was a very
14 strong driver. We can tell -- we can remember now that
15 getting children back to school for sure for September
16 was a very strong driver, and I can remember debate that
17 if we wanted children back at school -- and clearly we
18 did -- we might well have to put a lot of restrictions
19 on other kinds of activities.

20 **Q.** Thank you.

21 **A.** Especially given that contact tracing was not ramping up
22 as fast as we had hoped.

23 **Q.** Indeed.

24 Now, if I may take you, please, to paragraph 120 of
25 your statement at page 36. This is dealing with the
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1 into the summer months of then May 2020, you took part
2 in -- well, over the course of the pandemic -- a number
3 of Number 10 Downing Street press conferences.

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

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

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

20 **Q.** Thank you.

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

24 **A.** Yeah.

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

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

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

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

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

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

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

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

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

21 But perhaps then therefore going to the summer of
 22 2020, and you've explained that infections were low, the
 23 R rate was around 0.7 or so at that stage in the summer,
 24 we then move into the June, July, August period, and
 25 of course in July, the Eat Out to Help Out policy was

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1 22 June 2020, and it's INQ000074930, it's page 1, and if
 2 I can go to paragraph 4.

3 Here, what we see within SPI-M-O is effectively it's
 4 looking at how one goes forward and takes NPIs forwards
 5 and relaxation, and what's set out here is that:

6 "Rather than focusing on re-introduction or
 7 relaxation of individual measures in isolation, it is
 8 necessary to consider a package of interventions as
 9 a whole and what implications one measure may have for
 10 the choices in [another]."

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

12 **A.** Yeah. Absolutely.

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

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

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

23 **A.** Yeah.

24 **Q.** So the committee:

25 "... do not believe it is possible to return to

75

1 announced.

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

4 **A.** That is right.

5 **Q.** Was SPI-M-O consulted?

6 **A.** We were not consulted.

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

10 **A.** Correct.

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

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

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

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

24 **Q.** If I can just call up, please, a SPI-M-O paper which
 25 deals with social distancing measures. It's dated

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1 a 'pre-COVID' normality, without levels of contact
 2 tracing and COVID security effectiveness that would be
 3 difficult to achieve without some sort of additional
 4 increase in immunity ..."

5 Or vaccines, and so on.

6 Just to be clear, Covid security; effectively, NPIs?

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

13 **Q.** If we continue at paragraph 5, it states:

14 "In order to be able to re-open schools in September
 15 without causing a second wave, it [is] therefore
 16 critical that some measures remain in place."

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

20 **A.** Yes.

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

23 **A.** And August.

24 **Q.** And August.

25 **A.** And September.

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- 1 Q. Indeed.
- 2 Now, at that point of the advice in June and through
- 3 July, the R number was 0.7 to 0.9, and it began
- 4 increasing in August. Indeed, upon school return in
- 5 September, it was between 0.9 and 1.1, and then
- 6 increased to an R rate of 1 to 1.2 by 11 September, and
- 7 then we saw an increase upwards.
- 8 So in respect of that second wave, was that second
- 9 wave foreseeable?
- 10 A. Yes, that second wave was foreseeable. I mean -- but
- 11 because -- for the simple reason that virtually nobody
- 12 had had it.
- 13 Q. And, indeed, winter was also coming.
- 14 A. Yes.
- 15 Q. And we've heard from Professor Sir Chris Whitty that
- 16 history has taught us that, in pandemics, second winter
- 17 waves often far exceed the first wave.
- 18 A. They do indeed. Actually, I think most parents know
- 19 that September is a time of year when respiratory
- 20 infections are often rife.
- 21 Q. Indeed, September to December is constant germ after
- 22 germ.
- 23 A. Yeah.
- 24 Q. So if I can then move into the September period, so
- 25 schools returning, and if I could just take you, please,

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1 So it would have been in our minds all along that if

2 we wanted this time to keep infections flat whilst they

3 were still low, so not get ourselves into a panicky

4 situation where it's all running away from us, this was

5 when we needed to do it, and, you know, this idea that

6 the interventions that keep an epidemic flat are not as

7 bad, not as damaging, as the ones that you have to

8 impose if you've got to get cases down really fast.

9 So that was the time to act, we felt, and we kept

10 saying so, and I suppose we couldn't understand: why

11 weren't we explaining clearly enough that this was what

12 we needed to do?

13 Q. Indeed.

14 If I could just call up the SAGE minutes from

15 17 September of 2020.

16 A. Yeah.

17 Q. -- it's INQ000061565, and it is paragraph 3 on page 2.

18 A. Yeah.

19 Q. What we see here is advice in relation to

20 a circuit breaker, and it explains:

21 "... where more stringent restrictions are put in

22 place for a shorter period could have a significant

23 impact on transmission. Modelling indicates that

24 a 2-week period of restrictions similar to those in

25 force in late May could delay the epidemic by

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1 to paragraph 153 of your statement. It is on page 47.

2 You describe this quite acutely as the "worst moment

3 of the pandemic". Why do you say that? Why do you

4 describe it in those terms?

5 A. It was very frustrating for us to have been asked to

6 advise the government, and to advise the government that

7 the autumn would be difficult and that that difficulty

8 would manifest as rising numbers of infections, and then

9 we had this astonishingly good ability to watch that

10 happening with the ONS Covid infection study, and it

11 proceeded to happen, so we said, "You should do

12 something now", but nothing happened.

13 Q. Do you recall the earliest point at which you said, "You

14 should do something"?

15 A. Let's have a think. I ... we had made the -- in the

16 summer, we had made the new reasonable worst case, so

17 that was the one that sort of ran from, I should think,

18 about August into late autumn, and in the reasonable

19 worst case -- which, as I say, was based on actions

20 specified by Covid-S -- cases start to tick up in early

21 September, as we would always have expected it to have

22 done, and I can't remember where the words came from,

23 but in the reasonable worst case, somebody gets a grip,

24 so actually what happens is that cases are then flat

25 through September.

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1 approximately 4 weeks."

2 A. Yes.

3 Q. So was a circuit breaker the advice that was being given

4 at that point?

5 A. Yes, that was the SAGE advice. So a circuit breaker is

6 an intense intervention where what you do is you bring

7 cases down, say for a fortnight, and then you let go

8 again.

9 Q. So something short of, effectively, a full lockdown, or

10 if you were looking at it in a slightly different way

11 and using your earlier terminology, an intermittent

12 lockdown of a shorter period.

13 A. Yes.

14 LADY HALLETT: What's the point of doing that if it's just

15 going to come back, if you don't know when you're going

16 to have a vaccine?

17 A. That eventually you're going to have to do something.

18 So keeping infections low may be with intermittent

19 lockdowns, so you do circuit breakers for two weeks, you

20 go back to normal life for four weeks, but that is not

21 as damaging as the -- what Tom Hale described as the

22 rollercoaster, where you let infections grow until

23 you're just about to break the NHS, and then you bring

24 in a massive, massive lockdown. So it's a way of

25 keeping infections low whilst not being in lockdown all

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1 the time.

2 **LADY HALLETT:** Why aren't intermittent lockdowns

3 a rollercoaster?

4 **A.** Because it's a very boring, little rollercoaster. So,

5 I mean, you're just going like this (indicated).

6 So, I mean, for example, your contact tracing works

7 better because you've never got very high incidence.

8 Your hospitals work better because they're not

9 completely full. I mean, one of the things that we

10 often -- well, that we saw was that fatality rates in

11 hospital were higher when the hospitals were fuller.

12 There were plenty of good reasons why intermittent,

13 short lockdowns could well have been better than the

14 long, harsh lockdowns that we had to live because we put

15 them off to the last possible moment.

16 **MS CECIL:** And that's pulling it back to the low --

17 **A.** Yes.

18 **Q.** -- incidence rate, as opposed to the high incidence

19 rate, running an epidemic hot or cold?

20 **A.** Yeah.

21 **Q.** Trying to keep a lower level of infections, albeit they

22 go up and down and rise up and down. They don't meet

23 that peak, effectively.

24 **A.** That's right.

25 **Q.** Now, you were subsequently invited to a meeting with the

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1 explanation of -- I think the title of the meeting was

2 something like, "Should the government act now?"

3 **Q.** Indeed, I'm going to move to that in just a moment --

4 **A.** Okay, fine.

5 **Q.** -- and we'll discuss the meeting and what views were put

6 across within that meeting and, indeed, your view at

7 that point.

8 **A.** Yeah.

9 **Q.** And then what we see here, just to round this off so we

10 can take it away, from Patrick Vallance back is:

11 "This is a meeting where the [Prime Minister] wants

12 to hear from a range of scientists (specifically the

13 Heneghan and Gupta let it rip variety). We have got

14 a rather balanced group to make sure he hears all sides.

15 Message re getting a grip - yes please."

16 Indeed, I'm going to maybe just deal with that now:

17 do you consider that you got across that message within

18 that meeting?

19 **A.** I said those words. I don't know -- I mean, nothing

20 happened, so inadequately at best.

21 **Q.** If I can turn to that meeting now, and you were just

22 speaking about speaking with one voice. So

23 Sir Patrick Vallance was on the same page as you, is

24 that fair to say, at that point?

25 **A.** I think so, yes.

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1 Prime Minister on 20 September of 2020, and I just want

2 to deal with something very shortly before that and

3 prior to the meeting on 18 September.

4 It is some messages with Sir Patrick Vallance. It's

5 on INQ000229601. It's the bit at the bottom that I'm

6 interested in. It says:

7 "I have an invite to a zoom with the

8 [Prime Minister] at 1730 on Sunday. I'd be honoured to

9 accept that invitation. However I assume this is the

10 meeting you and Stu were organising yesterday

11 [presumably a reference to Stuart Wainwright at

12 GO-Science]. Does it fit your plan if I rock up and say

13 'RWCS [reasonable worst-case scenario] assumes someone

14 gets a grip at this stage of things and it would be

15 great if that happened'."

16 Can you explain in your own words what you were

17 trying to impress upon certainly Sir Patrick at that

18 point and your view?

19 **A.** I wanted to -- I'm quite a believer in the single voice

20 of consensus science. So what I was checking here

21 was -- basically running past Patrick what I'm planning

22 to say so that he knows in advance of the meeting. And

23 "[Reasonable worst-case scenario] assumes someone gets

24 a grip at this stage", we just talked about that.

25 We were all invited to write a single-page

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1 **Q.** SAGE and SPI-M-O?

2 **A.** Yes.

3 **Q.** So all unanimous going into that meeting in terms of

4 that perspective.

5 Now, if I can just call up the meeting, please.

6 Thank you. This is the "Covid-19 small group scientific

7 discussion", that was the formal name given to it. We

8 see that, indeed, you're right about the question, the

9 essay question, as it may have been posed, or exam

10 question: "Should government intervene now and if

11 so ..."

12 We see a list there of attendees. We have the names

13 redacted, but the reality is it's all in the public

14 domain in any event and, indeed, we have a statement.

15 The first of those is Professor Gupta and the second of

16 those is Anders Tegnell, the Chief Scientist in Sweden.

17 But we see the Prime Minister, the Cabinet Secretary,

18 who is chairing it, Sir Patrick Vallance, Professor Sir

19 Chris Whitty, Professor John Edmunds -- and we'll move

20 to him in a moment -- Professor Carl Heneghan, who we've

21 also heard from, and then you.

22 For the purposes of this meeting, as you've just

23 explained, you were asked to set out your views in

24 a one-page document, a very short document.

25 If I can just deal with the position in relation to

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

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

9 **Q.** Indeed.

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

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

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

22 "I believe there is a strong consensus that with
23 a pandemic a government needs to be active even if we
24 know that most of the non-medical measures have
25 comparatively little effect and the evidence for how and

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1 interventions. At the bottom of that page, to the left,
2 you explain that both scenarios assume that decisive
3 action is taken now.

4 **A.** Yes.

5 **Q.** And it says -- expands a little bit:

6 "... assume decisive action in mid-September brings
7 R back to 1 so that new infections remain flat for
8 6 weeks."

9 **A.** Yeah.

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

12 **A.** Yes.

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

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

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1 when they work is limited. But even so there is
2 a possibility to make a difference."

3 So that's Professor Tegnell's view.

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

7 **A.** Yes.

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

10 **A.** Yes.

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

12 **A.** That's right. So that little picture at the top left
13 was given to SPI-M-O by Covid-S saying, "Do something
14 a bit like the top -- the red line here", so a difficult
15 autumn followed by a large winter peak. So that red
16 arrow, I think, that I've put on there says: this is
17 roughly where we are towards the end of September.

18 Things were okay in July, they've been getting a bit
19 worse. There it is, with the -- so can you see the
20 dotted red line being flat for a while through October.
21 So that wasn't going to happen without some substantial
22 intervention.

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

25 You then set out a position where with

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1 they're getting worse.

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

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

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

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

21 **A.** Yeah.

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

24 **A.** Yes.

25 **Q.** So those that were most badly hit in the first wave are

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1 also being most badly hit in the second wave.
 2 Then finally, in part 3 of your paper --
 3 **A.** Yeah.
 4 **Q.** -- you explain what happens next, where does this end
 5 up --
 6 **A.** Yeah.
 7 **Q.** -- the trajectory.
 8 **A.** Yeah.
 9 **Q.** And what you explain here is that under the current
 10 trajectory, hospitalisations will increase
 11 exponentially, surpassing the first wave by early
 12 November.
 13 **A.** That's right.
 14 **Q.** Then you go on to explain about the governmental
 15 planning, you explain that epidemiology is in line with
 16 the reasonable worst-case scenario but infections are
 17 still rising, and you explain that you expect that
 18 reasonable worst-case scenario to be breached.
 19 **A.** In days.
 20 **Q.** In days.
 21 **A.** And I think that closing sentence is worth noticing:
 22 "[Test and trace] will not function effectively in
 23 a large second wave."
 24 **Q.** And, of course, that's one of the tools in the pandemic
 25 toolbox.

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1 because he has explained his views earlier in the
 2 evidence, but I certainly can. If I can just call it
 3 back, they're in the pages that precede this one.
 4 I believe they're on pages 10 and 11, from recollection,
 5 I'm afraid, if I can just go to those, but we can
 6 certainly have a look at them. **(Pause)**
 7 Back one further page, in that case. Start on
 8 page 9.
 9 This is Professor Heneghan's views. We see here
 10 that, halfway down the first paragraph, he takes the
 11 view that:
 12 "Recent responses are out of proportion to the
 13 threat. They are underpinned by a lack of understanding
 14 of the data, the role of community pathogens and an
 15 overreliance on predictive modelling."
 16 He very strongly bases that on the fact that it has
 17 effectively been influenza preparedness, and that that
 18 has had a significant impact upon the advice that's been
 19 provided, and effectively that advice is wrong.
 20 What are your views in relation to that?
 21 **A.** I think that we were expecting a large autumn wave and
 22 that something needed to be done to prevent it. Sadly,
 23 that large autumn wave did happen. I don't really think
 24 that's to do with was this influenza or was it
 25 a different respiratory infection; it was a respiratory

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1 **A.** Yeah.
 2 **Q.** Now, Professors Gupta and Heneghan put forward
 3 an alternative view within that meeting. A large part
 4 of that was effectively advanced on segmentation or
 5 protecting and isolating vulnerable groups, and
 6 establishing a degree of herd immunity.
 7 What were your views in relation to those
 8 alternative views?
 9 **A.** I think our experience had already been that it was
 10 extremely difficult to protect vulnerable groups; that
 11 first of all it was practically very hard to put in
 12 enough protections so that infection never reached the
 13 known vulnerable, that's thing 1; and, secondly, there
 14 were lots of people who ended up very ill, either with
 15 acute Covid or with Long Covid, who were not amongst the
 16 known vulnerable. So we didn't think -- I didn't think
 17 it was a practical approach at all.
 18 **LADY HALLETT:** Ms Cecil, I don't know if you're going to
 19 come to it, but you've referred us to the Swedish
 20 expert's views on the screen, and Professor McLean's
 21 views. Are Professor Gupta and Professor Heneghan's
 22 views going to be displayed, or are they not in this
 23 document?
 24 **MS CECIL:** They are in this document. I wasn't going to
 25 take you to them in relation to Professor Heneghan

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1 infection to which there was very, very little immunity
 2 in the population at that time because, dreadful though
 3 the first wave felt, it actually infected rather a small
 4 proportion of the population.
 5 **Q.** If we can just look a little bit further down this page,
 6 please. I touched upon it earlier in relation to the
 7 control strategies that they were -- collectively, there
 8 are differences between their papers, but one aspect of
 9 it was about those targeted measures and segmentation,
 10 and there has been a criticism levelled that
 11 segmentation was never considered properly by SPI-M-O or
 12 SAGE.
 13 What do you have to say about that?
 14 **A.** It was quite carefully considered. Segmentation can be
 15 used in several different ways. One way of thinking
 16 about it would be simply on age. Should we have let the
 17 over 40s -- sorry, the under 40s or the under 45s live
 18 a normal life whilst everybody else was in lockdown?
 19 I would say it's very clear. You don't need modelling.
 20 You can just look at the data that we have about
 21 household composition, so what age of people live with
 22 other people, or we have beautiful data about who mixes
 23 with whom. I talked a bit about that with the BBC data.
 24 It was very, very clear that there was far too much
 25 mixing between different age groups for that sort of

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1 segmentation plan to work, because even a little bit of
2 leakage from -- if you had half the population leading
3 a normal life, back into the segmented, is enough to be
4 very, very damaging at this point in time, when immunity
5 in the population was so very low. So that's age
6 segmentation.

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

18 **Q.** Just dealing, if I may, then with segmentation. Indeed,
19 there's various different ways of referring to it; we
20 have heard about shielding, we've heard about
21 super-shielding and we've heard some evidence on
22 cocooning as well. But in terms of SAGE, SAGE had
23 indeed sought earlier advice and notes on
24 segmentation --

25 **A.** Yeah.

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1 a whole lot of new immunity between May and September
2 that would have made our situation better, and contact
3 tracing was revving up, but was more like 20% efficacy
4 than anything higher.

5 **Q.** Thank you.

6 Then if I can just take you, please, to
7 Professor Gupta, and she is a professor of theoretical
8 epidemiology at Oxford University.

9 **LADY HALLETT:** The same department you have been in.

10 **MS CECIL:** Indeed, at the department of zoology. She has
11 been a fairly high-profile critic of the approach
12 undertaken by, indeed, SAGE, SPI-M-O and the government
13 during the pandemic.

14 In summary, her views, as espoused within this
15 document, are that restrictive measures that have been
16 imposed have been outweighed by the cost, particularly
17 for those poorest or most vulnerable, firstly. That is
18 a broader issue, rather than simply the epidemiological
19 position, or the public health position, because
20 obviously that takes -- that's looking at socioeconomic
21 considerations and other considerations. But also
22 refers to herd immunity, if I can just ... It's at
23 page 8 of the document, please.

24 The starting premise here in terms of the key issue
25 from her perspective in terms of her note was:

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1 **Q.** -- all the way back in the summer, effectively,
2 June/July, and indeed shielding conversations had taken
3 place much, much earlier than that.

4 **A.** Yes.

5 **Q.** Thank you.

6 One aspect that you may have found some level of
7 agreement with Professor Heneghan in relation to was
8 that relating to care homes that he flags.

9 **A.** Yeah.

10 **Q.** There is an aspect in relation to nosocomial infections.
11 He's advancing something that is effectively a much less
12 restrictive set of NPIs, with a 50% work at home
13 strategy; on young people, simplify messaging; and then
14 also, in his view, seeking to increase the personal
15 threat perception should also be reconsidered, and that,
16 alongside a couple of others, was considered to be
17 sufficient.

18 In your view, as at 20 September 2020, would those
19 measures have been adequate or sufficient to have
20 prevented the second wave?

21 **A.** I think not. Particularly -- I mean, if you look at
22 what's happening here, the only community-level
23 intervention here is 50% work at home strategy. If you
24 think about those pictures I showed you earlier of ready
25 reckoners, 50% wouldn't be enough. We hadn't acquired

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1 "... whether or not it is justified to take
2 extraordinary measures in response to Covid-19 - given
3 that no extraordinary measures are in place for other
4 infectious diseases such as influenza, pneumococcal
5 pneumonia, and ... other coronaviruses."

6 And that's because:

7 "We have reached an accommodation with [those] and
8 accept that they cause a level of disease, suffering and
9 death, but not sufficient to change our way of life."

10 She accepts it's not possible or realistic to
11 attempt to eliminate Covid-19, but that the goal should
12 be to achieve levels of herd immunity.

13 She then goes on to speak about herd immunity not
14 being a policy and gives a little bit more of
15 a description there.

16 What is your view in relation to that?

17 **A.** I think these issues about: could we -- I think it says
18 here we can't tell -- we don't know how close we are to
19 the herd immunity threshold. I would disagree with that
20 statement. I think we could tell from quite
21 straightforward antibody tests that were available at
22 that time that could be applied in closed populations
23 with big outbreaks, where we could see how extensive
24 an epidemic would be before it naturally came to an end.
25 But we did have reasonable measures of how close we were

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1 to herd immunity and that we were a very long way from
2 it, and could therefore expect a large autumn wave,
3 which indeed did then happen.

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

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

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

21 **A.** Yeah.

22 **Q.** She speaks about:

23 "... the very low death rates of Covid-19 in much of
24 the population, while permitting and supporting the rest
25 to adopt social distancing measures commensurate with

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1 didn't do what we said, did they?

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

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

13 **A.** Yes.

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

21 **A.** Yes.

22 **Q.** And you're talking here about lockdown, and:

23 "If we had a better sense of how unpalatable
24 lockdown was to decision-makers, if anything this would
25 have expedited strong advice to lock down, rather than

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1 their risk."

2 And in fairness, Professor, I think you've already
3 dealt with those issues, because really it's talking
4 about, again, segmentation or cocooning or shielding in
5 some way, and then herd immunity.

6 So in terms of the meeting or the group and how it
7 progressed, were each of you given an opportunity to
8 present your papers and present your views?

9 **A.** That's right, that's how it went.

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

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

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

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

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

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1 give us cause to delay providing the advice or to weaken
2 its terms."

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

7 **A.** Yes, and --

8 **Q.** Here specifically about pandemics.

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

10 **LADY HALLETT:** I do apologise.

11 **A.** No, it's fine.

12 **MS CECIL:** In terms of how those views were expressed,

13 obviously that's how they were expressed on paper;
14 you've already explained that you did say to those in
15 the meeting, which of course included the Prime Minister
16 and other senior members of the government, that they
17 needed to get -- that somebody needed to get a grip.

18 **A.** Yes.

19 **Q.** How was that received?

20 **A.** In silence. I mean, they just sat there in silence and
21 listened to us. I don't remember there being many
22 questions, except -- I mean, a few -- except towards the
23 end, where I think somebody said, "What do you think we
24 should do?" They just went round the four of us and
25 said, "What do you" -- well, five of us, sorry, "What do

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1 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, but 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,

19 Anders Tegnell?

20 **A.** No.

21 **Q.** Or indeed --

22 **A.** John I do remember, because John said we need to be in

23 lockdown now, and it was unusual -- and I remember

24 thinking: oh, well, gosh, is he right and I'm wrong?

25 Can we sort of afford -- you know, have we got enough --

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1 combined reduced the R number to about 0.7. Indeed,

2 that's what we were looking at, if you recall,

3 earlier --

4 **A.** Yeah.

5 **Q.** -- when we looked at what the R number was in the

6 summer, June, when SAGE and SPI-M-O met.

7 So what he then says is:

8 "... to meet [Her Majesty's Government's] aim [as it

9 was then] of keeping R below 1 a large package of

10 interventions will have to be implemented, not just one

11 or two."

12 It talks about educational institutions; if they are

13 to remain open, a very wide package of other

14 interventions will be essential. And then what he talks

15 about is the imperative for speed of action. Response

16 "needs to be fast and large. The harder the measures,

17 the less time they need to be in place for."

18 **A.** Yeah.

19 **Q.** It then continues to explain that the UK responded

20 slowly in March and paid a heavy price for this in terms

21 of deaths.

22 "This shows - unambiguously - that the key factor

23 for the large number of deaths in the UK was the

24 lateness of our response. We should not make the same

25 mistake again."

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1 if we just need to keep incidence flat, can we manage

2 that with schools open?

3 **Q.** Indeed, we can bring up -- I've just realised we've not

4 taken you to Professor John Edmunds' paper, but that's

5 on page 7 of INQ000137261, and we see that he sets out

6 the current picture within the UK epidemiologically.

7 **A.** Yeah.

8 **Q.** In dealing with the herd immunity point, perhaps bullet

9 point 4 is relevant. His view was that only around 7%

10 of the population had been infected. Did that accord

11 with your view?

12 **A.** Yes, that's right. No, we had epidemiology. So we knew

13 that 7% of the population had antibodies, but we also

14 knew from a big outbreak that had happened on a fishing

15 vessel that antibodies appear after you have been

16 infected.

17 **Q.** It's explained here:

18 "Yet, around 50,000 have died. Letting the epidemic

19 run in the remaining 93% would result in around half

20 a million deaths."

21 Explains large incidence, including increase of

22 incidence in care homes. Epidemic is doubling every

23 seven to eight days. It then deals with a need for

24 a package of measures, lockdown and closure of all

25 facilities, et cetera, and all of those in March

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1 It goes on:

2 "Immediate action has an enormous impact when cases

3 are increasing exponentially, which they now are."

4 He sets out his graphs -- more graphs, I'm afraid --

5 which show the effect of an immediate circuit breaker.

6 "Any delay will result in far more cases ([and you

7 see the] dotted line on Figure 1b) and therefore

8 hospitalisations and deaths."

9 Then unequivocally he ends with:

10 "No intervention would be disastrous ..."

11 In terms of your views and Professor John Edmunds',

12 did they align?

13 **A.** I think pretty much, in that the bit where he says if we

14 want -- well, I certainly agree that no interventions

15 would be disastrous, that's for sure. I think the bit

16 where he says if we want to keep educational

17 institutions open, we will have to have very substantial

18 measures pretty much everywhere else, I think that was a

19 different way of saying the same thing: lockdown,

20 schools open.

21 **Q.** He speaks in here about not making the same mistake

22 again in relation to delay.

23 **A.** Yes.

24 **Q.** Did you consider that government was potentially making

25 the same mistake again at that point in September?

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- 1 **A.** I felt we were at that stage at risk of making the same
2 mistake again. If we had acted decisively then, we
3 would have learnt from March, but we didn't;
4 implication: we had not learnt from March.
- 5 **Q.** We know that there was no circuit breaker in September
6 at this stage.
- 7 **A.** No.
- 8 **Q.** Was that in your view, from your public health
9 perspective and epidemiological perspective, a mistake?
- 10 **A.** Yes, I believe that was a mistake. I think if we'd had
11 a circuit breaker in September, we could have kept
12 cases -- cases would have dropped a little bit and then
13 we would have bought some time.
- 14 **Q.** In the absence of a circuit breaker at that stage,
15 again, what were the consequences, from your
16 perspective?
- 17 **A.** The number of infections kept rising through September
18 and October with attendant hospitalisations and, sadly,
19 deaths.
- 20 **Q.** Had there been a circuit breaker, therefore, again, in
21 your view, would the number of deaths have been lower?
- 22 **A.** Yes.
- 23 **Q.** Now, in terms of the remainder of that meeting, were any
24 views expressed by the Prime Minister that you can
25 recall?

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- 1 "A package of interventions will need to be adopted
2 to reverse this exponential rise in cases."
3 And it then goes on to talk about single
4 interventions, coming back to the single or package of
5 interventions that we've discussed:
6 "Single interventions by themselves are unlikely to
7 be able to bring R below 1 ..."
8 And we see the confidence intervals. We've
9 discussed those previously in evidence.
- 10 **A.** Yeah.
- 11 **Q.** High confidence in that assertion.
12 "The shortlist of ... (NPIs) that should be
13 considered for immediate introduction includes ..."
14 And that's where we see:
15 "• a circuit-breaker ... to return incidence to low
16 levels.
17 "• advice to work from home ...
18 "• banning all contact within the home with members
19 of other households ...
20 "• closure of all [retail and hospitality, and so
21 on] ...
22 "• all university and college teaching to be
23 online ..."
24 So at this point, these are recommendations with
25 schools staying open.

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- 1 **A.** I don't remember the Prime Minister saying anything.
- 2 **Q.** The Cabinet Secretary?
- 3 **A.** No, I remember one person, but I don't remember who it
4 was, asking this question about: what should we --
5 meaning they, the government -- do, which we've just
6 talked about.
- 7 **Q.** Did either of Sir Patrick Vallance or Professor
8 Chris Whitty express a view in the meeting?
- 9 **A.** I'm sorry, I can't remember.
- 10 **Q.** Then we also understand that the Chancellor was present.
- 11 **A.** Well, I think perhaps he called in. I'm not certain.
12 I'm sure he was there.
- 13 **Q.** Did he make any contribution?
- 14 **A.** Well, you see, I think it was him who asked, "What
15 should we do?", but perhaps that's just an incorrect
16 memory.
- 17 **Q.** Now, after that meeting, the following day, there was
18 a further SAGE meeting on 21 September, and if I can
19 just pull that up, it's INQ000061566, page 2, please.
20 It's paragraph 2. It starts by setting out that
21 Covid-19 instances increasing across the country; talks
22 about the effect on schools, colleges and universities;
23 doubling time could currently be as short as seven days.
24 Then it goes on to make recommendations at this
25 point:

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- 1 **A.** Yeah.
- 2 **Q.** So that's the recommendation of the 21st.
3 We then see, on 24 September, a further SAGE
4 meeting, and that's at INQ000061567. If we can go to
5 page 3, please, at paragraph 16. If we look at
6 paragraph 16, it talks about SAGE's previous advice, the
7 one that we've just seen:
8 "... a 2-week 'circuit-breaker', where more
9 stringent restrictions are put in place for a shorter
10 period, could have additional impact. A shorter break
11 of a week or less is likely to be less effective in
12 reducing the number of infections and slowing the growth
13 of the epidemic."
14 So at this stage the advice is still
15 consistent: circuit breaker.
- 16 **A.** Yeah.
- 17 **Q.** At any point was there any alternative advice in
18 September, aside from the need to have a circuit breaker
19 to deal with the rise in cases?
- 20 **A.** No.
- 21 **Q.** So looking and turning to the issue about delay and
22 delay in decision-making, at this stage, no decision had
23 been taken.
- 24 **A.** That's correct.
- 25 **Q.** And that, as we've discussed, is a positive choice in

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1 itself with consequences.
 2 **A.** Yes.
 3 **Q.** You've described a period of frustration; how were you
 4 feeling at this stage?
 5 **A.** Very worried, because having lived through the first
 6 wave with its horrible consequences, I couldn't
 7 understand why we weren't doing things to try hard to
 8 avoid a second autumn wave. We'd been telling them
 9 since we started that there will be an autumn wave, and
 10 I suppose I'd thought in the summer, with the Covid-S
 11 scenario, that that had been brought on board, that we
 12 would try to do things, inasmuch as we could, to prevent
 13 an autumn wave, and nothing was happening.
 14 **Q.** We subsequently had the tier system that was introduced
 15 in October of 2020, 14 October. You described that as
 16 being suggestive of a lack of caution on the part of
 17 decision-makers. Why is that?
 18 **A.** Because of the way it was introduced. So if what you do
 19 is you introduce a set of tiers where in places where
 20 incidence is low, you put in controls that are
 21 insufficient to stop incidence from growing, all that
 22 will happen is that in all those places, incidence will
 23 grow. We sometimes referred to it as the levelling-up
 24 scheme. It was a scheme that would allow incidence of
 25 infection to rise in many, many parts of the country.

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1 **A.** Yeah.
 2 **Q.** -- at the moment, just so that we know where we were at
 3 the time --
 4 **A.** Very good.
 5 **Q.** -- or you were there at the time --
 6 **A.** Okay, but we would have said -- if we had been asked, we
 7 would have said: no, this is the wrong way round.
 8 **Q.** Now, on 23 October of 2020, you emailed Sir Chris Whitty
 9 and Professor Sir Patrick Vallance. It's at
 10 INQ000062800. What you ask here -- it is the SPI-M-O
 11 chairs and the secretariat that are talking, and you
 12 explain here:
 13 "After Sage on Thursday SPI-M Chairs and secretariat
 14 asked themselves, how long have we got?"
 15 And then you go on to set out some
 16 back-of-an-envelope calculations that you made.
 17 Presumably those are the ones that you made out of that
 18 meeting.
 19 **A.** So at --
 20 **Q.** These are the calculations that you made between you at
 21 that meeting, the SPI-M-O -- the --
 22 **A.** We will have made these by correspondence, yes.
 23 **Q.** By correspondence?
 24 **A.** Between the four of us.
 25 **Q.** Thank you.

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1 **Q.** Now, just to be clear, neither SAGE nor SPI-M-O were
 2 asked to advise on that policy.
 3 **A.** That's correct.
 4 **Q.** In your view, at that stage in October, moving through
 5 into November, were the tiers working or were they
 6 failing?
 7 **A.** In October? Well, we did a big study on that
 8 afterwards. They were failing in the sense that
 9 incidence across the country -- in gross measures,
 10 incidence in the country was rising, which was not what
 11 we wanted. In the parts of the country that were in
 12 Tier 3, or Tier 3 and a bit more, which is what some
 13 places did, you can actually see that incidence did fall
 14 in those places.
 15 **Q.** Now --
 16 **A.** Can I just add, I didn't -- there's nothing wrong with
 17 geographically targeted measures, it's just this
 18 business of starting off with something very low,
 19 letting it grow, putting in something that barely keeps
 20 it stable, so that it grows in most places.
 21 **Q.** Thank you.
 22 I'm going to deal with the report --
 23 **A.** Yeah.
 24 **Q.** -- that was subsequently written in due course, but if
 25 I can just keep to the chronology --

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1 What you explain here, as we go on down, is that you
 2 were projected to hit the level of admissions -- and
 3 let's just deal with this, this is about the assumption
 4 of avoiding the first wave of peak hospital admissions.
 5 At that point, that was around the 3,100 mark, just
 6 below.
 7 **A.** That's right.
 8 **Q.** And you've done some calculations and you explain that
 9 you will exceed that on 21 November.
 10 **A.** Yeah.
 11 **Q.** To stop that, you need to reduce the R to less than 1 by
 12 10 November.
 13 **A.** Yeah.
 14 **Q.** And if you want to do better than the first wave peak,
 15 for example 2,000 hospital admissions a day, you have to
 16 get the R below 1 by 28 October, so five days' time.
 17 **A.** Yes. I think this was an attempt for us to arm Chris
 18 and Patrick with some numerical reasoning to say: we are
 19 running out of time.
 20 **Q.** So was this an intervention, effectively, by SPI-M, the
 21 secretariat?
 22 **A.** The four of us, yeah.
 23 **Q.** The four of you.
 24 **A.** I mean, I don't think we thought Chris and Patrick
 25 didn't agree, we were just trying to -- we were

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1 searching for evidence that we could give to them to
 2 take to decision-takers.

3 **Q.** Were you trying to prompt some level of action at this
 4 stage?

5 **A.** Oh, yes.

6 **Q.** Now, on 24 October, the following day, Wales instigated
 7 their firebreaker. Do you consider that that was
 8 a success, first of all?

9 **A.** It was probably better than nothing. It didn't bring --
 10 if I remember rightly, we might be able to look at it,
 11 actually, because there will be a graph of it. I don't
 12 think it had a huge -- it didn't cause a great decrease
 13 in cases, is my memory. On the other hand, what's the
 14 counterfactual? What would have happened if they hadn't
 15 done it?

16 **Q.** I've been asked to ask: do you consider that that was
 17 early enough, the firebreaker in Wales, or should that
 18 have been earlier?

19 **A.** I think all of these things should have been done in
 20 September, so that whilst incidence was low, we could
 21 have kept it low and given ourselves time to come to
 22 terms with the fact that: yes, we are having an autumn
 23 wave, we don't know when we're getting vaccines, what
 24 are we going to do about it?

25 **Q.** Indeed, you're subsequently tasked with the task and
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1 introduce measures (such as Tier 2) that can be hoped to
 2 retard the growth everywhere and maintain low
 3 prevalence."

4 **A.** Yes.

5 **Q.** And that's a reference back to what you've discussed in
 6 terms of how to implement it.

7 "As soon as rising prevalence is detected, measures
 8 should escalate to interventions that are associated
 9 with negative growth rates (such as Tier 3)."

10 **A.** Yes.

11 **Q.** So looking back in terms of an evaluation of those
 12 autumn interventions, were they successful, in your
 13 mind?

14 **A.** They were successful in some places.

15 **Q.** And what places were they?

16 **A.** Tier 3 -- if you look at the places that were put into
 17 Tier 3 and look at the epidemic growth rate the week
 18 before they were put in Tier 3 and the week after, what
 19 you see is that the growth rate is always lower, and
 20 usually negative, in places that were under Tier 3.

21 We do have to be really, really careful because
 22 these weren't experiments. Places that were in Tier 3,
 23 there was probably something pretty special about them
 24 that they needed to go into Tier 3, but this is what we
 25 had. So we need to be very careful to say: this was the
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1 finish group on the impact of recent NPIs across the UK,
 2 and that involves an evaluation of the tier system,
 3 firebreaks and other NPIs that were put in place across
 4 the four nations.

5 **A.** Yeah.

6 **Q.** And you present a subsequent paper that is amended or
 7 updated slightly later with some new material, but in
 8 short, it's broadly the same paper.

9 **A.** Yes.

10 **Q.** And that's presented to SAGE initially on 19 November of
 11 2020, it's the UK's four nations autumn interventions,
 12 the updated version presented to SAGE on
 13 26 November 2020.

14 In terms of England, what it states in there, if
 15 I can just pull it up, please, it's -- thank you very
 16 much ... I believe it's towards the end. I'm afraid
 17 I've missed off the paragraph reference. But what it
 18 says is:

19 "Throughout the autumn England waited until after
 20 prevalence had increased to impose measures just about
 21 able to slow or stop epidemic growth. The inexorable
 22 outcome was high prevalence in many places and the need
 23 for four weeks of national restrictions."

24 **A.** Yes.

25 **Q.** "For the future a more logical procedure might be to
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1 pattern we saw, and not -- try really hard not to use
 2 words that implies causality. But you can look at
 3 the -- you can look at the patterns of growth rate
 4 before and after a tier was introduced.

5 **Q.** Then we come to the second national lockdown.

6 **A.** Yeah.

7 **Q.** You described that in your witness statement as
 8 a "terrible moment". Why was that?

9 **A.** Well, because the thing that we had been trying to avoid
 10 by having smaller interventions at lower prevalence had
 11 had to be done, and in the same -- it felt like March
 12 all over again: we wait till the last possible moment,
 13 we delay and delay a decision, and then we have to slam
 14 the brakes on as hard as possible with the attendant
 15 social costs and economic costs.

16 **Q.** At that stage schools were also closed.

17 **A.** Is that right? I thought schools were open already.

18 **Q.** Have I got that wrong? It may be that I have got that
 19 wrong and it's schools were closed in -- schools were
 20 certainly closed in the third lockdown. It may be me.

21 **A.** Yes, I think that's right.

22 **Q.** I'm turning to that now, if I may.

23 Before we get to the third lockdown after that, we
 24 then have the Alpha wave that comes through in
 25 December --
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1 **A.** Yes.

2 **Q.** -- of 2020 through to January -- well, indeed, the
3 winter of 2020 into 2021.

4 You describe some successes there in relation to
5 surveillance and genomics.

6 **A.** Yes.

7 **Q.** Can you just expand a little bit in terms of
8 surveillance, firstly?

9 **A.** So I think we're all really, really proud of what the
10 Office for National Statistics did with their Covid
11 infections survey, so we knew what prevalence of
12 infection was across the country every week, and with
13 actually quite a lot more detailed local investigation
14 of what was happening with infection, much of which came
15 actually from test and trace, we could see -- right as
16 we came out of the November lockdown, we could see
17 straightaway that there was a problem in the south east
18 and that infections were rising very fast in the south
19 east, and that was the first observation, so just there
20 were lots more positive tests in this part of the
21 country, what's happening? And then because of COG-UK,
22 because of the amazing genetic studies that we had, we
23 could see straightaway that the virus that was spreading
24 there was different.

25 So in a -- you know, it was a triumph of science.

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1 **MS CECIL:** Thank you.

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

9 Now, in respect of that, there is a communication
10 between you and I believe it's
11 Professor John Medley (sic) on 17 December in which he
12 expresses the view that you had missed the timing of
13 lockdown with half term -- this is, as I say,
14 17 December:

15 "... and today the politicians just went ahead and
16 made policy anyway, without any guidance from SAGE, so
17 it is finally a victory for common sense but actually we
18 have failed to inform policy over the last few months."

19 Was that a view that you shared?

20 **A.** Yes.

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

24 **A.** Much more closely from then on, that's right.

25 **Q.** And there's quite a lot of thinking that is done then in

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

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

5 **A.** Yes.

6 **Q.** Synthesis of data, all of those things,
7 surveillance. Testing now had a 24-hour turnaround.

8 **A.** Yes. We had a good picture of what was happening with
9 this infection in our four countries at this stage.

10 **LADY HALLETT:** Could I interrupt? I'm being asked to take
11 a break, which is obviously going to be apparent.
12 I'm getting very concerned about time, Ms Cecil.

13 **MS CECIL:** Of course.

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

20 **MS CECIL:** Of course.

21 **LADY HALLETT:** Thank you.

22 **(12.09 pm)**

23 **(A short break)**

24 **(12.14 pm)**

25 **LADY HALLETT:** Ms Cecil.

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1 January and February of 2021, is that fair to say?

2 **A.** That's right, I mean, I think the work that was led by
3 Rob Harrison and turned into those plans to unlock from
4 the third lockdown are a wonderful example of using
5 scientific evidence in order to make a long-term plan,
6 and I don't -- I think the reason, if you could take
7 a tiny bit of time to look at them, is I think they make
8 a useful contrast to events in 2020.

9 **Q.** Of course. I'll just call that up briefly now. It's
10 INQ000238597.

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

17 If I can go to page 4, please, and for the first
18 time we see, in terms of the roadmap, that coming out
19 of -- I say coming out of lockdown or easing
20 restrictions, there is a roadmap with a test. And
21 that's about a third of the way down, it says:

22 "This assessment will be based on four tests."

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

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

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

12 **A.** It's not just a priority, it's the priority.

13 **Q.** The priority.

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

21 **A.** Objectives, things we're going to measure, things that
22 we are actually able to measure, and actually we haven't
23 found it, but the bit that says "and we're going to
24 space these things out, we're going to space these
25 decisions out in a way that is consistent with being

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1 possible was that Rob Harrison, through taskforce, put
2 together a team from across government, bringing in
3 advice from all sorts of different people, working
4 together at the officials level, to absorb advice into
5 government at the level of official working.

6 **Q.** Indeed. And it's not just epidemiology that we see
7 within the document, we also see analysis of
8 socioeconomic impacts, mental health impacts, all --
9 other forms of inputs and issues that need to be taken
10 into consideration. As I say, it's a substantial
11 document in that sense.

12 If I may now just move very briefly to just ask one
13 very quick question in relation to children --

14 **A.** Yeah.

15 **Q.** -- and transmission. You and John Edmunds wrote a paper
16 on that back in October of 2020 suggesting that children
17 indeed can be infected and do contribute to
18 transmission. Does that remain your view?

19 **A.** Yes.

20 **Q.** Thank you.

21 Then finally, if I may just take you to the issue of
22 testing, we know that the will of the World Health
23 Organisation at the time was to test, test, and test,
24 and you set out within your statement that testing plays
25 both a role at the initial stages of the pandemic but

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1 able to measure how much difference did the last set of
2 measures that we lifted make".

3 **Q.** Indeed.

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

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

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

16 **A.** That's right.

17 **Q.** And so you have those triggers.

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

23 **A.** That's right.

24 **Q.** Deliverability?

25 **A.** Yes. Can I just say, so I think some of why this was

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1 also subsequently, both in relation to surveillance but
2 also in relation to it being a tool in the arsenal.

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

7 **A.** That is correct.

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

10 **A.** That is my understanding.

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

13 **A.** Yes.

14 **Q.** Thank you.

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

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

24 **Q.** In fact within your statement, I don't need to take you
25 through it now in detail because you set it out there,

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1 you refer to the experiences of both South Korea and
 2 Germany as inspiring and examples that the UK should
 3 look to?
 4 **A.** Yes.
 5 **Q.** Thank you. And indeed that there are lessons to be
 6 learnt there in terms of their experiences and the use
 7 of that technology and testing, surveillance and
 8 tracing?
 9 **A.** That's still my view, yes.
 10 **MS CECIL:** Thank you very much.
 11 Thank you, Professor, I've no further questions for
 12 you.
 13 Does my Lady have any questions?
 14 **LADY HALLETT:** No, I don't, thank you very much indeed. And
 15 again, I apologise for the -- your evidence was
 16 certainly very illuminating.
 17 **THE WITNESS:** Thank you.
 18 **LADY HALLETT:** Even if I didn't find the graphs
 19 electrifying. Thank you very much.
 20 **THE WITNESS:** Thank you.
 21 **(The witness withdrew)**
 22 **MR KEATING:** Yes, please, thank you.
 23 **MS KEMI BADENOCH (sworn)**
 24 **Questions from COUNSEL TO THE INQUIRY**
 25 **MR KEATING:** Do sit down, please. Thank you.

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1 So you are elected as Member of Parliament for
 2 Saffron Walden since June 2017?
 3 **A.** Yes.
 4 **Q.** You were Parliamentary Undersecretary of State (Minister
 5 for Children and Families) July 2019 to February 2020,
 6 and from February 2020 to September 2021 you were
 7 Exchequer Secretary to the Treasury and Minister for
 8 Equalities?
 9 **A.** Yes.
 10 **Q.** And you were on maternity leave for a short period at
 11 the beginning of that time period, so it's from
 12 February 2020 to April 2020 --
 13 **A.** Yes.
 14 **Q.** -- you were on maternity leave, which is relevant
 15 because that's at the outset of the Inquiry.
 16 Later on, in 2021, you became minister of state at
 17 the Department for Levelling Up, and you held that role
 18 until July 2022, and you currently -- outside
 19 the Inquiry's time periods, but you currently are
 20 Secretary of State for International Trade and president
 21 of the Board of Trade, and also in October 2022 you were
 22 appointed as Minister for Women and Equalities?
 23 **A.** Yes, business and trade, not international trade.
 24 **Q.** Business and trade?
 25 **A.** More has been added to the role, yes.

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1 **THE WITNESS:** Thank you.
 2 **LADY HALLETT:** I hope we haven't kept you waiting for too
 3 long.
 4 **THE WITNESS:** That's fine.
 5 **MR KEATING:** Could you give us your full name, please.
 6 **A.** Kemi Badenoch.
 7 **Q.** Ms Badenoch, thank you so much for attending today.
 8 Thank you for assisting the Inquiry with its
 9 investigations. You have provided a statement dated
 10 26 June of this year to the Inquiry, and it runs to over
 11 38 pages, and you have had the opportunity to check
 12 that, you've signed it, and it's true to the best of
 13 your knowledge and belief, and you've also provided, as
 14 we can see in the top right-hand corner, 87 exhibits.
 15 Thank you so much in relation to that.
 16 Before going into your evidence, let's briefly set
 17 out your professional background. You're here really in
 18 your capacity at the time as Minister for Equalities,
 19 which you held that post between February 2020 and
 20 February 2022, which is the time -- forgive me.
 21 **A.** With -- it's not quite. July 2022.
 22 **Q.** Yes, which is after February 2022.
 23 **A.** Oh, I see, yes, yes.
 24 **Q.** Let me run through the timetable with you, and it's my
 25 fault if I am confusing.

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1 **Q.** Yes.
 2 So thank you so much for attending. And in terms of
 3 the role of Minister for Equalities, and that's what
 4 we're dealing with, so back during the pandemic, how
 5 would you describe the responsibilities for the Minister
 6 for Equalities?
 7 **A.** So I would say that until I took on the role, returning
 8 in April 2020 and I'd say in particular June 2020, the
 9 role for a Minister for Equalities was actually quite
 10 different. It was very much limited to looking at
 11 LGBT-related issues and women's issues, in particular
 12 around women's economic issues, gender pay gap and so
 13 on.
 14 **Q.** Okay, so your previous responsibilities changed
 15 significantly, and you set out what those workstreams
 16 are in your statement at paragraph 9. And as
 17 an overview of the work you did, we can see that at
 18 paragraph 9 of your statement, one of the main areas was
 19 quarterly reports on progress to address Covid-19 health
 20 inequalities?
 21 **A.** Yes.
 22 **Q.** And we will go through those reports, not each report in
 23 detail, but we'll touch upon key features of those.
 24 You refer to ad hoc attendance at Covid-O meetings
 25 in your capacity as Minister for Equalities, and that

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1 was often discussing disproportionately impacted groups,
2 that would have been a specific phrase term?

3 **A.** Yes.

4 **Q.** Public health communications, a key feature also. And
5 lastly, one of the significant features, it appears from
6 your evidence, written evidence, is increasing vaccine
7 uptake within ethnic minority groups.

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

10 **A.** Right.

11 **Q.** So we will touch upon your work but perhaps not in the
12 detail that would be done otherwise.

13 In terms of the ministry, in terms of the Minister
14 for Equalities, at that stage would it be fair to
15 describe it as a junior ministerial role?

16 **A.** My role was.

17 **Q.** Yes.

18 **A.** It is not -- strictly speaking, it's an odd department
19 because it's not really a department, it's
20 a directorate, currently within the Cabinet Office, but
21 it would move with the department of whoever the
22 Secretary of State, who was also Minister for Women and
23 Equalities.

24 **Q.** Which was Liz Truss at that time?

25 **A.** At the time, yes. So strictly speaking we were in DIT,
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1 principles research primarily in the LGBT and women's
2 space. We did not cover equality across the board.
3 What we looked at was the Equality Act specifications,
4 which is around protected characteristics, and
5 preventing discrimination, rather than inequality that
6 might arise from other areas.

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

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

21 Let's move on to the next report which is of
22 relevance, direct relevance, to your involvement. So as
23 you were about to take up your post, you became aware
24 that there had been requests made of the
25 Secretary of State, Matt Hancock, in relation to

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1 as it was, the Department for International Trade, but
2 there were recommendations made by the Commission
3 on Race and Ethnic Disparities that the unit should stay
4 in the Cabinet Office for consistency and continuity.

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

10 **A.** Yes.

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

19 **A.** Not initially. I did become aware of it later on
20 in 2020, but I think it's probably worthwhile giving
21 some context as to why that would be the case. The
22 Equality Hub operates a hub and spoke model, even before
23 it was the Equality Hub, it became a bit more broad
24 based, but every department is responsible for managing
25 its own equality work. So we would do perhaps first

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1 a review into factors affecting the health outcomes for
2 ethnic minority groups, especially those who were
3 working on the frontline?

4 **A.** Yeah.

5 **Q.** And they commissioned a report of Public Health
6 England --

7 **A.** Yes.

8 **Q.** -- PHE on 4 May 2020, and you set that out in your
9 statement, and that report was published on
10 2 June 2020 --

11 **A.** Correct.

12 **Q.** -- the PHE report, which we've touched upon already,
13 *Disparities in the risk and outcomes of Covid-19?*

14 **A.** Yes.

15 **Q.** Published June 2020. There was an update in relation to
16 that in August 2020 and some updated or corrected data,
17 which perhaps we don't need to worry about too much at
18 the moment.

19 In relation to the concerns that you note in your
20 statement about that report, if we look at paragraph 17,
21 so we just have the context of how you express it,
22 I just want to seek your clarification. So paragraph 17
23 of your statement, please, thank you.

24 The first line:

25 "The PHE report highlights some apparently

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1 significant disparities in both risk and outcomes from
2 COVID-19."

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

6 **A.** What do I mean by "apparently"?

7 **Q.** In that context.

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

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

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

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1 the different disparities. Age being one.
2 Significantly, the older one is the greater the
3 likelihood, sadly, of mortality. It talks about gender,
4 male higher risk than female. And it talks about those
5 in -- to use their terminology -- black, Asian and
6 minority ethnic (BAME) groups, having a higher risk than
7 those in white ethnic groups.

8 It's really -- this also touches upon those who are
9 in a range of caring occupations, which is later on in
10 this document, those who drive passengers and road
11 vehicles, and security guards, and so forth.

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

15 **A.** Yes.

16 **Q.** -- particularly in relation to ethnic groups?

17 **A.** Yes.

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

21 **A.** Yes.

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

25 **A.** It's -- using the term "BAME" masked what was actually

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1 Let's perhaps just briefly touch upon the report
2 itself, the PHE report, and that's at INQ000089740. We
3 see that's the front page. Page 4, please, thank you,
4 paragraph 1. Thank you.

5 The third line down, it says:

6 "It confirms that the impact of COVID-19 has
7 replicated existing health inequalities and, in some
8 cases, has increased them. These results [which were
9 carried out by the report] improve our understanding of
10 the pandemic and will help in formulating the future
11 public health response to it."

12 Again, just in the context, if we go to page 6,
13 please, thank you, the first paragraph, deprivation is
14 a feature which is touched upon, an important feature,
15 and it says:

16 "People who live in deprived areas have higher
17 diagnosis rates and death rates than those living in
18 less deprived areas. The mortality rates from COVID-19
19 in the most deprived areas were more than double the
20 least deprived areas, for both males and females. This
21 is greater than the inequality seen in mortality rates
22 in previous years ..."

23 Perhaps we could go back to page 4, please, and
24 paragraph 2, then we can move on from this report.

25 I'm going to summarise, if I may. It talks about

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1 happening within different ethnicities. By lumping
2 people who are black with people who are Asian, very,
3 very different -- very, very different groups of people,
4 it was -- it made it harder to actually look at the
5 underlying factors. So what the PHE report did was tell
6 us what was -- what we're seeing, it didn't tell us why,
7 and lumping people into one group completely obscures
8 different bits of information, which we were then able
9 to single out once we started splitting -- once we
10 started splitting groups apart.

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

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

23 **A.** Yes.

24 **Q.** With that context very much in mind, I want to deal with
25 one other matter regarding this publication, this

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1 report. Within a couple of days it was announced in
2 Parliament that you were going to lead this review.
3 Were you also aware that there was concerns expressed by
4 a number of organisations, including FEHMO and British
5 Medical Association, regarding features of the PHE
6 report which were missing, such as recommendations and
7 also the input from a number of groups who had exchanged
8 and discussed their experiences?

9 **A.** Yes, very much so, because I also experienced quite
10 a lot of personal abuse around the non-publication of
11 that, despite -- despite people not understanding
12 exactly why there was a slight delay in publishing. And
13 the reason for that was because there were actually two
14 reports written, and participants assumed that there was
15 only one. One of them was the report which we
16 commissioned, which we published, and the second was
17 a sort of stakeholder report, which was less what is
18 happening but how people feel. And because we hadn't
19 commissioned that, we didn't publish it straightaway, it
20 was something that went into the system for a review
21 understanding what was going on. And the assumption
22 from people who didn't know that there were two separate
23 reports was that the government was hiding something,
24 which was very unfortunate, because it immediately
25 created some distrust, which should not have been the

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1 responses had been captured, I felt was not how it
2 should have been done.

3 If you go out and ask people who are unhappy "Why
4 are you unhappy?" you can get a totally skewed view,
5 rather than asking everyone how they feel. And as
6 I read that report I could see that the people who
7 already believed that the system was set against them
8 were the ones that were more likely to reply.

9 I recognised many tropes in the documents and in the
10 responses which were coming from a place -- not from
11 a clinical or medical analysis, but more general social
12 commentary, probably even more political, and I felt
13 that we needed to make sure that we separated the two
14 things.

15 I'm very keen that we have as much rigour as
16 possible when we analyse data, and we should separate
17 quantitative from qualitative, and the way that it had
18 been published meant that it wasn't easy to do so.
19 Publishing them in stages meant that we could look at
20 what was happening and deal with that and then talk
21 about the stakeholder responses after.

22 **Q.** Thank you for that answer.

23 Let's look at the report very briefly, and I'm just
24 going to follow up on your answer in a moment. So if we
25 could turn to INQ000176354, and that's *Beyond the data:*

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1 case, because the assumption was that this was being
2 hidden from people for deliberate reasons rather than
3 additional information which we hadn't commissioned
4 which we were taking longer to respond to.

5 **Q.** So in relation to the messaging, using the sort of
6 political terminology, perhaps, the messaging of the two
7 reports, is it fair to say that the PHE report doesn't
8 message that there's going to be another document which
9 is going to run --

10 **A.** No.

11 **Q.** -- thereafter?

12 **A.** No, it did not.

13 **Q.** Was it the case that the second report, which we're
14 going to touch upon in a moment, the *Beyond the Data*
15 report --

16 **A.** Yes.

17 **Q.** -- was that something which was really disclosed
18 thereafter because of this outcry regarding --

19 **A.** No, no, that's not true. First of all, this was
20 a report that was written by an independent body, so,
21 irrespective of whether we published it or not, it could
22 always have been published. So it wasn't because of
23 an outcry. It was more the fact that it was being
24 presented as missing data when actually stakeholder
25 analysis and responses, especially the way that those

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1 *Understanding the impact of COVID-19 on BAME groups*, and
2 that was published on 16 June, two weeks after the first
3 report.

4 Perhaps if we could go to page 6, please, I'm just
5 going to do two passages in relation to this. The
6 second paragraph. Stakeholders -- there was
7 a significant amount of input in relation to this,
8 which -- under the umbrella of stakeholders. It states
9 this:

10 "Stakeholders acknowledged that while actions are
11 already being undertaken, the results of the PHE review
12 and other studies should be used to strengthen and
13 accelerate efforts moving forward. Clear, visible and
14 tangible actions, provided at scale were called for now
15 with a commitment to address the underlying factors."

16 Lastly in relation to this report, if we could go to
17 page 9, please, and the final paragraph, halfway down we
18 see:

19 "The engagement sessions highlighted the BAME groups
20 deep concern and anxiety that if lessons are not learnt
21 from this initial phase of the epidemic, future waves of
22 the disease could again have severe and disproportionate
23 impacts. All were united in the commitment that urgent,
24 collaborative and decisive action is required to avoid
25 a repeat of this in the future."

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1 I have extracted two parts to it, not controversial,
 2 you would agree --
 3 **A.** Well, I don't disagree with some of the explanations and
 4 assessments, and certainly in terms of what stakeholder
 5 groups would have been feeling. That's something that
 6 I very much recognise.
 7 **Q.** Were you listening to these concerns which were being
 8 expressed about how certain groups felt that they were
 9 being treated and felt that they were exposed to
 10 Covid-19?
 11 **A.** Absolutely. So if you -- if we go back to the first
 12 clip, I think you said it was page 6 or paragraph 6,
 13 I can't remember.
 14 **Q.** That's correct, it was, I believe --
 15 **A.** Many of the recommendations in that report were what
 16 informed our decision to publish the four quarterly
 17 reports. It was quite clear to me that the
 18 recommendations were things that would be needed in
 19 order to provide assurance the government was taking
 20 this seriously. But one of the reasons why I was quite
 21 keen to do the work -- so I wasn't just asked to do it,
 22 I did speak to other ministers and let it be known that
 23 I would be happy to take on some of this work to help
 24 with capacity, because these were concerns that I was
 25 having as well. I am a black woman. I was reading that

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1 **A.** Yes.
 2 **Q.** And that there was accountability; is that fair?
 3 **A.** Yes.
 4 **Q.** We see, I'm not going to read them all, there was
 5 a number of terms of reference, eight in total, the
 6 first one, to:
 7 "Review the effectiveness and impact of current
 8 actions being undertaken by relevant government
 9 departments and their agencies to directly lessen
 10 disparities in infection and death rates of COVID-19.
 11 Factors to be considered -- but aren't limited to --
 12 should include age and sex, occupation ... "
 13 And so forth, and includes ethnicity at the end.
 14 So in terms of the first term of reference, a wide
 15 term of reference?
 16 **A.** Yes.
 17 **Q.** Summarising the rest of them, it's to consider whether
 18 there's going to be modifications to new policy. Data
 19 key feature, at terms of reference 3, to "commission
 20 further data" and to examine the collection of existing
 21 data and its quality. And engagement with other
 22 departmental ministers, further stakeholder engagement,
 23 and to improve public communications, at the bottom of
 24 the page.
 25 **A.** Yes.

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1 this was something that was impacting black people.
 2 That's my family, that's my friends, and so on. And
 3 I felt that having that personal interest would mean
 4 that I would be not just focused, but also be able to
 5 provide reassurance to many of those groups who feel
 6 that people who don't look like them can never represent
 7 them, that they were having a minister who was black,
 8 who was of the community, if you're speaking strictly on
 9 race, looking at this work and leading on it.
 10 And I was also quite keen that Professor
 11 Kevin Fenton, who at the time -- also a black man --
 12 head of PHE in London, worked closely and certainly was
 13 involved in how we were pulling together the terms of
 14 reference for the report and how we ended up making sure
 15 that we could communicate it in a way that would provide
 16 reassurance to people who, for whatever reason, had
 17 genuine concerns which I felt needed to be addressed.
 18 **Q.** So with that in mind, that you were listening, you were
 19 personally invested in this, you touched upon the terms
 20 of reference we can see these in your statements at
 21 paragraph 18(a) to (g), if we could bring that up in
 22 a moment, please. A number of terms of reference but
 23 the first point I suppose is the terms of reference
 24 there are important to scope the work that you're
 25 dealing with?

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1 **Q.** And at that stage, so we're June 2020, we're in the
 2 stage that we're still in lockdown number 1?
 3 **A.** Very much so.
 4 **Q.** In your view, it was an area that still required work to
 5 improve public communications?
 6 **A.** Yes. And in coming up with these terms of reference
 7 I was very keen -- this is probably my engineering,
 8 project management, et cetera, background -- that we
 9 don't try to duplicate work that other people are
 10 already doing, that we provide support and assistance,
 11 we don't -- we are ambitious but not so ambitious that
 12 it is not feasible for us to deliver, and look for where
 13 there are gaps that we can add -- we can add value.
 14 And by the time this report -- pardon me, this terms
 15 of reference was being drafted, I could already see the
 16 comments about people not understanding -- if you
 17 remember, we had those sort of daily 5 pm announcements
 18 and who could shield and who didn't need to, and so on,
 19 and I knew that communications was an area where there
 20 was lot of talk about people not necessarily
 21 understanding or not watching the same channels. And
 22 making sure that we were able to be as inclusive as
 23 possible, I wanted to review how we were communicating,
 24 not just what we were doing on the BBC, and that's why
 25 I added 7 to it. What I did not want to do was try and

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1 be the Department of Health. That's not what the
 2 Equality Hub does.

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

8 **A.** Yes.

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

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

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

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1 devolved administrations were doing?

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

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

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

20 The disproportionate impact was very much on the
 21 elderly, not on children. That's something that came
 22 across very quickly and very early. So there was
 23 limited -- there was a limited need to look at how the
 24 disease itself was impacting children. There would have
 25 been indirect impacts such as schooling, for example,

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1 information.

2 **Q.** You used the word "communication" and "sharing
 3 information". The statement paragraph, which is open,
 4 suggests that was really having material which was
 5 available online, transparency as you describe it. Was
 6 there any more active communication with the devolved
 7 administrations?

8 **A.** Certainly when reports were published we informed them.
 9 But given -- I think certainly given capacity there
 10 would not have been anything to do beyond letting them
 11 know what we were doing.

12 Communication is two-way, it's what lessons are
 13 being learned, it's how were things going. A lot of
 14 that we knew already, so that wasn't any need to provide
 15 additional activity in that space. We were at capacity.
 16 So I'm not sure what more we could have done with
 17 devolved administrations, given that they were also
 18 quite overwhelmed dealing with the pandemic in the
 19 various nations.

20 **Q.** And one has to be realistic. You say you were at
 21 capacity twice in that answer, and it was during the
 22 heart of the pandemic. In hindsight, was this not
 23 an area, especially something like public
 24 communications, where there would have been synergies
 25 between the work you were doing and perhaps the work the

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1 and later on, as we discovered, children living in
 2 multigenerational households we knew were actually
 3 passing the disease on to their elderly relatives, and
 4 as we discovered that sort of information we made sure
 5 that it was taken into account whether in risk
 6 assessments, in communication that we were passing on.
 7 We tried to get into channels looked at by young people,
 8 letting them know that they might be at risk or they
 9 might be creating a risk for their family members. But
 10 beyond that I would not have expected -- unless you have
 11 some examples -- I would not have expected children to
 12 be much further in scope for the work that I was doing.

13 **Q.** Well, it's your answer. The focus, for the reasons you
 14 set out, were on other groups, and when one considers
 15 age, the focus was on those who were older, rather than
 16 children.

17 **A.** Yes.

18 **Q.** That's your evidence.

19 Disabled is the second group I wanted to ask you
 20 about, and really what part, if any, your remit included
 21 consideration of the impact on those who would fall into
 22 the category of disabled persons, disabled people?

23 **A.** It was limited because there was already a minister of,
 24 Minister for Disabled People, Justin Tomlinson, who
 25 I believe has already given evidence.

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1 Q. Yes.

2 A. As I said earlier, making sure that we weren't
3 duplicating efforts was quite important, and he already
4 covered that part of the brief quite well. Where I did
5 look into disability was where disability interacts more
6 on the health -- much more on the health side. So where
7 we discovered that diabetes, for example, was
8 a significant risk factor in terms of whether people
9 died from the disease or not, those sorts of things we
10 looked at. But disability generally, across the board,
11 no, that would not have been within my remit.

12 Q. What sort of interaction would you have with
13 Justin Tomlinson, the Minister for Disabled Persons
14 around that time?

15 A. Update meetings and we had Equalities ministers meetings
16 where we gave updates on our work across the board. The
17 senior Minister for Women and Equalities as well as
18 myself, Minister for Women, and the Minister for
19 Disabled People would have been present in those
20 meetings.

21 Q. Yes.

22 A. And at official level all of that information of course
23 would have been shared.

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

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1 about to move on to a large topic.

2 **LADY HALLETT:** Certainly, of course, I was just thinking
3 about the comment about how meetings don't necessarily
4 prove productive.

5 I shall return at 1.50.

6 **MR KEATING:** Thank you, my Lady.

7 (12.57 pm)

8 (The short adjournment)

9 (1.50 pm)

10 **LADY HALLETT:** Mr Keating.

11 **MR KEATING:** Thank you, my Lady.

12 Welcome back. We were, before luncheon, dealing
13 with the PHE reports, the terms of reference for the
14 work you were doing investigating the apparent -- to use
15 your phrase -- inequalities in relation to certain
16 groups, and we'd dealt with the terms of reference and
17 the scope of your work, which was from June 2020
18 onwards.

19 So the next part of our timeline really moves on to
20 September 2020, and it's a Covid-O meeting which you
21 were present at -- and I'm very grateful, it's right in
22 front of us there -- chaired by Michael Gove, and we see
23 Justin Tomlinson, who is the Minister of State for
24 Disabled People, and overleaf, top of page 2, you're
25 there in your capacity as Minister for Equalities.

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1 Ministry meetings?

2 A. I think we had regular meetings and then anything else
3 that was needed in between would have been often enough.
4 But also I was quite keen that we didn't have meetings
5 for the sake of them. If we didn't have anything to
6 say, we wouldn't have the meeting just because it was in
7 the diary, and -- this is me trying to recollect.

8 I know that when we did speak there was an agenda
9 item that needed communication between us, but quite
10 often a lot of that would have been done at official
11 level as well. I'm also very conscious of other
12 ministers' time and it's not that easy to schedule
13 things into the diary, so as and when necessary.

14 Q. So there's no mystery, you have been asked to obtain
15 that information, you've kindly agreed that your team
16 will go away and obtain the documentation in relation to
17 the agendas for those meetings --

18 A. Yes.

19 Q. -- any read-outs?

20 A. But I would like to stress the frequency of meetings
21 does not necessarily indicate the level of action that's
22 taking place. You can have lots of meetings and nothing
23 happens.

24 **MR KEATING:** Well, actions is something we're going to talk
25 about, but that may be a suitable moment, my Lady. I'm

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1 But if we could go to page 5, please. In terms of
2 context at page 5 of this document, we see that the
3 first and second paragraphs, it's discussing that the
4 first wave of the pandemic, BAME communities had seen
5 higher case rates than their white counterparts. This
6 was being repeated in the second wave of the Covid
7 pandemic. There's reference to data being perhaps
8 skewed as a result of testing, but reference still that
9 a BAME person -- that's their terminology -- was still
10 more likely to die from coronavirus, even once the
11 socioeconomic factors had been removed, with black men
12 twice as likely to die as their white counterparts. It
13 talks about:

14 "The increased death rate of BAME communities was
15 linked to the fact that these ethnicities were
16 over-represented in eight of the twelve most high-risk
17 coronavirus occupations."

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

20 So against that context, this Covid-O meeting then
21 refers to disabled persons, and it says this:

22 "... 60 per cent of those who had died from
23 coronavirus identified as disabled and, even once
24 accounting for other risk factors, disabled people were
25 1.6 times more likely to die from coronavirus."

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1 And that spikes considerably when one considers age,
2 and it talks about the difference in relation to gender.

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

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

15 **Q.** Correct.

16 **A.** There was no need to. They were doing work, certainly
17 from my perspective, that would just have been
18 a duplication. Simply adding it to our workstream would
19 not have provided any additional insights. They were
20 still part of the broader equalities directorate, and
21 they were focusing on a particular area, and given that
22 the work that my -- by which time the quarterly reports
23 that I was doing were focusing on comorbidities and
24 multivariant analysis, it was taking into account other
25 things like age, like sex, like geography, for instance.

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1 **A.** Yes.

2 **Q.** What we're going to do is we're going to draw out some
3 aspects of this. It's a significant report in terms of
4 length.

5 Perhaps if we could turn to page 5, please. That's
6 the introduction there, and the third paragraph sets out
7 the work which was ongoing, and:

8 "Given the stark findings in relation to ethnicity,
9 the RDU ..."

10 Perhaps you could explain to everybody what that is.

11 **A.** It's the Race Disparity Unit.

12 **Q.** Yes, thank you:

13 "... main focus has been to consider why this virus
14 has had such a disproportionate impact on people from
15 ethnic minority groups, and in particular men from
16 within those groups."

17 It talks about a separate strand of work when
18 government is considering other disproportionately
19 impacted groups, that being disabled persons.

20 **A.** Yes.

21 **Q.** The report makes 13 recommendations. If we could see
22 those at page 6. We see the first two at page 6, and
23 perhaps we could just focus on some of those, not them
24 all. But we see there the recommendations which you
25 made to the Prime Minister at the time, which had been

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1 So we were looking at this in its entirety. Whether or
2 not it was in a particular workstream or another I don't
3 think would have made much of a difference.

4 **Q.** What would you say to the concern that the interests of
5 disabled people was actually secondary and wasn't given
6 sufficient prominence at that stage in September 2020?

7 **A.** I would disagree with that. I think just because you're
8 looking at things separately doesn't mean that there is
9 a hierarchy of need. The evidence showed that disabled
10 people were more impacted, and we were keen to ensure
11 that it was the people who were most impacted that got
12 the most attention, and that was roughly in order of
13 priority: the elderly, and then disabled people. This
14 was something that was a factor, and in terms of
15 interventions being made, those would have been
16 considerations that DHSC would have taken into account.

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

19 **A.** Yes. Yes.

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

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

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1 accepted in full.

2 The first two -- and I'm going to summarise them, if
3 I may -- is that:

4 "NHS England must ensure that Trusts implement plans
5 for the next stage of the pandemic, and that these plans
6 continue to reflect the latest evidence about ethnic
7 disparities and risk factors."

8 And recommendation 2:

9 "Departments must put in place arrangements for the
10 effective monitoring of the impacts [of] their
11 policies ..."

12 So October 2020, these are quite broad
13 recommendations, would you agree, in terms of: you must
14 have plans and you must be monitoring the impact of your
15 policies?

16 **A.** Yes, they are broad, but I don't think we should assume
17 that they would have been done if it hadn't been
18 explicitly set out. But also, what these
19 recommendations are doing are letting it be known that
20 there is someone else marking the homework. It's very
21 easy for people to say, "Oh, don't worry, we've got some
22 plans in place", but by formalising these
23 recommendations, they were things which we were going to
24 be going back to check up on later, and it's almost that
25 evidence-checking process that is being validated with

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1 recommendations.

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

5 **A.** Yeah.

6 **Q.** Or should be in place in any event.

7 Let's turn overleaf, please, and look at
8 recommendation 4:
9 "Departments should continue to work at pace to
10 develop new policy interventions to mitigate COVID-19
11 disparities, informed by the latest evidence."
12 You touch upon that in your statement, that this
13 was -- paraphrasing -- a personal issue to you, and your
14 view -- and perhaps you could paraphrase it or say it
15 yourself -- was that you considered more needed to be
16 done; is that correct?

17 **A.** Yes, certainly so.

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

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

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1 "For some policies [this being October 2020, as
2 we're in the tier system], departments have yet to
3 establish effective metrics and monitoring arrangements.
4 While this is understandable with more recent
5 initiatives, this must be a priority for departments
6 over the coming months. This will enable the [Race
7 Disparity Unit] to monitor and assess short and longer
8 term impacts and to assess which interventions are most
9 effective."
10 So the work you had done had revealed that there was
11 an absence in certain quarters of effective metrics and
12 monitoring; is that correct?

13 **A.** Yes. We -- and -- but this was part of what we were
14 looking to identify. Where there were gaps, where some
15 departments weren't doing as well as they could or
16 should we wanted to highlight that. And I imagine the
17 way we write these documents might seem odd, but there
18 is a lot of reading between the lines. We don't want to
19 demoralise or overcriticise the people that we're
20 working with, but effectively what this paragraph is
21 saying is that some people haven't yet done what they
22 should be doing, and in the context of everything that
23 was going on at the time -- many departments
24 overwhelmed, lots of officials being pulled from their
25 day-to-day work to support in the pandemic -- I don't

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1 don't need to", and it was reinforcing that principle
2 that equalities work is done by every department, not
3 just the Equality Hub.

4 **Q.** And it may be civil service or political phraseology,
5 but "work at pace", what does that mean?

6 **A.** Quickly.

7 **Q.** Yes, that's pretty much common usage.

8 **A.** Yes.

9 **Q.** In terms of metrics and using your project management
10 background, if we look -- was there metrics to measure
11 these recommendations? Was there something in place to
12 make sure that, as you say, the homework was being
13 marked?

14 **A.** Yes, the actual process of the quarterly reports was the
15 metric checking, effectively. That was how we were
16 measuring. So, routinely, my team within the Race
17 Disparity Unit would ask departments to report back:
18 "What have you done? We made these recommendations.
19 Can you send us a list of actions that show how you are
20 meeting this", which is all part of the homework
21 marking.

22 **Q.** Yes.

23 **A.** I would say part of the process.

24 **Q.** Let's go to page 10, please, in relation to this theme
25 as to metrics and monitoring. We see at paragraph 8:

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1 think it was surprising, which is why we said: well,
2 this is understandable. But there was more that we
3 wanted to see and we knew that people weren't moving as
4 quickly as we would have liked.

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

16 **A.** Yes, there would have been more detail -- I can't recall
17 off the top of my head, but there would have been more
18 detail in the report about what specifically -- there
19 would have been specifics. So this -- I can't remember,
20 I'd need to read the report again to remember exactly,
21 but we commissioned this in June. I think we took about
22 a month just to get everything together, get the right
23 people into the RDU to carry out the work, put the terms
24 of reference, so first report comes out in October.
25 This is after there has been a lull. If you remember,

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1 we had a summer where there was a lull in terms of
2 infections and there was some easing generally.
3 So this was just the assessment that was being made
4 in terms of: if there's a new spike, have we got
5 everybody ready, I think perhaps to do risk assessments
6 and so on. And departments need to answer for
7 themselves specifically why that was the case, but we
8 had looked at what they were doing and we felt that, by
9 the metrics we were measuring, not everything was being
10 met.

11 **Q.** Was there, in your view, sufficient capacity to deal
12 with these matters during summer 2020 so that we were
13 prepared for the second wave?

14 **A.** I don't think so. I think that -- it's -- a pandemic
15 like that, and the amount that we were doing, I'm not
16 sure there would ever have been enough capacity.
17 Because on the one hand, government is doing everything
18 it can to support those who were dealing with the
19 disease. But even we, whether it's the officials, the
20 civil servants, we're also being impacted ourselves.
21 Within the cohort of people working in the civil service
22 were people who were shielding or who had family members
23 who were dying and so on.

24 So I don't think that this was a case of people
25 slacking off or people not doing as much as they could

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1 Thank you.

2 This relates to this point, is that:
3 "There is a significant amount of work being carried
4 out at the local authority level and by Directors of
5 Public Health which is not currently being captured
6 centrally. Capturing this will be a focus in the coming
7 months."

8 So, again, drawing that together, your work revealed
9 that there was a lack of visibility in central
10 government about what local government colleagues were
11 doing in relation to these areas?

12 **A.** I'm not sure whether that was about the central
13 government visibility. I think it might have been the
14 RDU's visibility into -- being a separate department,
15 into what was going on. I suspect that DHSC would have
16 known what directors of local -- local directors of
17 public health were doing, and probably in MHCLG, as it
18 was at the time, there would have been some insight.
19 But making sure that we had that information and we were
20 able to capture that in our work I suspect is part of
21 what we were looking at.

22 I can't remember exactly, but that -- reading that
23 now, I think that that is what we were saying. I don't
24 think what we were saying was that nobody knows what
25 anyone is doing.

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1 do. Sometimes it would be people just not having in
2 themselves their own personal capacity, literally no
3 other person to join or perhaps those with the right
4 skillset. And you can't skill up quickly for a pandemic
5 and you can't have pandemic-sized response capacity just
6 sitting there waiting all the time.

7 **Q.** I won't repeat the chronology points again, but the last
8 point on metrics is that one of the recommendations --
9 we don't need to look at it -- recommendation 10, was
10 that you were going to work with other departmental
11 colleagues to establish metrics going forward.

12 We're going to move on to one last point, which is
13 recommendation 3. So if we could go back, please, to
14 page 5, or page 6 it's probably on, so you have it in
15 front of you. And overleaf, thank you.

16 "There should be a rapid, light-touch review of
17 action taken by local authorities and Directors of
18 Public Health to support people from ethnic minority
19 backgrounds, in order to understand what works at
20 a local level."

21 If we fast forward to page 9, please, just to help
22 you, because I'm conscious these are long documents
23 which you have seen recently, but some of them are more
24 in the past.

25 Page 9, please, thank you. The last paragraph.

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1 **Q.** We'll read in context, but you don't like duplicating
2 other people's work, but one of your recommendations is:
3 we need to do a review, we need to know more.

4 **A.** Yes.

5 **Q.** Dealing with the last themes very briefly, but they're
6 important points, data, data remained an issue, which --

7 **A.** And -- sorry to interrupt -- if I was to refer to --
8 that's point 5. If I was to refer to point 3 on that
9 page, we document what we did, asking for a set of
10 returns, and it could also have been that departments
11 sent us some but not all of what they had, and making
12 sure that we're reviewing what information they had as
13 opposed to what they were sending was also part of it.
14 Sometimes they just didn't send us everything. They
15 might have thought it wasn't relevant. Sometimes
16 a particular team may not even know what another
17 department -- what another part of the department has.
18 Government is very big, and the bigger it is, the harder
19 it is to find information.

20 **Q.** That goes back to the question before lunch about your
21 role as Minister for Equalities and whether that had
22 a sufficient seniority and importance to get a response
23 from other departments. Was that an issue?

24 **A.** I think that was not an issue because this was a report
25 commissioned by the Prime Minister, so it had his

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1 authority behind it, and remember I was not the only
2 Equalities Minister; there was a more senior Equalities
3 Minister as well.

4 I never felt that they did not take this work
5 seriously, but I did feel that they were very much at
6 capacity.

7 **Q.** Okay.

8 Data, and I'm going to summarise. Data was a real
9 issue. There was:

10 "... no single dataset [which held] all the
11 variables needed to gain a full understanding, different
12 organisations have been linking datasets over the last
13 4 months ..."

14 We don't need to turn to that, it's page 14.

15 It says later on at page 20:

16 "... the emerging picture points to areas of general
17 concern about data quality ..."

18 So a real feature was: we don't have one dataset,
19 we're merging a number of datasets; secondly is that
20 there's issues regarding data quality, data collection,
21 and the need for harmonisation of data standards.

22 **A.** Absolutely.

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

25 **A.** Yes, I remember that.

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1 **Q.** We touched upon already that the 13 recommendations in
2 this first quarterly report in October 2020 were
3 accepted in full by the Prime Minister, and that this
4 formed the framework going forward for your work, is how
5 you said in your statement.

6 I want to fast forward now to the second quarterly
7 report --

8 **A.** Right.

9 **Q.** -- which is in February 2021, so we're now in the third
10 lockdown in terms of the narrative, and if we could open
11 up, please, INQ000089744. We have it there, thank you
12 so much.

13 This was published on 26 February and, as you
14 summarise in your statements, looked at causes of higher
15 infection and mortality rates for ethnic minority groups
16 in greater detail, and the work undertaken to mitigate
17 risks. You explain that the impact on ethnic groups had
18 changed between the first and second waves.

19 Did you want to, rather than me summarising
20 everything, explain your assessment at that stage? That
21 was quite a significant part of your work.

22 **A.** Yes. I don't have the exact page in front of me, but
23 I do recall that there had been a change between what we
24 saw for black males and -- or at least the black cohort
25 and whites, there was an equalisation in terms of risk,

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1 **Q.** Communications. We discussed it already, it was in your
2 terms of reference. Another one of your recommendations
3 for this first quarterly report was to continue to
4 improve public communications. It was an ongoing issue.
5 Is that fair?

6 **A.** Yes.

7 **Q.** And risk. Perhaps we could turn to look at this.

8 Page 16, please, second paragraph, thank you, risk
9 factors, and how some occupations carry a higher risk of
10 getting infected. We touched upon this when looking at
11 the Covid-O report:

12 "... as the job cannot be undertaken at home; people
13 still need to commute to work in order to provide
14 essential services for the community."

15 These figures are significant:

16 "1.4 million key workers were from ethnic
17 minorities, making up to 14% of all key workers (5% of
18 the total workforce) and 20% of those in high risk
19 occupations compared to their 11% involvement in the
20 total workforce."

21 So there is a recognition there of risk, risk being
22 a factor, and risk being a factor linked to the
23 occupations where certain ethnic groups were more
24 prevalent in; is that correct?

25 **A.** Yes.

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1 whereas on the side of Pakistani and Bangladeshi groups,
2 I think -- I can't remember whether it stayed the same
3 or it had got worse, but suddenly black African and
4 white British men, there was no disparity, but it
5 continued within the Asian groups.

6 **Q.** Yes. That's a fair summary. We have it in front of us
7 there.

8 Perhaps, in fact, if we pull out for a moment,
9 I think page 6, paragraph 3 is probably a better
10 reference. I may be wrong. Okay. Let's go with this
11 reference.

12 It says overall the direct impacts of Covid-19
13 improved for ethnic minorities as a whole during the
14 early second wave, and it describes the difference in
15 the first wave, and how in the early part of the second
16 wave the risk of death was the same for black African
17 and white British men, what you've just said to us.

18 **A.** Yes.

19 **Q.** To underline the second part:

20 "At the same time, however, the second wave has had
21 a much greater impact on some South Asian groups. Work
22 is underway to consider why the second wave to date has
23 had such a disproportionate impact on Pakistani and
24 Bangladeshi groups. Relevant considerations include
25 regional patterns in first and second waves ...

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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 **Q.** So in relation to that --

15 **A.** Yes.

16 **Q.** -- the community champions was something which was
17 an important part of your work. You mentioned in your
18 reports that funding was granted in January 2021, so
19 just at the beginning of the third lockdown.

20 **A.** Yes.

21 **Q.** This is your report in February 2021. Community
22 champions and that trusted voice for different
23 communities, was that something which perhaps should
24 have been done at an earlier stage?

25 **A.** I don't see how we would have done that. If you

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1 were previously roughly equally impacted was how many of
2 them had grandparents effectively living with the family
3 and exposure to young children.

4 So we put out lots of communication around -- to
5 diaspora communities, by this point the community
6 champions programme is starting where we know that
7 clearly with some of these groups, not all of them are
8 going to be going to gov.uk to read through all the long
9 bits of advice --

10 **Q.** Just pausing there, we have a remote stenographer, so
11 I'm just --

12 **A.** Oh, sorry.

13 **Q.** No, not at all, just to give a pause to your answer.

14 **A.** Yes.

15 **Q.** You were dealing with communication --

16 **A.** Yes.

17 **Q.** -- and community champions, which is one of the topics
18 I was going to deal with.

19 **A.** Okay.

20 **Q.** Explain to those who are listening what community
21 champions were and how that was brought about.

22 **A.** Right. So if I take a step back and provide some more
23 context.

24 At this point we can see that there are
25 multigenerational households who were particularly

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

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

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

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

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1 address that.

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

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

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

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

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

24 **A.** Yes.

25 **Q.** We talked about metrics, and one of those, if you fast

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1 people as possible have access to the right amount of
2 information and hopefully that eventually transmits, but
3 there are some things that you cannot rebut.

4 Community champions was a way of reaching those
5 people, perhaps, who might not be -- might be digitally
6 excluded, might have low levels of English, hopefully
7 are slightly distanced from a lot of the conspiracy
8 theory spread and misinformation spread, but who would
9 perhaps go to a church or a mosque or a religious
10 institution, perhaps a clinic, people who were coming
11 face-to-face with those who might be suspicious of
12 intervention from government.

13 And remember, within ethnic minority populations,
14 there is a very high level of first generation
15 immigrants who come from countries where people don't
16 trust the government, and there is no reason to assume
17 that just because the government is saying something,
18 that they will take it as verifiable information that
19 they have to act on, especially with the backdrop of
20 conspiracy theory.

21 **Q.** The lack of trust and the need for trust is something
22 you have mentioned a number of times.

23 **A.** Yes.

24 **Q.** And it's a feature of your work how this community
25 engagement, community champions, was one vehicle to

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1 forward to page 49, was your recommendation 10 from the
2 first report. There was an update in relation to
3 recommendation 10 which you wrote to colleagues in
4 December 2020, encouraging departments to establish
5 metrics for assessing the impact of their policies,
6 accompanied by a technical annex, and you also met the
7 minister for Covid-19 vaccinations.

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

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

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

25 I seem to recall by this point we were heading into

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1 periods where religious festivals were taking place. We
 2 knew that large gatherings of people were occurring,
 3 especially in certain minority communities; how to make
 4 sure that people protected themselves and did not --
 5 you know, did not end up in a situation where large
 6 non-compliance activities were taking place.

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

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

17 Let's move to the third quarterly report. It's
 18 25 May 2021. We're into summer 2021. Things are
 19 improving relatively, INQ -- it's right in front of us,
 20 thank you so much. Page 3, please.

21 We see there in the last paragraph:
 22 "This report summarises work across government and
 23 through national and local partnerships, to improve
 24 vaccine uptake among ethnic minorities."

25 It describes:

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1 been contributing to ethnic minority disproportionate
 2 impact, fear -- not participating in clinical trials
 3 would mean that: what if people were getting the vaccine
 4 and then it wasn't working because of genetics or
 5 something else? So increasing vaccine uptake, but also
 6 encouraging people to understand what vaccines are
 7 about, that they're safe, taking part in clinical trials
 8 was really important to me. I took part in clinical
 9 trials myself. I trialled -- I went on the Novavax
 10 vaccine trial, publicised that, to let people know that
 11 this wasn't something that they should be afraid of.

12 There was a lot of fear by this point that the
 13 government wants to -- or the -- how can I put this?
 14 There was a fear that a lot of the communication about
 15 disproportionate impact was actually a secret conspiracy
 16 to scare ethnic minorities into taking vaccines, which
 17 was a way of the government culling the population. So
 18 even the things which we are doing in order to identify
 19 risk were being manipulated into conspiracy theories to
 20 deter people from doing what would have helped them
 21 mitigate that risk, and that was something that I was
 22 particularly concerned about.

23 **Q.** You recognised that there was mistrust in the
 24 communities, not one community, and there were efforts
 25 which are set out in this report to address that and

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1 "A data-informed approach, targeted communications
 2 and engagement and flexible deployment models are the
 3 cornerstones of vaccine equalities delivery."

4 It refers to supporting it during Ramadan, extending
 5 the use of places of worship, and out of completeness,
 6 at the bottom of the paragraph, refers to further
 7 funding, £4.2 million:

8 "... to local sustainability and transformation
 9 partnerships to enable targeted engagement in areas with
 10 health inequalities and with communities ..."

11 By this stage, your work -- is this a fair
 12 summary -- in May 2021, the huge focus of it was in
 13 enabling vaccine uptake?

14 **A.** Yes.

15 **Q.** Why was that?

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

18 **Q.** Yes, it does.

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

24 Vaccines, on the other hand, were proven, and
 25 looking at some of the things that I felt would have

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1 improve communication and improve vaccine uptake.

2 What do you say to the question regarding whether
 3 the balance was right? Was too much of the effort at
 4 this stage into addressing ethnic minority
 5 disproportionate impacts on vaccines? Should more have
 6 been also done in relation to other areas, such as
 7 financial support, for instance?

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

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

18 But I also think that -- I remember reading lots of
 19 recommendations and lots of reports at the time. What
 20 people were suggesting was racial segregation: let's
 21 treat black people differently because they're
 22 disproportionately impacted, let's give them the vaccine
 23 first -- something that we didn't do, for example -- or
 24 let's target support packages for ethnic minority
 25 communities, and I think that a lot of this -- it goes

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1 back to the point I was making about use of the word
2 "BAME". Ethnic minorities don't just exist as
3 communities of segregated people. We are part and
4 parcel of this country. We are related to people who
5 don't come from our ethnic background. My husband is
6 white, my children are mixed race; there are families
7 like ours all across the country. Targeting ethnic
8 minorities in this way rather than targeting households
9 and families would have been completely the wrong thing
10 to do, and that applies to both the clinical
11 interventions, as well as things like economic packages
12 and so on.

13 **Q.** Let's pause there for a second, because it's just --
14 we're on points.

15 **A.** Yes, okay.

16 **Q.** And you're talking about support packages for ethnic
17 minority groups.

18 One of the features from your work is that
19 recognition of the higher rate of mortality in relation
20 to --

21 **A.** Yeah.

22 **Q.** -- British Pakistani, British Bangladeshi, and in the
23 type of occupations they work more in, and we talked
24 about key workers as well.

25 So, against that background, was it not the case
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1 drivers, who are particularly exposed, who are from that
2 background. But they are no more exposed than taxi
3 drivers of another background. You could say: well,
4 let's give extra money to all taxi drivers. But then
5 there are other groups of people, not least of all
6 health workers, who are also similarly exposed. There
7 is no perfect way of finding a particular group to give
8 extra cash to, and extra cash in and of itself would not
9 have solved the problem which we were trying to resolve
10 of making sure people were protected and away from the
11 virus.

12 **Q.** Just --

13 **A.** If I may, there is one extra point. What this
14 highlights is the trade-off, that is the trade-off that
15 we, as government ministers, have to balance.

16 Deprivation is one of the reasons why people say
17 that there is inequality. Making sure that people can
18 stay economically active -- it's not just about the
19 earning of the money but also the things that come with
20 it. If you reduce that, you also create factors that
21 can lead to inequalities later. So we have to look at
22 all of those things in the round and find the right
23 balance and --

24 **Q.** Can I ask you a question in relation to this, because
25 I'm conscious that there was a long answer and I don't
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1 that earlier in the pandemic, perhaps before vaccines,
2 there should have been greater financial support to help
3 people in areas, such as in the north of England?

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

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

22 **Q.** I don't think that was the suggestion, in fairness.

23 **A.** I'm giving examples, I'm not saying that's what you are
24 suggesting.

25 You could have said: let's give money to the taxi
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1 want to lose it all.

2 **A.** Right.

3 **Q.** So one of the areas which is an alternative was whether
4 there should have been more financial support in
5 relation to those occupations, or people generally --
6 putting ethnicity to one side -- who may have been
7 self-employed or working in low paid areas which, if
8 they were sick, they would get sufficient financial
9 support so they could self-isolate. That's the vehicle
10 for this sort of support, which I'm sure you're familiar
11 with. Was that not something that your work should have
12 included or at least explored?

13 **A.** That was work that was taking place in the Treasury.
14 I wasn't the minister responsible for that, but that was
15 looked at in the Treasury. I'm afraid I only have the
16 Equality Hub notes for this module, but that definitely
17 was done, and I remember standing at the despatch box
18 and explaining how we came to devise the packages which
19 we did. There always has to be a cut-off, and there is
20 a cost to everything.

21 So the package -- the furlough and a lot of the
22 quantitative easing and money printing which we did then
23 is directly related to some of the issues that we're
24 seeing now with high interest rates, with inflation. So
25 more interventions are not without cost or consequences,
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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:
 19 "This third report summarises the data for deaths in
 20 the second wave up to 31 January ... which was not
 21 available ... The latest data confirms the finding from
 22 the second report that people from South Asian ethnic
 23 groups, particularly the Pakistani and Bangladeshi
 24 groups, were at the greatest risk of death from COVID-19
 25 during the second wave."

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1 relation to your work -- this was the third report --
 2 was there any work done to explore Long Covid in terms
 3 of its impacts on ethnic minority groups?
 4 **A.** No, I think for several reasons. One, it would have
 5 been outside our immediate terms of reference. This is
 6 very much health work, and by that I would say sort of
 7 frontline research analysis, whereas the analysis that's
 8 done within my unit is more statistical. But it was
 9 something that we thought was worth highlighting,
 10 especially -- certainly in my personal opinion, the
 11 health and social care workers was emphasising that this
 12 is something to do with exposure, you know, being
 13 exposed is likely to -- or the frequency of exposure is
 14 likely to trigger Long Covid. But we would not have
 15 been the right place for that kind of work to have taken
 16 place, but it was something that we thought was worth
 17 referencing in this report.
 18 **Q.** Thank you.
 19 We fast forward to the final report, which is the
 20 fourth quarterly report, which is dated 3 December 2021.
 21 So just as we are -- Omicron is around at that time,
 22 December 2021. This was a long report, even for the
 23 report you undertook on our behalf, 133 pages.
 24 We see, if we could turn to page 5, please, the
 25 understanding is much clearer, in your view, and the

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1 In terms of those numbers, I would summarise it, at
 2 page 22, is that compared to white British men and
 3 women, Bangladeshi men and women were 6.1 and 6.3 times
 4 more likely to die from Covid, Pakistani men and women
 5 were 4.4 and 3.8 times as likely to die from Covid, and
 6 that they adjusted -- they reduce, but not
 7 significantly, for other factors as well.
 8 In relation to one other feature which arises in
 9 this report for the first time -- and it's an interest
 10 to groups which are core participants -- is at page 29,
 11 Long Covid. That's something which is raised for the
 12 first time in this third report. I'm just going to
 13 touch upon it briefly, if I may, and ask you what work,
 14 if any, was done.
 15 It describes Long Covid as "an emerging phenomenon
 16 that is not yet fully understood", and describes the
 17 impact of that, which I can summarise. The prevalence
 18 rates for self-reported Long Covid were highest for (a)
 19 people with a pre-existing activity-limiting health
 20 condition and (b) health and social care workers, and we
 21 see that in the middle of the page. In very simple
 22 terms, those in the white ethnic groups had the highest
 23 prevalence rates of Long Covid compared to the Asian
 24 ethnic groups.

25 Quick question on an important topic, but in

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1 work that was undertaken on your behalf.
 2 "The main factors behind the higher risk of COVID-19
 3 infection for ethnic minority groups include occupation,
 4 (particularly for those in frontline roles, such as NHS
 5 workers), living with children in multigenerational
 6 households, and living in densely-populated urban areas
 7 with poor air quality and higher levels of deprivation."
 8 So occupation, deprivation, and household make-up,
 9 significant factors:
 10 "Once a person is infected, factors such as older
 11 age, male sex, having a disability ..."
 12 And we touched a lot on disability:
 13 "... or a pre-existing health condition (such as
 14 diabetes) ..."
 15 And you've touched upon that:
 16 "... are likely to increase the risk of dying from
 17 COVID-19."
 18 And in relation to the work you've done, your
 19 summary was, in the statement, that vaccination was the
 20 most significant measure, in your view, to protect
 21 ethnic minorities.
 22 **A.** (Witness nods).
 23 **Q.** Was that the position?
 24 **A.** Sorry, vaccination was taken in a sufficient enough ...?
 25 **Q.** No, I'll say it again, it's my fault if it's lost.

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1 What you say in your statement is that vaccination
2 was the most significant measure to protect ethnic
3 minorities.

4 **A.** Yes, yes.

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

8 **A.** Yes.

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

20 **A.** Yes.

21 **Q.** Not controversial.

22 **A.** No. I hope not.

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

25 In relation to -- thank you for turning overleaf --
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1 everyone being treated regardless of their ethnicity.
2 And the Equality Act states very explicitly that
3 positive discrimination is illegal.

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

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

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

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

3 We've mentioned it a couple of times. Perhaps this
4 is the opportunity to deal with that and stigmatisation.
5 What were the concerns regarding stigmatisation during
6 your work in relation to the impact on ethnic minority
7 groups?

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

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

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

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

7 **A.** All right.

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

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

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

13 **A.** Okay.

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

18 **A.** Because I felt that if we had had that -- and I don't
19 know why it wasn't recorded, I don't know if there was
20 ever a reason, it was just something that wasn't
21 recorded -- if we had had that, we might, not certainly,
22 but we might have been able to spot the disproportionate
23 impact a little bit earlier. But this -- this was
24 certainly speculation, reasonable speculation on that
25 basis for that problem. But it seemed an odd place to
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1 not capture it, given that we capture it in all sorts of
2 datasets.
3 **Q.** Two final questions. First one, your view of the
4 greatest success of the work that your team achieved in
5 relation to this area?

6 **A.** Yes, I think we had a -- I think we had a lot of
7 successes actually. I'm very proud of the work that my
8 team -- my team did. I think under a lot of pressure
9 and with very high expectations, I think that they
10 delivered. I think the work that they did was rigorous,
11 it was very carefully done, it was very sensitive. They
12 won an award, in fact. They won an ONS award in
13 research excellence for the analysis that they did, and
14 that was in competition -- the other shortlisted people
15 were universities, so the quality of the work they
16 produced was very high.

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

25 I think we saw things like greater vaccine uptake
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1 information travels at lightning speed across the world.
2 I don't know how we solve it. But in terms of gaps,
3 I think that that is -- there was a lesson in the
4 pandemic that this is an area that needs more
5 addressing. And I hear of a lot of work being done in
6 departments, whether it's Cabinet Office or DSIT I'm not
7 sure, but I don't see -- I don't see it. So maybe there
8 is lots of being work being done and it's covert, but
9 it's hard, if that is the case, to know what is being
10 done. So I think that's an area.

11 I think another area that we should have done more
12 on was on the economic impact. We were looking very
13 much at the health side, and I think that we should have
14 had an economic impact of lockdown, I think that now we
15 are seeing many -- many outcomes which are related to,
16 you know, the missing children in schools, for example,
17 what happened to them. No one's quite got to the bottom
18 of that. The economic impact of lockdown, how that
19 might have triggered even more inequality further down
20 even if people had furlough or a safety net immediately.
21 I'm not sure that that work was done because we were
22 very, very, very focused on the health side. And
23 I think when we have these sort of grand problems, we
24 need to have multiple lenses through which we're looking
25 at them.

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1 because of the work that we did, and some of the
2 recommendations we made, family jabbing, for example, so
3 that people felt more comfortable doing this because
4 they had -- taking the vaccine because they had people
5 who they cared about and who they trusted going along
6 with them. Things like increased participation in
7 clinical trials by ethnic minorities which I think is
8 important if you're going to get vaccines that work and
9 pick up the right data on health issues.

10 So I think there are a lot of successes.

11 **Q.** Thank you.

12 And the other side of the coin, with the view to
13 learning lessons, what do you think is the greatest
14 lesson we can learn to improve going forward in relation
15 to this area?

16 **A.** Where does one start? I think for me I am still very,
17 very concerned about the issue of misinformation and
18 just how -- and I say this even as a constituency MP,
19 the number of people who come up to me in the street and
20 tell me that I am part of a grand conspiracy to infect
21 them and so-and-so died because of the material that we
22 were putting out is very disturbing. I don't think
23 government's got a handle on dealing with
24 misinformation. I don't think that we have adapted to
25 this age of social media carrying -- you know, where

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1 And this is hindsight analysis, but the fact that we
2 looked at things purely from a health perspective
3 without the -- without opportunity costs analysis or
4 what was happening looking at it through another lens,
5 I think we should not have done.

6 **Q.** And you were a junior Treasury minister during that time
7 as well, that was an observation you recognise.

8 **A.** Yes.

9 **Q.** I said that was my last question. I will keep my
10 promise.

11 My Lady, there are the questions, all I have. You
12 have granted permission to core participants, but it may
13 be that my Lady wants to have a short break before we
14 move on to that.

15 **LADY HALLETT:** No, I'm going to carry on. If the
16 stenographer has to take a break, then she'll take
17 a break.

18 **MR KEATING:** I understand.

19 **LADY HALLETT:** So if Mr Thomas is ready, I am.

20 Thank you.

21 **Questions from PROFESSOR THOMAS KC**

22 **PROFESSOR THOMAS:** Ms Badenoch, let me introduce myself,
23 I am Leslie Thomas and I act on behalf of FEHMO, the
24 Federation of Ethnic Minority Healthcare Organisations.

25 I have a small handful of questions, but can I just

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1 pick up on something you said to Counsel to the Inquiry
 2 just a moment ago, you were talking about tackling the
 3 cause as opposed to just looking at the issue, why
 4 certain groups were affected disproportionately. One of
 5 the reasons for that surely would be structural
 6 inequalities, would you agree?
 7 **A.** I'm not sure that I do agree because it depends on what
 8 you mean by structural inequalities --
 9 **Q.** Poverty --
 10 **A.** Yes.
 11 **Q.** -- for example --
 12 **A.** Yes, but we don't -- we don't have a cure for poverty.
 13 If we did, we would have done it.
 14 **Q.** I hadn't finished.
 15 **A.** Okay.
 16 **Q.** Poverty, for example, discrimination based on race,
 17 perhaps gender, perhaps other factors such as, you know,
 18 we know that some people suffer from disability suffer
 19 from discrimination, so factors such as that, that's
 20 what I mean by structural inequalities.
 21 **A.** Okay, so you mentioned discrimination as an example.
 22 That was not something that was found in any of the
 23 evidence that we carried out. And these are things
 24 which there are processes in place to address, but in
 25 terms of the issues around deprivation, poverty, health

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1 So, for example, when we looked at the
 2 intersectionality of age and gender, we found that being
 3 male was a bigger issue than being female in terms of
 4 catching the disease and in fact dying from it. We
 5 looked at the intersectionality of things like age and
 6 disability. So that was all taken into account. We may
 7 not have called it "intersectionality", but there were
 8 lots of multivariate analyses that took place, including
 9 things like geography which don't always get taken into
 10 account.
 11 **Q.** Let me cut to the chase. If you took into account the
 12 intersections between certain factors and you've
 13 outlined some of them, did you have, in government,
 14 targeted strategies to address those disparities
 15 comprehensively and if not why not?
 16 **A.** The strategies we had would have dealt with
 17 intersectionality in and of themselves, there was no
 18 reason to believe that there was something -- that there
 19 was a gap. Unless you can give me an example of a gap
 20 that you have identified. I would be quite keen to hear
 21 it.
 22 **Q.** I'm going to ask you this: do you accept that gathering
 23 and understanding the data was important?
 24 **A.** Yes.
 25 **Q.** So we can agree on that. Can we also agree that because

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1 comorbidities, a lot of work was done to look at things
 2 that we could do to tackle that. But we can't cure
 3 diabetes, we can't remove poverty. So saying that
 4 structural inequalities had an impact on incidence, yes,
 5 that is true, but that doesn't mean that there is
 6 a silver bullet to resolve them.
 7 **Q.** Do you remember in your evidence this morning, I think
 8 we can agree on this, you said that the label "BAME" is
 9 unhelpful because it is kind of like a one size fits all
 10 and you need to look at the situation and the impact and
 11 it's much more nuanced. We can agree on that, yes, that
 12 "BAME" is an unhelpful term?
 13 **A.** That is what I said.
 14 **Q.** Yes. So with that in mind, and I'm referring -- I'm not
 15 going to call up the documents unless you want to go to
 16 them, but I'm referring to your witness statement, and
 17 just for the record paragraphs 44, 47, 48, where you
 18 discuss disparities and they're highlighted. My
 19 question is this: how were the intersection of ethnicity
 20 with other factors such as gender, disability,
 21 socioeconomic status, dealt with?
 22 **A.** So if by intersectionality you're talking about
 23 a coincidence of protected characteristics, that would
 24 have been taken into account just by looking at the
 25 cohort of people that were being sampled.

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1 of the importance of data, particularly data in how it
 2 related to disparities, efforts should have been made to
 3 make sure that data was accessible and transparent to
 4 the public? Can we agree on that?
 5 **A.** Yes.
 6 **Q.** How was this done?
 7 **A.** Well, the reports that we published provided our
 8 assessment of the data, but we don't hold data, data is
 9 held by public authorities by the ONS. Is there
 10 a specific data that you feel was not published that
 11 should have been published?
 12 **Q.** Given the heightened risks faced by certain groups, and
 13 you've mentioned in particular men of Pakistani origin,
 14 and because I represent healthcare workers, I'm just
 15 interested to know that some of these disparities were
 16 highlighted very early on. We know that, for example,
 17 the first ten doctors who died from the virus were
 18 doctors of colour. We know that and we've heard
 19 evidence.
 20 Can you just help the Inquiry with this: if this was
 21 known fairly early on, what specific initiatives or
 22 measures were taken and implemented to prevent those
 23 demographics from that high -- disproportionately high
 24 risk of exposure and mortality?
 25 **A.** Well, the first thing we did was the report that we

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1 commissioned by PHE to check what was going on. That
 2 was one of the anecdotal pieces of information that
 3 alarmed me. But knowing that the first set of doctors
 4 who died were from an ethnic minority background doesn't
 5 tell you why they are dying, it just tells you that that
 6 is happening. So finding out the "why" is important to
 7 address the issue. And as we've seen from all the
 8 research that has been carried out, if we had simply
 9 made an assumption that being an ethnic minority in
 10 itself was the risk factor -- it wasn't, this was not
 11 a disease that targeted people on that basis -- then we
 12 would have carried out the wrong interventions.

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

25 Question: in the light of the substantial and severe
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1 evidence", "we must widely disseminate and discuss the
 2 report before deciding what needs to be done".

3 My question is: in the light of the substantial and
 4 severe disparities in the infection and mortality rates
 5 evidenced by the publicised and stats since late March,
 6 why the need to wait?

7 **A.** So we didn't wait --

8 **MR KEITH:** I'm not at all sure that this is an area on which
 9 you have given permission in the Rule 10 process.

10 **LADY HALLETT:** I was thinking the same, Mr Thomas. This
 11 wasn't a matter that was raised in Parliament, was it?
 12 Who is Gill Furniss?

13 **PROFESSOR THOMAS:** My Lady, I'm surprised at the
 14 intervention, because we were given permission to ask
 15 this question.

16 **LADY HALLETT:** It may be that I have the wrong copy,
 17 Mr Thomas, it may well be.

18 **PROFESSOR THOMAS:** So I'm looking at the permission and it
 19 clearly says "CP may ask this question, however please
 20 reformulate the question" --

21 **LADY HALLETT:** I remember saying that.

22 **PROFESSOR THOMAS:** Yes.

23 **LADY HALLETT:** The only other concern was, it's not to do
 24 with proceedings in Parliament, is it?

25 **PROFESSOR THOMAS:** No.
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1 disparities in the infection and mortality rates, which
 2 was evident from the widely publicised datasets and
 3 statistics from late March 2020 onwards, why did the
 4 government feel the need to wait before taking any
 5 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,
 11 highlighting the disparities. It was put to the
 12 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,
 17 but shortly afterwards what Gill Furniss is putting to
 18 you and government is: well, the report is simply
 19 confirming what's already known. Okay?

20 And the response was -- she was suggesting it was
 21 important for the government to risk assess, to urge --
 22 call on employers to risk assess black, Asian and
 23 minority ethnic workforce. And in response you said on
 24 behalf of government that you need to wait to "ensure
 25 that we do not take action that is not warranted by the
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1 **A.** Gill Furniss I believe is an MP, a Labour MP, am I
 2 correct?

3 **PROFESSOR THOMAS:** Yeah?

4 **A.** Right. Okay.

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

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

17 What I was referring to was not knowing why
 18 something is happening means that you don't know how to
 19 fix it. And that means looking at a report and getting
 20 the data out. And as it happened, I didn't think that
 21 the report that PHE published answered the question why,
 22 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
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1 to trespass --

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

5 **LADY HALLETT:** Indeed. I apologise.

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

9 **LADY HALLETT:** Right, anyway, it's done now, Mr Thomas.
10 Anyway I apologise for interrupting if you had
11 permission. By the sounds of it, it probably shouldn't
12 have been given permission, and that's my fault.

13 Right, next, I think, it's Mr Stanton.

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

19 **Questions from MR STANTON**

20 **MR STANTON:** Thank you, my Lady.

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

24 **A.** All right.

25 **Q.** I'd like to briefly revisit an issue that Mr Keating

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1 Subsequently, four days after this letter, a 69-page
2 report was indeed published, with seven recommendations.

3 I appreciate what you've had to say about the
4 circumstances of this publication, but was it not the
5 case that the fact that information had been removed
6 from the original planned report had become an open
7 secret and that forced the government's hand to publish?

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

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

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

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1 addressed with you earlier in your evidence in
2 connection with the Public Health England report of
3 2 June, and the concerns that you made reference to,
4 or of a number of organisations, about the possibility
5 that information had been withheld from that report.

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

11 **A.** Yes.

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

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

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

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

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

16 **Q.** Thank you.

17 **A.** Thank you.

18 **Q.** The 69 pages deal exclusively with the issue of
19 disproportionate impact on ethnic minority groups and,
20 as you will know, the BMA became very concerned from
21 an early stage, from April 2020, about this issue,
22 particularly as early data had shown that, among the
23 doctors who had died in the early months from Covid-19,
24 94% were from a BAME background.

25 Given the seriousness of this issue and the

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1 seriousness of the BMA's concerns, what was it about
2 this particular area that necessitated a separate
3 report?
4 **A.** It was qualitative analysis, not quantitative analysis,
5 and the recommendations, as I said, were actually not
6 very clear, although we did in the end understand, after
7 a lot of engagement with PHE and with
8 Professor Kevin Fenton, who was the London regional
9 director. But when you have recommendations like having
10 cultural competency, that could mean any number of
11 things. Simply publishing that without a clear response
12 or a clear idea of how to carry out those things I don't
13 think is a responsible thing for a government to do.

14 But also, the BMA was rightly concerned. They are
15 a trade union for doctors. If doctors are dying, they
16 should be concerned. I was concerned. My father, who
17 was alive at the time, was a black doctor. If doctors
18 who were black were impacted, this was something that
19 would impact me. So I did care about this issue. But
20 I think that there is so much suspicion now around the
21 motivation for something being published that aspersions
22 were cast which didn't need to be. We took this very
23 seriously and we worked closely with them in order to
24 get those recommendations acted on, and they were.

25 **Q.** One of the, perhaps, areas in which misunderstanding has
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1 a risk assessment can have on safety for doctors and
2 healthcare workers?

3 **A.** So one of the things that is a limitation for me as
4 equalities minister is that I don't have levers, and
5 this was not a report for me, this was a report for the
6 Department of Health, so I would not have dealt with
7 that recommendation. However, I do recall that areas
8 like PPE and how they might have fitted on people of
9 different ethnicities and, in fact, people of different
10 sexes and so on, a lot of work was done in that space.
11 It was then -- I remember it was discovered at the time
12 that some PPE which was just uniform was unsuitable, and
13 this was for lots of different demographics. That's one
14 example.

15 So I do know that that work took place, but it
16 wouldn't have been within the remit of my department.

17 **MR STANTON:** Thank you.

18 Thank you, my Lady.

19 **LADY HALLETT:** Thank you very much, Mr Stanton.

20 Mr Friedman.

21 Questions from MR FRIEDMAN KC

22 **MR FRIEDMAN:** Thank you, madam.

23 Secretary of State, I act for four national disabled
24 people's organisations. We have listened to your
25 evidence carefully today and you've explained that

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1 been allowed to creep in is because the original terms
2 of reference of the review included a requirement to
3 make recommendations --

4 **A.** Yes.

5 **Q.** -- and recommendations only appeared in the second
6 report.

7 **A.** Yes.

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

9 **A.** No. No, and in fact I did get an apology from PHE for
10 doing that, because they mixed the two things together.
11 They didn't provide -- and that for me was actually
12 highlighting the fact that they didn't know what to do
13 on the substance of the findings which they had. They
14 didn't make recommendations as we had commissioned;
15 instead, they did a separate piece of work that was
16 different and made recommendations there.

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

18 **A.** Thank you.

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

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

6 **A.** Yes.

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

11 **A.** Right.

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

19 So was he consulted on that matter?

20 **A.** I don't remember whether he was consulted on that
21 matter. However, the Minister for Women and Equalities,
22 I was senior minister, who had overall responsibility
23 for this area, would have known about it. I can't
24 recall. However, if we look again at the genesis of how
25 this report came to be, and it relates to the previous

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- 1 question on intersectionality which was asked by the
2 previous counsel, you need to be able to disaggregate
3 data before you can look at them in the multivariate
4 analysis, you can look at the way that they interact.
5 So whether or not we took this work into account, the
6 data -- within our workstream or they looked at it
7 separately, the data would still have been there. So if
8 the question --
- 9 **Q.** Well, I just -- I'm going to come on to it, I'm only
10 interrupting you just because I'll come on to that. But
11 I think the answer you've given is that you don't know
12 about Justin Tomlinson but you think maybe Liz Truss, in
13 her position --
- 14 **A.** I don't recall whether or not Justin Tomlinson was but
15 Liz Truss would have been.
- 16 **Q.** Right, because I'm going to ask a second question
17 following that, if I may, which is that we have seen
18 none but was there a documented decision along those
19 lines around disabled people in relation to your
20 investigation or is it a more informal consultation that
21 you're recalling?
- 22 **A.** I don't think it is either. If we look at the -- one of
23 the quarterly reports where we talk about a separate
24 workstream --
- 25 **Q.** It's the final one.

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- 1 **A.** I would not have needed to have those conversations
2 because that happens anyway. If you are disabled and
3 work is being done around disability, ethnic minorities
4 who are disabled will be captured and vice versa. So we
5 don't need to have a discussion to make sure that this
6 happens. This will simply be the case.
- 7 **Q.** Well, we don't need to study all your published reports,
8 but you don't deal with it in any way at all in your
9 reports?
- 10 **A.** We don't reference it because we are speaking
11 specifically -- the report is about ethnic minorities,
12 so we are talking specifically about that.
- 13 We didn't -- there are nine protected
14 characteristics. Age is a huge -- was the biggest
15 factor, that is also not mentioned in the report. That
16 didn't mean that older people were neglected during the
17 pandemic.
- 18 **Q.** Then lastly this, you have been asked about
19 intersectionality and perhaps the difference between how
20 much it was considered in substance as opposed to
21 definitional form, but the Oxford English Dictionary
22 defines intersectionality as:
- 23 "The interconnected nature of social categorisations
24 such as race, class and gender ..."
- 25 We would add disability.

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- 1 **A.** Yes.
- 2 **Q.** December 2021, in a footnote.
- 3 **A.** Yes, where we talk about a separate workstream. This is
4 a directorate that has all these units working together,
5 but the knowledge of disability as having such a severe
6 impact meant that it didn't need to be in -- it didn't
7 need to be within my bit of work.
- 8 **Q.** Okay.
- 9 **A.** If I may?
- 10 **Q.** Yes.
- 11 **A.** With the bit of work that I was doing, my workstream,
12 we're trying to understand why ethnicity would've had an
13 impact. For disability it's a lot more obvious. There
14 were fewer questions to be asked about why disability is
15 having an impact. It's clear to see. So there was no
16 need to mix those two workstreams together and in fact
17 I would not -- knowing what I know now, I would not
18 recommend it.
- 19 **Q.** Well, I understand that. How much discussion, though,
20 did you have with Minister Tomlinson or indeed the
21 Disability Unit about how disability or disabilities
22 interact with health and, in your work, how the various
23 ethnic minority groups could also be parts of disabled
24 groups and vice versa when it comes to risk and
25 outcomes?

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- 1 "... regarded as creating overlapping and
2 interdependent systems of discrimination or
3 disadvantage; a theoretical approach based on such
4 a premise."
- 5 Secretary of State, do you recognise
6 intersectionality as a matter that all inequality
7 related ministerial portfolios ought to have taken into
8 account during Covid response decision-making?
- 9 **A.** No, I would disagree with that, in fact.
- 10 **Q.** And in the short time we have, could you say why to the
11 Chair.
- 12 **A.** Because as -- I think if we go back to the question
13 around BAME, the sort of work that we do requires quite
14 a lot of disaggregation. The whole purpose of
15 multivariate analysis is that it's looking at
16 different -- it's looking at different incidence rates
17 and it's -- it then looks at them in terms of how they
18 interact.
- 19 So starting off with the intersectionality is not
20 how you should do it. You start off with the
21 disaggregation. You can layer the data together to come
22 out with what intersectionality may be occurring, but if
23 you do it the other way around you get a mixed picture,
24 so I certainly wouldn't recommend that. And I wouldn't
25 start off by using the term "intersectionality" as a way

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1 to find out exactly what the answer is.
 2 What we are doing in government is trying to use our
 3 resources as effectively as possible. So we start out
 4 with the measures that will help the largest number of
 5 people, not the measures that will tackle the most niche
 6 groups, whose intersectionality of race, of gender, of
 7 sex, of class and so on. That is very complicated data
 8 that actually -- an analysis that actually requires
 9 a lot of work. If you are dealing with a pandemic and
 10 there is a lot going on, you need to be able to manage
 11 resources effectively, and starting off with work that
 12 is the most complex means that you will help the least
 13 number of people. And that is why I would not recommend
 14 that.
 15 **Q.** I think you've taken my question as: always do it first.
 16 **A.** Right.
 17 **Q.** I think your answer is "I never recommend doing it
 18 first", for the reasons you've just given, but you don't
 19 seem to be excluding its relevance once you have done,
 20 as it were, the more disaggregated work?
 21 **A.** Yes, but you use the term "intersectionality",
 22 epidemiologists would talk about multivariable
 23 analysis -- multivariate analysis. They are not
 24 different things.
 25 **Q.** Yes, but am I right: never first, but a formula of that
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1 many examples affecting domestic abuse victims, is it
 2 correct that these issues are spread across various
 3 departments without there being ultimate responsibility
 4 in one minister or department?
 5 **A.** I don't think that is true. We have a Minister for
 6 Safeguarding who put through domestic abuse legislation,
 7 and that would -- what you have described would
 8 primarily sit with that minister, but there was
 9 a Minister for Women, the ministers -- and there was
 10 a Minister for Women and Equalities as well, separate to
 11 me as Minister for Equalities, so actually I think that
 12 this is something which is covered by one minister but
 13 loads of others actually provide support in that space.
 14 **MS SERGIDES:** I'm grateful, my Lady.
 15 **LADY HALLETT:** Thank you very much indeed.
 16 I think that completes the questions.
 17 **MR KEATING:** It is, my Lady, thank you very much.
 18 **LADY HALLETT:** Secretary of State, thank you very much
 19 indeed for all your help. I'm sorry I had to ask you to
 20 come back after lunch, but ...
 21 **THE WITNESS:** No, not a problem, thank you very much.
 22 **(The witness withdrew)**
 23 **LADY HALLETT:** Very well. I think that completes the
 24 evidence for today, and we shall return on --
 25 27 November?
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1 kind relevant to all work within the scheme of things?
 2 **A.** I think -- I think it's probably safe to say that that
 3 is something that is routine, I don't think it's
 4 something that is neglected.
 5 **MR FRIEDMAN:** Thank you, madam.
 6 **LADY HALLETT:** Thank you, Mr Friedman.
 7 I think there was a matter that wasn't covered by
 8 Counsel to the Inquiry's questions and therefore,
 9 Ms Sergides, I think you're going to ask a question.
 10 Can you see the questioner?
 11 **THE WITNESS:** Yes.
 12 **Questions from MS SERGIDES**
 13 **MS SERGIDES:** Can you see me?
 14 **A.** Yes, I can.
 15 **MS SERGIDES:** I'm grateful, my Lady.
 16 Secretary of State, I appear on behalf of Southall
 17 Black Sisters and Solace Women's Aid. I only have one
 18 question for you, relating to the overall responsibility
 19 for victims of domestic abuse in government.
 20 Can you see me?
 21 **A.** Yes, I can.
 22 **Q.** Your role as Women and Equalities Minister is not
 23 a Cabinet position, but looking at the wider needs of
 24 victims of domestic abuse during lockdown and their
 25 children, including for example housing, just one of
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1 **MR KEATING:** Sounds good.
 2 **LADY HALLETT:** I'm losing track of the days and months.
 3 **MR KEATING:** Next Monday.
 4 **LADY HALLETT:** 27 November at 10.30.
 5 Thank you, everybody.
 6 **(3.20 pm)**
 7 **(The hearing adjourned until 10.30 am**
 8 **on Monday, 27 November 2023)**
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