IN THE MATTER OF THE INQUIRIES ACT 2005
AND IN THE MATTER OF THE INQUIRY RULES 2006

UK COVID-19 INQUIRY

THIRD WITNESS STATEMENT OF MATT HANCOCK

I, Matt Hancock, Member of Parliament for West Suffolk, House of Commons, London SW1A 0AA, will say as follows:

1. I make this third statement in response to a request from the Inquiry dated 8 September 2023 made under Rule 9 of the Inquiry Rules 2006 ("the Request") asking for a witness statement in connection with Module 2 of the Inquiry.

2. This third statement should be read in conjunction with my second statement, as it is written in response to further queries following that second statement, and as such covers much of the same ground. This statement is to the best of my knowledge and belief accurate and complete at the time of signing. The Department of Health and Social Care ("the Department") continues to work on its involvement in the Inquiry, and should any additional material be discovered I will of course ensure that this material is provided to the Inquiry and I would be happy to make a further supplementary statement if required.

Long Covid

3. You have asked about my evolving understanding of Long Covid during the pandemic and the extent to which consideration was given to the risk of Long Covid in decision-making in response to Covid-19.

4. I was advised verbally by the Chief Medical Officer ("CMO") early in 2020 about the possibility of this virus, as with other viruses, causing post-viral complications and persistent symptoms. I was, therefore, aware of the possibility of longer terms complications from a very early stage of the pandemic.

5. In April 2020 I was aware of public discussion of post viral fatigue, and in May 2020, I became aware of the term, Long Covid, emerging as people shared their anecdotal experience about their failure to recover. I also know people who had (and still have) longer term symptoms and therefore I believed that something needed to be done.

6. I requested NHS England ("NHSE") consider what we must do. I asked Sir Simon Stevens to develop plans for provision for those suffering with Long Covid in May 2020, and on 1 June 2020, I was sent the final draft for review of the NHSE guidance on the long-term healthcare needs of Covid-19 patients and the recommended actions for healthcare providers to meet those needs [MH3/01 – MH3/03 – INQ000292619; INQ000292618; INQ000292620]. The guidance was published on 5 June 2020 [MH3/04 - INQ000050846].

7. On 5 July 2020, I announced that a major new UK research study – the post-hospitalisation Covid-19 ("PHOSP-COVID") study – would be carried out by the National Institute for Health Research ("NIHR") together with UK Research and Innovation ("UKRI") to understand and improve the long-term health impacts of Covid-19 [MH3/05 – INQ000283372]. It was supported by the award of a £8.4 million funding package. On the same day NHSE announced its 'Your Covid Recovery' service which was an online rehabilitation service that provided, a bespoke interactive package of online-based aftercare to assist their recovery [MH3/06 – INQ000283370].

8. On 31 July 2020, I convened and chaired an expert roundtable to discuss Long Covid [MH3/07 – MH3/10 – INQ000292625; INQ000292627; INQ000292628; INQ000292629]. The objective of the roundtable was to identify what further research was required to investigate and mitigate the long-term impact of Covid-19 on survivors. The roundtable was attended by the Deputy CMO ("DCMO"), Professor Dame Jenny Harries, directors from NHSE, various clinical experts and academics and a number of observers from the Department and UKRI. I set out during the meeting my view that there was a need for further research in the community to understand and improve the longer-term effects of the virus in those who did not require hospitalisation. I strongly supported these conclusions, and acted upon them.

9. By September 2020, I remained concerned that more needed to be done in respect of those people suffering long-term symptoms who had not been hospitalised [MH3/11 – MH3/12 – INQ000218365; INQ000292630]. On 15 September 2020, we discussed at a Quad meeting the clear need to rapidly establish a significant cross-cutting programme of

work on the long-term effects of Covid-19 which ensured there was better integration between primary and secondary care so as to better understand the incidence and long-term effects of Covid-19 [MH3/13 – MH3/15 – INQ000292631; INQ000292632; INQ000292633]. I pressed the need to make progress on this work at a meeting of departmental leaders on 22 September 2020 [MH3/16 – INQ000292638].

10. Lord Bethell took this work forward [MH3/17 – MH3/20 – INQ000292634; INQ000292635; INQ000292637; INQ000292636]. On 28 September 2020, Lord Bethell held an internal roundtable on Long Covid [MH3/21 – INQ000292639]. This led to the introduction from 13 October 2020 of a series of monthly external roundtables which continued throughout the pandemic [MH3/22 – INQ000058536]. They were attended by patient representatives, clinicians, ministers, departmental officials and other key stakeholders to discuss the challenges, ongoing research, emerging data and issues so as to shape the response to Long Covid. I understand the minutes of those roundtables will be produced to the Inquiry separately by the Department.

11. On 7 October 2020, NHSE announced that £10 million would be invested as part of a five-part plan to boost NHS support for Long Covid patients [MH3/23 – INQ000283373

    a. New guidance to be commissioned by the National Institute for Health and Care Excellence ("NICE") by the end of October 2020 on the medical 'case definition' of Long Covid;
    b. 'Your Covid Recovery' online rehabilitation service to continue providing personalised support to patients;
    c. Establishment of specialist Long Covid clinics across England to provide joined up care;
    d. NIHR funded research on Long Covid working with 10,000 patients to better understand the condition and improve treatment; and
    e. Establishment Long Covid Taskforce to include patients, medical experts and researchers.

12. On 21 October 2020, we launched a film about Long Covid in which I warned of the long-term effects of Covid-19 as a means of underlying the importance of complying with social distancing measures [MH3/24 – MH3/25 – INQ000292640 INQ000238594]. This reflected that the best way of preventing people from suffering Long Covid was to prevent them from contracting Covid-19 in the first place.

13. On 12 November 2020, UKRI and NIHR launched a £20 million joint research call to fund research into the longer term physical and mental effects of Covid-19 in non-hospitalised individuals [MH3/26 - INQ000283379]. In response to the call, on 18 February 2021, £18.5 million was awarded to four new research studies aimed at better understanding and addressing the long-term health effects of Covid-19 [MH3/27 - INQ000283412]

14. Further to NHSE's announcement on 7 October 2020 (paragraph 11 above), on 16 November 2020, I announced that the NHS were to launch a network of 40 specialist Long Covid clinics within weeks, bringing together doctors, nurses, therapists and other NHS staff to help those suffering with the long-term effects of Covid-19. This announcement built on the Long Covid clinics already up and running. [MH3/28 - INQ000292641].

15. On 18 December 2020, NICE published guidance on the identification, assessment and management of Long Covid [MH3/29 - INQ000283459].

16. On 29 January 2021, I was sent a briefing on Long Covid and, in particular, progress against the NHS five-point plan [MH3/30 – MH3/31 – INQ000292647 INQ000292648]. It noted that, by that stage, the number of specialist Long Covid clinics had increased to 69 with further to launch. It also stated that the assumption, based on early literature, was that about 2% of all those infected warranted assessment in a Long Covid clinic, with a gradual capacity ramp-up. This reflected the capacity constraints at the time and the time required to establish Long Covid services.

17. On 17 February 2021, I attended a pre-briefing meeting for the fifth Long Covid roundtable meeting [MH3/32 – INQ000292652]. I then chaired the roundtable on 23 February 2021 [MH3/33 – MH3/35 – INQ000292653 INQ000292654 INQ000060080]. I noted that, while much progress had been made, there was much to be done. In particular, there was a need for the NHS to set their future direction in respect of Long Covid on further research, tackling health inequalities and broader rehabilitation services. I committed to continuing to drive the Long Covid agenda forward.

18. On 26 February 2021, I was provided a note on the NIHR strategy for developing Long Covid research [MH3/36 – MH3/37 – INQ000292655 INQ000283416]. Following which, on 25 March 2021, the NIHR launched a second call for research proposals on helping and supporting people with Long COVID [MH3/38 - INQ000283429]. I pressed for the research to be carried out at pace [MH3/39 – INQ000292658]

19. At a Quad meeting on 29 March 2021, I urged the maintenance of funding for Long Covid treatment [MH3/40 – INQ000292657].

20. From April 2021, the Office for National Statistics ("ONS") began to publish estimates of population prevalence of Long Covid in the UK which added to our understanding of the proportion of people affected and the demographics [MH3/41 – MH3/42 – INQ000292659; INQ000292660].

21. On 11 June 2021, I attended a Long Covid update meeting [MH3/43 – INQ000292661]. It was noted that there were currently 80 Long Covid specialist clinics. I was provided with an update on the response to NIHR's research call, which had received over 70 applications. I was also updated as to the progress of NHSE's Long Covid Plan for 2021/2022 for which they had already announced £24 million investment with a further £124 million proposed. NHSE published 'Long COVID: the NHS plan for 2021/22' later that month [MH3/44 – INQ000283498].

22. All of this work drove forward the support for those who had Long Covid. However, the central fact concerning the management of Long Covid was obvious from the start: the best way to reduce cases of Long Covid, with all the damage and anguish it brings, is to reduce the number of cases of Covid-19.

Tackling inequalities and improving inclusivity in the NHS workforce

23. Throughout the pandemic I was concerned about the unequal impact of Covid-19. From the start it was clear that older people, those in frail health, and people with pre-existing health conditions were unequally at risk. Further, detailed data science demonstrated that men and obese people faced higher risks. From early in the pandemic it became clear that a higher proportion of those from ethnic minority backgrounds were affected. As guardian of the NHS and social care, which each employs many people of all backgrounds, and is one of the most diverse organisations in the country, I was acutely aware of the impact of the virus on NHS staff.

24. On 2 April 2020, at the Downing Street Press Conference, I gave tribute to the dedication of the frontline staff who had come to the UK from abroad to work and make a difference in the NHS and who had lost their lives to Covid-19 [MH3/45 – INQ000292602]. I was shocked by the fact that the first doctors to die in the UK from Covid-19 were all from ethnic

minority backgrounds [MH3/46 – INQ000292603]. This added to my growing concerns about the unequal impact of Covid-19 across wider society. I strongly supported work to understand the causes of this, and action to mitigate it. The science essentially needed to understand the extent to which the cause was clinical – due to a different impact of Covid-19 according to genetic make-up – and what was environmental. I therefore commissioned research to get to the bottom of it.

25. As I set out at paragraphs 455-462 of my second statement, I was concerned about the unequal impact of the virus [MH3/47 - MH3/48 – INQ000292607; INQ000292612]. In mid-April 2020, at my request, the CMO commissioned Public Health England ("PHE") to report on disparities in outcomes and risks from Covid-19, and in response to PHE's findings in early June 2020 the Prime Minister commissioned the Minister for Equalities to take this further.

26. On 10 June 2020 the Minister of State for Social Care, who also held responsibility for the NHS workforce, sent me a WhatsApp message [MH3/49 – INQ000176785] related to the ongoing work being done to support black, Asian and minority ethnic ("BAME") people in the NHS as part of the NHS People Plan, which was published on 30 July 2020 [Exibit MH3/50 – INQ000292624]. This second iteration of the NHS People Plan had been in train for 12 months, building on the publication of the Interim NHS People Plan in June 2019, which I announced in a speech on 3 June 2019 at East London Foundation Trust, highlighting the need to ensure that the NHS is a workplace were everyone is looked after and treated fairly [MH3/51 – MH3/52 – INQ000292599; INQ000292600]. The People Plan was the workforce strategy to deliver on the NHS Long Term Plan which had been published in January 2019, and has since been developed further with the publication of the NHS Long Term Workforce Plan in June 2023 [MH3/53 – INQ000292664]. I had appointed Prerana Issar as Chief People Officer of the NHS on 1 March 2019 to lead on this area, which was one of my top three priorities before the pandemic. This work was not, therefore, a response to the pandemic, albeit it captured important learnings from the first few months of the pandemic, including in relation to the disproportionate impact of Covid-19 on the BAME workforce. The Minister's WhatsApp message to me on 10 June 2020 followed the leaking to the Guardian on 8 June 2020 of the report by NHS Blood and Transplant into mistreatment of BAME staff at their Colindale site [MH3/54 – INQ000292621], and a subsequent meeting I held with the Minister on 10 June 2020 about how best to support NHS staff against racism [MH3/55 – INQ000292622]. We agreed that we would commission further work looking at the experience and treatment of the BAME

workforce across the NHS, which I asked the Minister to lead on [MH3/56 – INQ000292623]. That work fed into the publication of the next iteration of the NHS People Plan on 30 July 2020 and the recommendations it made to NHS employers to tackle systemic inequalities I was aware of in the NHS, and to improve the experience of the BAME workforce without whom neither the NHS nor social care could operate.

27. At all times, I advised core decision makers to approach issues of racism and equalities within the NHS in an objective, science-based and sensitive manner.

Advice from SPI-B

28. In relation to paragraph 23 of my second witness statement, I referred to strong advice from the Scientific Pandemic Insights Group on Behaviours ("SPI-B"). SPI-B is a sub-committee of the Scientific Advisory Group for Emergencies ("SAGE"), and so its work was considered at SAGE, and then formally presented to me as Secretary of State by the CMO. In this paragraph I was referring to SPI-B prepared papers dated 4 March 2020, 'SPI-B insights on combined behavioural and social interventions' [MH3/57 – INQ000109111] and 9 March 2020, 'SPI-B insights on self-isolation and household isolation' [MH3/58 – INQ000236398] which I read. These papers translated into the strong advice I reference in paragraph 23 of my second witness statement.

Exercise Nimbus

29. In respect of paragraph 189 of my second witness statement, the key lesson I learned from Exercise Nimbus was, as I set out in my previous statement, that the Government must ensure that the NHS was not overwhelmed. Reflecting on the Exercise focused my mind on the critical requirement of stopping the spread of the virus and not, as I said previously, of just managing its impact. In due course I ensured this was one of the Government's central objectives, and in reality, we successfully ensured the NHS was not overwhelmed.

Critical role of monitoring/surveillance

30. My understanding of the role of monitoring/surveillance is that it is critical in terms of measuring and controlling infection during a pandemic. You can't manage what you can't measure.

Asymptomatic transmission

31. I set out my views on asymptomatic transmission in paragraphs 338-339 and 341 onwards of my second witness statement. I understood asymptomatic cases to be instances of the virus being transmitted from person to person without symptoms having been present. As set out in my second witness statement, from 27 January 2020 onwards I was pushing for the possibility of asymptomatic transmission to be considered and planned for [MH2/59 - INQ000106067], but it was not until later, in April 2020, that the matter was appropriately addressed (cf. paragraphs 342-346 of my second witness statement).

32. As I have previously indicated, with hindsight I regret not acting on the assumption of the worst-case scenario that asymptomatic transmission was occurring. I invite the Inquiry to consider the statements from the Chief Medical Officer ("CMO") about asymptomatic transmission (his First Witness Statement at paragraphs 6.55 to 6.63 and his Fourth Witness Statement at paragraphs 5.19 to 5.25). As the CMO makes clear, it was a gradual process of accumulation of evidence that led to asymptomatic transmission being considered a major part of the force of transmission of the virus. I agree with the views set out by the CMO, which should not be surprising as we discussed it regularly during this period.

Restricting staff movement between cares homes

33. In respect of staff movement between care homes, from the moment it became clear that staff movement was a vector of transmission, I pushed hard to limit, and then ban, staff movement. Various arguments against were presented, including that staff were essential for the sector, which of course they are, but I took the view that the need to stop infections getting into care homes was more important.

34. As stated at paragraph 49 of my second witness statement, as soon as I saw the initial evidence from PHE that staff movement was the main source of transmission [MH3/60 – MH3/62 – INQ000292613 ; INQ000292614 ; INQ000292615], I asked my team to undertake urgent work to restrict such movement. For example, on 11 May 2020 I wrote to the Prime Minister setting out a further support package for care homes. In that letter I noted that we had considered the option of banning staff movement, but considered it too fraught with operational risks at that time [MH3/63 – MH3/64 - INQ000292616 ; INQ000292617]. On 15 May 2020, we announced the Care Home Support Package which recommended that care homes restrict staff from working in more than one care home

supported by the Adult Social Care Infection Control Fund [MH3/65 – INQ000106429]. On 19 June 2020, we published further guidance on 19 June 2020 to that effect [MH3/66 – INQ000106486]. As a result of the action we took, 90% of care homes took action to restrict staff movement, and as a result staff movement between care homes fell dramatically over the summer of 2020 [MH3/67 - MH3/68 – INQ000292626 INQ000292663], and infections in care homes were much lower in the second wave.

35. As set out in paragraphs 486-491 of my second witness statement, notwithstanding that reduction in movement, and despite considerable resistance, from July 2020 to December 2020, I continued to push for regulations to be introduced to prohibit staff from working in more than one setting. It was only on 7 January 2021 that I finally accepted that we would not be able to make a full ban happen [MH3/69 – MH3/71 - INQ000234277; INQ000292642; INQ000292643], because key system partners no longer supported it, particularly in view of the decision to bring in the second lockdown and the vaccine rollout. Nevertheless, we maintained the guidance against such movement [MH3/72 - MH3/73 – INQ000292656 INQ000292662]. The key learning from this is that restriction of staff movement between care homes is absolutely critical in the protection of residents from infectious diseases – whether during a pandemic or in normal time. I maintain the view now that staff movement should be restricted, not just for coronaviruses but to prevent the spread of other infectious diseases too.

'Eat Out to Help Out' Scheme

36. I set out my position on the Eat Out to Help Out scheme at paragraph 432 of my second witness statement. As stated, I have no recollection of knowing about the scheme in advance of 8 July 2020 when it was announced. As set out at paragraph 290 and elsewhere in his witness statement, the then Chancellor has explained how it is normal for a policy responsibility of His Majesty's Treasury ("HMT") not to be approved by any Department – only by the Prime Minister – so we were not involved with its development in any way. When the scheme was announced case numbers were still falling, and I abided by the convention of collective responsibility and did not publicly voice concern. However, when it became apparent that the scheme was causing problems with (i) compliance with social distancing measures [MH3/74 – INQ000234442] and (ii) areas with local interventions in place, we notified HMT on 20 August 2020 [MH3/75 – INQ000184581] and I raised my concerns with Simon Case on 24 August 2020 so as to ensure the scheme was not extended [MH3/76 – INQ000129458].

Role of SAGE and approach to scientific advice in relation to local lockdowns and tiers

37. I have set out at paragraphs 12, 41 and 73 of my second witness statement the approach I took to scientific advice during the pandemic. As Secretary of State, I sought and received scientific advice directly from the CMO, DCMOs and/or the Government Chief Scientific Adviser ("CSA"). If they required advice from SAGE, they would commission it themselves. It was not my role as the Secretary of State to commission advice from SAGE. As with all other areas during the pandemic, I worked closely with the CMO, DCMOs and CSA in relation to local lockdowns and tiers and was guided by their advice when making decision about the impositions of such non-pharmaceutical interventions. I agree in its entirety with the CMO's statement on these matters.

Response to the criticism of the Government's response to Covid-19

38. In respect of the suggestion that Downing Street was not 'keen on' me making a statement to Parliament in mid-January 2020 with it wanting to keep the media focus on Brexit, as I previously set out, at that point very few people were talking about the virus. I repeatedly raised the question of the virus and was astonished that others did not seem interested. Specifically in relation to the Parliamentary statement, a Secretary of State can only table such a statement with the support of No. 10, yet the Prime Minister's Chief Adviser was restricting what ministers could talk about, and through what channels. This restricted my ability to talk about the virus in the media and delayed my ability to make a statement in Parliament. Eventually, having had the chance to raise the matter verbally with the Prime Minister, I did make a statement to the House of Commons on 23 January 2020 about the virus, setting out that:

    "...I would like to inform the House about the outbreak of a new coronavirus in China and the UK's response to protect the British public... There are no confirmed cases of this new infection in the UK so far. We have been closely monitoring the situation in Wuhan and have put in place proportionate precautionary measures. Our approach has at all times been guided by the advice of the chief medical office, Professor Chris Whitty... The chief medical officer has revised the risk to the UK population from "very low" to "low", and has concluded that while there is an increased likelihood that cases may arise in this country, we are well prepared and well equipped to deal with them... We are working closely with our counterparts in the devolved Administrations. The public can be assured that the whole of the UK is always well prepared for these types

of outbreaks, and we will remain vigilant and keep our response under constant review in the light of emerging scientific evidence."[1]

39. This was another example of the Prime Minister's Chief Adviser blocking action that the Prime Minister himself supported. This dynamic was a repeated problem in the early months of the pandemic.

40. You have asked whether my view was that Covid-19 was "akin to influenza." From 9 January 2020, when Chinese scientists confirmed that the novel pathogen was a coronavirus, my view was that it was indeed a coronavirus. I did not witness the Prime Minister express an initial view in early 2020 that Covid-19 was not a serious threat and was akin to swine flu. In all interactions with me he took the problem seriously. You asked who in the Cabinet Office made the decision not to call COBR in early January. As I have stated in public, my understanding, based on what I was told at the time, was that this decision was taken the Cabinet Secretary.

41. I have addressed questions concerning herd immunity in my second witness statement at paragraph 370. I agree entirely with paragraphs 7.143-7.149 of the Fourth Witness Statement of the CMO, who sets out the position on herd immunity with characteristic thoughtfulness and clarity. I set out my position on herd immunity in public when I was asked about this in the House of Commons on 16 March 2020:

    "We are very clear that herd immunity is not part of our plan. It is a scientific concept; it is not a goal or a strategy."[2]

42. My reference to 'make a case' in a WhatsApp message on 12 March 2020 was referring to making a case about the timing of action that the Government was looking at bringing in to combat the virus, as the WhatsApp message itself sets out.

43. You have also asked about what plans were in place for Shielding. There were no plans in place that pre-dated the pandemic. We discussed the protection of those most vulnerable to the virus from January 2020, as it was clear extremely early that the impact

---

[1] https://hansard.parliament.uk/Commons/2020-01-23/debates/38D462B1-70F8-4CC6-AABD-2CCF4E271C34/WuhanCoronavirus#contribution-13D68483-2D5F-4A9B-8EEF-6AC302D5CC81. I refer to this statement in Parliament to show what was said as a matter of historical fact.
[2] https://hansard.parliament.uk/commons/2020-03-16/debates/4748cf75-300a-430f-a802-65963409b523/CommonsChamber#. I refer to this statement in Parliament to show what was said as a matter of historical fact.

was unequal across the population, with age being the biggest determinant of risk. The name "Shielding" came later, after a number of iterations.

44. You have asked about various allegations raised against the Prime Minister. He did not at any point express the view to me that SAGE had 'manipulated' him into imposing the first lockdown. Nor at any point did I witness or become aware of the Prime Minister expressing the view that there should be *"no more fucking lockdowns – let the bodies pile high in their thousands"* or that he would rather *"let the bodies pile high"* than order another lockdown or words to that effect.

45. When I discovered that I had not been invited to the meeting that the Prime Minister had convened on 20 September 2020 with the CMO, CSA, Chancellor and various scientists, including Professor Gupta and Professor Heneghan, I made my frustration clear to him in person. I made clear that I, as his Health Secretary, should have been invited, and that I was worried that such a meeting was taking place with those whose views had already been discredited. I cannot recall precisely when I did so, but it likely would have been in the margins of another meeting. I received no adequate explanation for not having been invited.

46. I did not attend any meeting with the Prime Minister with newspaper editors between 18 and 23 September 2020.

47. In relation to paragraph 63 of my second witness statement, it is my recollection that the words used by the Prime Minister when apologising to me for appointing his Chief Adviser, and for the damage he did to the response to Covid-19, were: *"I'm sorry that I appointed him at all."*

48. The Prime Minister's Chief Adviser sought the removal of Sir Simon Stevens from his post as Chief Executive of NHS England from December 2019 onwards. The Prime Minister's Chief Adviser is best placed to speak to his reasons for doing so. He did not raise the topic with me again after February 2020, when I had consulted the Prime Minister directly, and discovered the Chief Adviser did not represent the Prime Minister's views. I do not consider any of this had any impact on pandemic handling, because I did not act on the Chief Adviser's instructions. The references in my WhatsApp conversation with the Cabinet Secretary on 2 August 2020 [MH3/77 - INQ000129442] were to Sir Simon Stevens having expressed an intention to retire from the role, having been in post for six years, which he

then did in July 2021 at a time of his choosing having given exemplary service over many years.

49. You asked about a WhatsApp exchange I had with my media adviser Damon Poole on 28 January 2021. Having considered the surrounding documentation, *"community transmission of the variant"* referred to community transmission – that is, transmission which does not have any link to relevant travel – of the South Africa variant (VOC-202012/02). The first cases of apparent community transmission of that variant had just been identified, and as I set out in the message, I had not yet informed No. 10, but had commissioned a note for No. 10 with an assessment as to the likelihood of any community transmission and the actions to eliminate it [MH3/78 – MH3/83 – **INQ000292644**; **INQ000292645**; **INQ000292646**; **INQ000292649**; **INQ000292650**; **INQ000292651**] Informing No. 10 of a development by note rather than me doing it directly was a completely normal way of operating – the judgement as to whether to inform No. 10 by phone call in advance of such a detailed note is the sort of judgement made constantly. The factors I would have considered in making such a judgement would have been: how important is the new development; how urgent; what other priorities are pressing; how quickly can the department produce a written note etc. This was a completely run-of-the-mill exchange. The rest of the exchange evidently relates to my instruction to my media advisor to try to defuse an apparent row the media were trying to stir up. I did not like stories of rows within Government, and we frequently tried to calm any such noise. I have no recollection of using the particular language in the message, and do not recall having done so before or since.

50. You have asked me about criticism of my and others' performance. Generally, everyone tried their best in extremely difficult circumstances. Any lessons for the future should assume people will try their best, but that the system will be run by humans, with all their strengths and flaws.

51. Within the Department, where levels of trust were generally very high, we worked very closely as a cohesive and determined team facing a challenge of a scale not seen in peacetime history. I actively encouraged constructive criticism, suggestions, and feedback. I wanted to perform as well as I could, and support my team to do the same. The atmosphere within the Department was hugely supportive and I believe that everyone involved would agree. My leadership style is open and I knew that people can sometimes feel intimidated to come forward to speak to a Secretary of State. I spoke regularly with trusted colleagues, including the Permanent Secretary, CMO, Special Advisers, and

ministers about performance. In a high performing team feedback is vital and must be encouraged from the top. Outside the Department, the Prime Minister and I talked about how best to handle something on this scale, and I talked to the Cabinet Secretary about how to try to get the best possible collective response. In trusted settings I spoke with appropriate candour, and if anyone senior had any concern about my performance I would have expected them to have raised them with me. I do not recall at any time anyone senior raising questions about my candour – and to have done so would have been unexpected, as we were as transparent as possible, given the very fast moving situation.

52. Sadly, not all relationships are trusting ones. I was aware that the Chief Adviser wanted to centralise all decision making in his hands and that he found my insistence on using the proper machinery of government frustrating. While I did find out from the media that he was agitating to have me moved, he did not raise any concerns with me over my performance, nor my candour, nor any plans to move me from the position of Secretary of State. No one raised with me any plans about dividing the remit of the Department, and I don't believe there were any credible plans to do so.

53. During and since the pandemic, many conspiracy theories have grown up around actions taken during the pandemic, and I have addressed some below:

    a. False accusations were made that the vaccine programme was apparently developed to allow me, with the help of Bill Gates, to inject the public with microchips. In fact the vaccine programme saved millions of lives, and the clinical validity of the vaccine is measured carefully, and the results published transparently, in one of the largest pharmacovigilance exercises in history.

    b. Various false accusations have been made about the allocation of contracts for testing and personal protective equipment ("PPE"). However none of the formal investigations have found any wrongdoing whatsoever on the part of Ministers or officials – and I was not involved in any of the contractual arrangements for PPE (or for that matter testing). There was just a huge amount of hard work in very difficult circumstances to get the equipment to keep people safe.

    c. Then there are the equally untrue and dangerous claims that I ordered the deaths of thousands with a palliative care drug called Midazolam. This is patently absurd, and there is no evidence whatsoever of it happening, as the Inquiry can no doubt attest.

d. It has wrongly been claimed that I rejected clinical advice on care home testing. On the day in question, 14 April 2020, I welcomed new advice to test those going into care homes [MH3/84 – MH3/86 – INQ000093326; INQ000292604 ; INQ000292605]. The advice changed due to an inability to operationalise the original proposal, and I acted on this subsequent advice articulated through official government channels not over WhatsApp [MH3/87 - MH3/91 - INQ000292606 ; INQ000292608 ; INQ000292611 ; INQ000292609 ; INQ000292610]. The fact this all happened on one day shows how rapidly we were working to keep people safe, according to the best advice. To suggest otherwise is both misleading and untrue.

e. There are also absurd conspiracy theories surrounding the government Covid-19 contracts awarded to Randox. For context, the UK testing capacity was very small at the onset of the pandemic. With my team we built the biggest testing system this country has ever seen, at speed and under exceptional circumstances. Randox was the UK's largest testing provider. While again I had no direct involvement in the contracts, for the team not to work with them during this unprecedented global pandemic would have been wrong.

f. I did not leak ONS data to The Times. I was very strongly in favour of good governance, and found the repeated leaks incredibly frustrating. I note that the amount of leaking declined radically after the departure from Government of the Chief Adviser in November 2020.

g. I did not provide assurances to the Prime Minister, Cabinet, other core decision makers or anyone else to the effect that "everything was fine" with PPE or that "we had it all covered". That would have been absurd.

h. I did not blame shortages of PPE on Sir Simon Stevens or the then Chancellor. As set out at paragraphs 294 to 295 of my second witness statement, we worked hard with HMT to change the approval process for buying PPE from the standard public procurement rules to emergency public procurement procedures in order to remove barriers to purchasing PPE. When the then Chancellor became engaged in that issue, he resolved it quickly. The switch to emergency procurement rules, and the removal of some of the HMT restrictions that are rightly in place in normal times, was vital to ensure that we could source sufficient PPE in a highly competitive international market. I have read and agree with the then Chancellor's account of

this particular issue. There were barriers to speedy procurement, and we worked together to remove them, to protect the public and to save lives.

54. In all of these areas, and others, allegations of wrongdoing are wholly false. Instead what happened was a large number of people worked extremely hard to save lives in a time of enormous difficulty.

55. In respect of the impact of breaches of restrictions on public confidence and compliance, the public's response to the restrictions was exemplary. People, by and large, understood the importance of the social distancing measures that were being taken. Like everyone I was of course concerned at the potential impact of breaches, for example of the Chief Adviser's trip to Barnard Castle on 27 March 2020 in the height of the first lockdown. However, we were relieved to see that the evidence in respect of people's movements at the time showed that it did not have a material impact on observance of the rules.

56. I have seen no evidence at all to suggest any material impact on the public's observance of the rules due to my resignation and events that led up to it, not least because almost all restrictions had been removed by then. I have addressed those events in my second witness statement, and do not intend to add any further to them.

57. Finally, as the Inquiry is aware I have cooperated at all times and provided all of my materials as requested. In respect of my own WhatsApp messages, in preparing for this Inquiry I have discovered a gap when I changed my phone in April 2020. I did not know there was a gap at the time, which I have discovered is due to my WhatsApp account being set to back up monthly. In any event I do not think this gap materially changes the evidence I have been able to present to the Inquiry because substantive decisions were not taken over WhatsApp and thanks to the abundant material – including the formal record – on which decisions were taken and on which this statement is based.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed **Personal Data**

Dated 4 Oct 2023