Witness Name: Matt Hancock
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**UK COVID-19 INQUIRY**

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**SECOND WITNESS STATEMENT OF MATT HANCOCK**

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

## INTRODUCTION

1. I make this second statement in response to a request from the Inquiry dated 13 February 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 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 supplementary statement if required.

3. As I said in my First Witness Statement for Module 1, there is not a day that goes by that I do not think about all those who lost their lives to this awful disease or the loved ones tragically left behind. I have met many families who lost loved ones in this pandemic, and I express my deepest sympathies to all those affected.

4. This Module of the Inquiry investigates the core UK decision-making and political governance. Before turning to a chronological description of that decision making, I hope it is helpful to set out my reflections on the biggest decisions, on the nature of decision

taking, and what did and did not change in the pandemic. This statement builds on the statement I made in Module 1, and also on the Department's corporate statements, which set out the formal decision-making structures very effectively.

5. As the Secretary of State for Health and Social Care ("the Health Secretary" or "Secretary of State") my motivation was to improve the health services in this country and to save lives. In the early days of the pandemic, huge decisions had to be made very quickly on the basis of very limited information. A vast amount of work by a very large number of people was done with diligence, due care and huge effort against the background that any pandemic involves enormous uncertainty; it is a response to a novel disease. My Civil Service and clinical advisers were exemplary.

6. The pandemic created an unprecedented challenge to ordinary decision-making processes. There was no book or report to pull off a shelf to tell us how to handle a pandemic, and there was no-one alive with experience of dealing with a pandemic of this scale. The scientific advice as to what we were facing and the depth of the threat, was exemplary, but necessarily changed frequently as new information became available. The logistical requirements were without doubt the most complicated in peacetime history. The reassurances from the World Health Organization ("WHO") that we were one of the best pandemic prepared countries in the world were wrong. We had to build many parts of our response from scratch.

7. Very early on, we found that instead of fighting an influenza virus, which had been the assumption underpinning the plans, we faced a coronavirus. For quite some time we did not know exactly how it could be transmitted; for example, whether the virus could live on surfaces such as the hand rails in public staircases or most importantly whether asymptomatic transmission was possible. We adapted to new information and the changes in scientific advice as we went on and at all times sought as much information as possible.

8. In a crisis of the scale of the pandemic, there are inevitably a vast number of decisions taken at all levels. The approach I took in leading the Department was to set the direction in which we needed to go, based on the best available advice, and encourage and empower all involved to take decisions to the best of their ability. There were thousands of decisions to be taken every day. One of the central tasks of the Department and wider Government was to make decisions at the right level.

9. I went into the pandemic with experience of crisis management both from my time at the Bank of England and in Ministerial roles for seven years. However, no one in public service had handled a crisis of this scale since the Second World War. As Health Secretary, together with the Department's senior official team, we consistently did our very best to manage the huge number and scale of decisions we had to make.

10. I tried to lead the Department using some basic rules of thumb:

    a. Delegate authority on a principle of subsidiarity, and take accountability;
    b. Empower the team at all levels to make decisions without fear of reprisal if it goes wrong;
    c. Demand as much information as possible to make a decision, but no more than is possible;
    d. Work as a team, and protect the team from undue interference and distractions;
    e. When something goes wrong, ask not the question 'who is to blame?' but rather 'how can we fix this?'; and
    f. Concentrate on saving lives, not how it will look afterwards.

11. A major responsibility of my job as the Secretary of State was ensuring the Department's work was as integrated as possible into the wider Government effort. At first this required pushing the rest of Government to recognise the potential threat of the pandemic. Later it involved protecting the Department, as much as was possible, from inappropriate political interference from No. 10, so officials could get on with their work. Throughout it involved the proper and appropriate integration of our work with the work of others, across the different parts of Whitehall, often in ways that were not typical before the pandemic.

## APPROACH TO SCIENTIFIC ADVICE

12. From January 2020 onwards, the Permanent Secretary, Chief Medical Officer ("CMO") and I discussed the proper approach to scientific advice. My approach was not to "follow" the science but to be *guided by* the science as presented to me by the CMO, the Deputy Chief Medical Officers ("DCMOs") and the Government's Chief Scientific Adviser ("CSA"). To "follow" the science implies accepting scientific advice without wider consideration. To be guided by the science is to take the scientific advice, and base decisions on it, taking into account reasonable challenge, operational and other wider considerations. My job as Secretary of State was to take all considerations into account

in making decisions. In very large part, I would follow scientific advice. However, scientific advice was understandably not always clear cut as uncertainty was huge, especially early on. I consider that the scientific advice I received, both before the pandemic and during it, was absolutely world leading.

13. Initially, we did not know how the virus was transmitted, how transmittable it was, whether it could be transmitted asymptomatically, who would be at most risk of illness, or many other key scientific facts that would become crucial to determining the public health response to the virus in later months. To take just one example, despite anecdotal evidence and significant uncertainty, even on 2 April 2020, the WHO stated *"…to date, there has been no documented asymptomatic transmission."*. This assertion placed enormous weight on the lack of 'documented' asymptomatic transmission, whereas, in the face of huge uncertainty, it is important to work on the basis of risk, not certainty or proof.

14. On occasion we would depart from the formal scientific advice, typically for one of two reasons: either (a) scientific advice was not operationally deliverable or (b) the need for a different approach based on wider considerations. For example, I decided we must quarantine individuals returning from Wuhan in February 2020, against the scientific advice, based on a precautionary principle and to maintain public confidence. In doing this we had to depart from scientific advice. On this occasion, as whenever the Departmental position differed from the scientific advice, I would always involve scientific advisers in the final decision to try to ensure that they regarded each decision as reasonable, and at the very least consistent with the best available scientific advice.

## MAJOR DECISIONS

15. Below I have set out a chronological description of decisions I made in the period of the pandemic for which I was in office, from January 2020 to June 2021. Before setting those out, however, I would like to draw particular attention to a number of major decisions that I consider were the most significant, and deserve particular attention.

*Focussing the Department on Coronavirus from mid-January 2020*

16. From around 20 January 2020, the CMO advised a 50/50 chance of the virus[1] going global and becoming a pandemic. At this point the Permanent Secretary and I refocussed the entire work of the Department onto the novel coronavirus. It is extremely unusual for a Government Department to be so wholly focussed on a single issue. Departmental daily meetings began on 23 January, with daily situational reports ("sitreps") generated. The Permanent Secretary delegated all of his non-coronavirus work to his excellent deputy, David Williams. This early decision ensured that the Department could make as many preparations as possible in the short time between then and the arrival of the virus.

17. We set out very early that a primary goal would be that the NHS should never be overwhelmed, as other health services around the world were. Despite the huge challenges, this was achieved. The impact of the pandemic was terrible, but could have been much worse.

*Backing the Vaccine*

18. From the first meeting in which we discussed this new disease on 6 January 2020, and especially from the moment on 28 January that we set the mission to achieve a vaccine within a year, the Department focussed on a vaccine as the route out of the pandemic. Delivering the vaccine took a huge effort from a very wide range of partners: academic research; commercial buyers; smart regulators and operational delivery, all underpinned by excellent data. The decision to back any safe and effective vaccine, and to throw all possible resources at making it happen as soon as possible, was vital. No one thought this was going to be possible, at least not that quickly, but we did it. I am now aware that some people criticised me for pushing so hard for a vaccine, but we did and it worked.

*Protecting the NHS and reducing the impact of the virus*

19. From March 2020 an explicit goal of Government policy was to protect the NHS. This was described to the public both to motivate altruistic action, such as staying at home, and also to protect the NHS from being overwhelmed, as it was in other countries like Italy.

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[1] Which I refer to in this section as Covid-19, notwithstanding that it did not receive this designation until February 2020.

20. Had the NHS been overwhelmed, treatment would have had to be rationed, and choices made between who to treat and who to leave. We managed to avoid this awful outcome, by suppressing the virus, shielding the most vulnerable, expanding NHS capacity for example through the Nightingale Hospitals, and then through vaccination.

21. At the time, the CMO advised that the only credible international comparison of the impact of the virus would be by comparing so-called excess death rates afterwards. The most comprehensive such study published in the Lancet (MH2/01 **INQ000234333** shows that the UK was hard hit by the pandemic, but avoided worse outcomes as seen in other similar countries like Germany, Italy and the United States of America.

*First Lockdown and Doctrine of Pandemic Response*

22. The decisions in early March 2020 on how to respond to the virus were extremely difficult, as there were no good options: the scale of the potential interventions were huge, the damage of the interventions themselves significant and the data extremely scarce. In my view the Department took the best decisions we could based on the information and scientific advice available. In this case we did follow the science and accepted scientific advice on the timing of the first lockdown.

23. With hindsight, and information we did not have at the time, it is now obvious we should have locked down much earlier. I say that with hindsight: it was not at all clear at the time. The scientific caution over locking down was based on uncertainty over how the public would respond, and poor data on where we were on the epidemiological curve. Between 10 and 14 March 2020 new evidence came to light that we were only about two weeks behind Italy, and so we needed to lock down fast, which we then did. The discussion was centred on the timing of the lockdown, because of strong advice (for example from the Independent Scientific Pandemic Insights Group on Behaviours, "SPI-B") that people would likely only put up with lockdown for a short period of time. This advice was given based on experts' best possible view with the best available information at the time, but clearly turned out to be wrong. This is only possible to say with hindsight. There were no politics involved in this judgement, just people trying to make very big decisions in a fog of uncertainty, as highlighted by the fact that the four nations of the UK, led by politicians of five different political parties, all made the decision to lock down at exactly the same time.

24. As I set out in my Module 1 statement, it is vital we embed a new doctrine of pandemic response to guide future decisions on whether, when, and in what way to lock down to suppress a pandemic.

25. The correct doctrine for responding to a pandemic is as follows: if the R number is above 1, and if the expected cost of inaction is greater than the expected cost of measures to suppress the virus, then it is best to take suppression measures earlier, wider and harder than feels comfortable at the time.

26. For example, when the doubling time is around six days, delaying a lockdown by a week leads to over twice as many cases at peak. In turn, a higher peak leads to a longer lockdown to get case numbers down again. Before a vaccine or effective treatments are available, when the R number is above 1 there is no trade-off between economic and health considerations, and it is wishful thinking to say there is: delaying action to suppress a pandemic leads both to more death and more economic cost.

27. Of course it also matters enormously choosing what is done to suppress the virus. Some measures to suppress a pandemic are much lower cost than others. For example, it is important to use testing and contact tracing throughout to reduce the number of other measures needed to get the R number below 1. There is no way testing and contact tracing alone could have suppressed Covid-19, but they are valuable tools because they reduce the amount of more costly measures that may be needed, whether by reducing the time more costly measures need to be in place or by removing the need for them at all. By contrast, the impact of school closures is much greater, so we tried to keep schools open as much as possible and only closed them as a last resort.

28. It matters enormously how to calibrate lockdown measures to get the R number below 1. These are very difficult judgements, made in the face of extreme uncertainty. Decisions on *how* to suppress a pandemic follow from, and cannot replace, the central doctrine of *whether* and *when* to suppress a virus that I set out above.

*Tiers*

29. The system of tiers introduced in autumn 2020 did not work. The tiers policy was introduced for good reason: so that less affected areas could be less impacted by lockdown than worse affected areas. But the tiers system had three main flaws:

a. We were blocked from bringing in measures in tier 3 strong enough to suppress the virus.
b. Even in areas of low cases, if the R number was above 1, then crisis levels of infection would come eventually, and so it is better to lock down earlier; and
c. The way tiers were introduced, requiring local leaders to sign off, meant they did not end the confusion, as they were designed to do.

30. Likewise, different approaches in the different nations of the UK were unhelpful, confusing and had no scientific justification. Viruses do not respect administrative boundary lines and a UK-wide approach would be best in future. I am glad that John Swinney, the Scottish National Party former Deputy First Minister, agrees with this approach.

*Second Lockdown*

31. While the delay to the first lockdown was understandable due to the fog of uncertainty and the unprecedented nature of the crisis, there were no excuses second time round. Case numbers rose from mid-July 2020, and it was clear that a second wave was coming from late-August. I began to call for measures to suppress the virus in early September. In reality, the choice the Government faced, ahead of the arrival of the vaccine, was to lockdown early, or lockdown later, for longer, at a higher case rate. That is exactly what happened, with both more deaths and more economic damage than if the country had locked down earlier and got the R number below 1. Whilst it was clear to me by the summer 2020 that the only possible strategy was to suppress the virus until a vaccine could deliver immunity to the population, I regret that I was unable to win that argument within Government until January 2021.

32. Given that we knew that the R number was above 1, and so the virus would grow exponentially, it was obvious to me that without action to keep R below 1 the NHS would be overwhelmed, and the pandemic would become completely out of control. There was to my mind no credible alternative to locking down, because the only alternative to lockdown was to let the virus run through the population, with horrific consequences. Some, wrongly, thought that it would be possible to avoid lockdown measures to protect the economy. This was naïve, wishful thinking.

33. Some argued in autumn 2020 that Sweden had showed an alternative approach, claiming that voluntary recommendations could control the virus without the need for

lockdowns. The evidence does not support this argument. First, Sweden did in fact bring in many statutory lockdown measures, including school closures, bans on gatherings, and vaccine passports, rather than the entirely voluntary approach its proponents assert. Second, the excess death rate in Sweden was 91 per 100,000, thirteen times that of neighbouring Norway (MH2/01 - INQ000234333), which is the appropriate comparator with similar geography. Swedish Prime Minister Stefan Löfven said *"…the fact that so many have died can't be considered as anything other than a failure."* (MH2/02 - INQ000234335).

*Vaccine Dose Interval*

34. The decision to extend the vaccine dose interval in late December 2020 was an excellent example of bold decision-making and the effective interaction of scientific advice, operational capability and political leadership.

35. This decision first came about when my political advisor brought to my attention a Tweet by a US academic containing a proposal to extend the dose interval (MH2/03 - INQ000234238). The Tweet set out that since the first dose gave roughly 90% protection, and the second dose 95%, those second doses were equivalent to protecting 50% of those unprotected from dose 1. Therefore, given constrained supply, more people would be more protected if more individuals had one dose (90% protection) than a second dose (a further 50% protection). I seized on this extremely clever idea immediately and took it to the CMO, who discussed it with the Deputy Chief Medical Officer ("DCMO") and others. We discussed whether we felt that we could carry the confidence of the public in making such a change. I judged we could if it were based on the CMO's clinical advice.

36. We took the decision to the Prime Minister who backed it. Over nine days over Christmas 2020 we lined up that clinical advice, prepared to change operational protocols and developed a communications strategy. On 30 December we announced the policy change. We dealt with criticism from those whose second dose was delayed, and from international companies and sceptical scientific voices. Later research estimated this change saved over 10,000 lives (MH2/04 - INQ000234331) It shows that no-one has a monopoly on good ideas.

*Asymptomatic Transmission*

37. My single greatest regret is not pushing harder for asymptomatic transmission to be the baseline assumption in the case definition of how the virus is passed on. The global

scientific consensus, reflected in the global scientific advice from the WHO until April 2020, was that there was no asymptomatic transmission. This was despite anecdotal feedback from January 2020 that the virus could pass from people who showed no symptoms. I was closely involved in this debate and challenged the scientific advice on a number of occasions.

38. I believe this consensus changed so slowly because of the application of the scientific method, which ordinarily and quite appropriately demands conclusive evidence before views can be changed. Of course this is important, for example in respect of the many spurious theories (like the effectiveness of hydroxychloroquine as a treatment) that were debunked by the rigorous application of the scientific method.

39. As Secretary of State I could not simply over-rule this global scientific consensus on a lack of asymptomatic transmission. I took the case definition as a clinically determined fact. With hindsight I should have insisted that instead of following the science, policy be based on a reasonable worst case scenario assumption of asymptomatic transmission. I did not push harder on this issue because I judged that I would have struggled to bring people with me on a policy that went against the global consensus, and so instead I tried, unsuccessfully, to challenge that consensus. The initial consensus that the virus could not transmit asymptomatically underpinned many decisions, including, for example, the Department's initial advice on the management of the virus in care homes.

*Care Homes*

40. From January 2020 we considered that care home residents were some of the most vulnerable to the virus, because of the frailty of many residents, and the strong correlation between age and morbidity of the novel disease. We also considered the very significant problems that we saw in countries affected earlier than the UK. In Spain, for example, we tragically saw deaths in care homes which were left unstaffed, leaving vulnerable residents alone, and in some cases reports that no residents survived. We were determined to ensure this did not happen.

41. As on all other areas, throughout the pandemic I worked closely with the CMO and the CSA, and was guided by the best available scientific advice.

42. The initial, very clear, scientific advice was not to test those without symptoms. I was told categorically that the tests would not work on people without symptoms, and that to test

someone without symptoms would risk a false negative, i.e., someone incubating the virus could be given a negative test result. This would be even more dangerous than not being tested, as it would give a false assurance. Instead we initially required care homes to isolate residents going into care homes. This was consistent with the then scientific advice on testing and asymptomatic transmission, and went further than the WHO advice, which said that care homes should be expected to admit Covid-19 positive patients but subject to isolation for 10 days.

43. Given the shortage of tests at that time, we published updated advice for care homes. We knew how deadly the virus was, especially to older people, and worried a huge amount about the best way to protect them. That guidance stressed the need to isolate residents going into care homes. NHS England ("NHSE") insisted that people had to leave hospital if medically fit, including because the dangers of infecting people in hospital were if anything greater than in care homes, as isolation is even harder, as well as the need for hospital capacity to save lives of those suffering from the virus. I accepted their advice on this point.

44. Having considered all the facts now available, and reflected in some detail on this decision, I believe that all the other options available at the time were worse. Had we left these vulnerable people in hospital, infections inside hospitals would have been much higher and more people would have died from the virus. Infections in care homes would have been almost exactly as high, as research has found that the vast majority of infections came into care homes from the community, not from new residents. Tests were not available in large enough numbers to test everyone going into a care home, and if tests had been redirected from their use within hospitals, more people would have died.

45. Even with the advantage of hindsight, having thought long and hard about this decision, and listened to all of the discussion on this very sensitive and important decision, I have not been able to identify a credible alternative that would have led to fewer infections and deaths. Even had asymptomatic transmission been assumed, any option at this point had to contend with three points of fact that made the situation extremely difficult:

    a. There were not enough tests, and tests of ill people in hospital saved more lives;
    b. Tests on asymptomatic patients, plus the 4-day turnaround time of tests, would have given false negatives; and
    c. Isolation facilities in care homes were not as good as needed.

46. It is my honest view that given the nature of the virus and what was available to us at the time, the policy decision made was the least worst of all the options alternative. Managing a pandemic is often about finding the least bad of a series of bad options. If a better option had been available I would have strongly supported it. There were no easy choices or good options.

47. When the CMO updated his scientific advice to advise that asymptomatic testing was possible, and changed the case definition to assume the possibility of asymptomatic transmission, I immediately acted, with him, to implement this new scientific advice. At first, we still did not have enough tests to test everyone, and the clinical advice on test prioritisation remained to test those with symptoms in hospital.

48. At the same time, I was driving the increase in testing as fast as humanly possible, against some opposition within Government. By 15 April 2020 I had succeeded in driving testing up to 38,766 per day and we were able to announce all residents going into a care home should be tested. By 28 April, due to the Department's rapid expansion of testing capacity, we began testing of all asymptomatic care home staff and residents.

49. A widespread concern has been that patients who were discharged from hospitals were the main cause of infections in care homes. While I understand why many people hold this view, we now know that this was not the case. During the summer of 2020 I was made aware of initial evidence showing that movement of staff between care homes was the main source of transmission, and asked for urgent work to be undertaken to place restrictions on such movements. I was subsequently provided with formal advice, and acted to limit staff movement. PHE later published evidence covering 30 January to 12 October 2020, which showed that a small fraction (1.6%) of outbreaks were identified as potentially resulting from hospital associated Covid-19 infection (MH2/05 - INQ000234332). The action we took to restrict staff movement reduced infections significantly (MH2/06 to MH2/07 - INQ000058526; INQ000233997). There is a vital lesson for future pandemics - and indeed for normal times - that staff movement between care homes should be limited.

*Use of Data*

50. Throughout the pandemic, work was undertaken to use data as effectively as possible. We started from a position of very little information, and ended with some of the best

operational and data management tools I have seen in public service. Likewise, operational data and data sharing was poor at the start of the pandemic despite significant recent work to improve it, which was invaluable. A number of pieces of work to improve the use of data to save lives are worth noting. Several of these have taken backward steps since the pandemic, and progress needs to be restored.

51. The most important change was freeing up front line services from onerous and regressive data protection rules that had become completely outdated. In March 2020 we introduced a new data protection protocol, designed by NHSX, aimed at front line staff, to allow them to use modern data tools so long as patient data was protected, which was notified by letters dated 17 and 20 March 2020 and signed on my behalf (MH2/08 to MH2/09 - INQ000101772; INQ000233781). Previously rules had been confused and complicated, and NHS staff had been prevented from using many modern tools such as email and WhatsApp, despite these standard tools having much better data protection and cyber security than the authorised in-house NHS versions. This saved many lives, and should be made permanent, but unfortunately has been made more cumbersome since the pandemic.

52. The second vital change was to bring in credible external data experts to develop data dashboards for management purposes. These became invaluable, and their use should be expanded for day to day and strategic management of health and social care.

53. Third, we worked incredibly hard to improve data linking, for example between GPs and hospitals, and between health and social care settings. These links saved many lives, and should be strengthened. Data linking across the four parts of the NHS in the four nations of the UK is still inadequate, and data sharing should be required.

54. Fourth, we allowed citizens to see their health data through the NHS app, which helped them manage their own health.

55. Fifth, by using data in a progressive, modern way, we developed the best clinical trial in the world (the RECOVERY trial) and also delivered the first vaccine in the world. Neither of these would have been possible without the most cutting-edge use of data, and the insights from their operation are vital lessons both for the next pandemic, and the day to day operation of health and social care in the UK.

56. The clearest validation of the decision to take a strongly progressive approach to the use of data is the success of the vaccine programme. In all four elements of the vaccination programme: research; purchasing; regulation and rollout, we used cutting-edge data techniques, which helped make it the most successful in the world. Without a modern use of data that would not have happened. These lessons are vital for the next pandemic, and work is needed now to ensure we are as well prepared as possible to use data to save lives from the start. Furthermore, the vaccine rollout shows that the NHS can and should interact with patients using modern digital techniques, including for the basics like booking appointments and updating the patient record. There is no longer any excuse.

## DECISION MAKING STRUCTURES

57. Having considered some of the major decisions thematically, before turning to a chronological assessment of the decisions taken, I have also set out an overview of the way in which decisions were taken by Government.

### *Cross-Government Decision-Making*

58. Decisions across Government are taken on a formal basis according to well established rules to ensure there is one "agreed" Government policy. It is in the nature of Government that no-one can take all the necessary decisions, and once a decision is taken everyone needs to get behind it. This formal basis is superbly set out in Sir Christopher Wormald's Departmental corporate statement (MH2/10 - INQ000184643_0013-0040) at paragraphs 56 to 223. This formal structure of decision making ensures that decisions can be taken at the right level, with formal advice, and recorded. Within the Department, submissions and minuted meetings remained the formal decision-making process during the pandemic wherever possible. Sometimes a formal minute is replaced with a list of action points due to time pressure. Government could not function without these formal decision-making procedures because action on a decision requires co-ordinated activity by a large number of people, many of whom would not have been involved in making the actual decision.

59. Careful consideration is needed as part of Government decision-making to choose at what level to take a decision (e.g., Does the Secretary of State need to see this? Who needs to be consulted? Do we need to get the views of the Devolved Administrations? Who needs to formally sign off? Do we need to ask the Prime Minister?). Making too many decisions at too high a level is inefficient and cumbersome. Making too many

decisions at too low a level risks them being overturned if a more senior decision maker did not know and disagrees strongly. The best senior decision makers can make good decisions quickly, are consistent in approach and only try to change a decision made at a lower level very rarely, i.e., when it really matters.

60. In normal times, No. 10 advises the Prime Minister, and seeks to ensure his or her mission is advanced across Government. Ordinarily all No. 10 staff are aligned with the Prime Minister's views and speak for him or her. If a No. 10 staff member does not know, or cannot reliably presume, the Prime Minister's views, they will find out, and in the meantime, not intervene. Whether a request from No. 10 is a direct request from the Prime Minister, or a request in the name of the Prime Minister, is often not clear but it can be reliably presumed to be the will of the Prime Minister. No. 10 operates on the basis of this constructive ambiguity.

61. During the pandemic, four different cross-Government decision making processes were used. From 24 January 2020 to 24 February 2020 the formal COBR system was used to co-ordinate the cross-Government response. Next, the Prime Minister's Chief Adviser instigated a decision-making process from No. 10, which he insisted supplanted Prime Ministerial decision making. This was replaced in March 2020 with a Cabinet Office Covid-19 Secretariat and four Ministerial Implementation Groups ("MIGs") specific to the COVID response, overseen by a Covid Strategy meeting chaired by the Prime Minister. These were in turn improved on when replaced by the COVID(S) and COVID(O) Cabinet sub-committees in May 2020, which worked extremely well and should be considered as best practice when an emergency becomes too big to be handled with ad hoc COBR meetings.

62. At the time, anonymous Government sources criticised the formal decision-making structures, saying that the initial response of Government was a failure of the state. My experience was precisely the opposite. The problem was not the COBR system: it was that the COBR system was not used properly. When the COBR system was used effectively it functioned extremely well. When the collective experience of the COBR system, combined with the proper authority of Ministerial decision making, was temporarily replaced by an informal series of meetings from which key personnel were excluded, decision making became confused. Effectively, the powerful and experienced COBR system was not used properly. This was a major mistake.

63. To give a practical example of the problems created by this, a No. 10 morning meeting, chaired by the Prime Minister's Chief Adviser, was scheduled at the same time as the already established Departmental morning meeting, to which many but not all of the same attendees were invited. This created unnecessary problems for officials, undermined proper Ministerial decision making, and inhibited the response. These No. 10 political morning meetings led to action points which sometimes contradicted Departmental decisions, or even decisions taken by the Prime Minister. I spent a considerable amount of time and effort in protecting the Department from the ensuing confusion and obstruction. The then Prime Minister has apologised to me for appointing his Chief Adviser and for the damage he did to the response to Covid-19.

64. This informal decision-making system was even more problematic because of the constitutional position of No. 10, which cannot formally over-rule or direct a Department, except through the Prime Minister making a cross Government decision within the formal decision making process. By contrast, when the Prime Minister chairs COBR, all decisions carry the immediate and full authority of Government. The entire Government machine respects this system, and so it is extremely effective when run properly. By contrast, informal meetings in No. 10 do not carry this weight and so cannot drive action as fast or effectively. This further undermined the response. In future the formal emergency management system based on COBR should be used to manage an emergency like a pandemic.

*Departmental Decision Making*

65. Within the Department, while the formal structures of decision making changed little during the pandemic, the nature of decisions inevitably changed a great deal:

    a. The speed of decision taking had to increase remarkably. Indecision was itself a consequential course of action, and so Government had no choice but to increase the speed of its decision making radically;
    b. The speed with which action was taken also accelerated radically. Things that would in normal times have taken months or even years happened in days;
    c. The scale of the consequences of many decisions increased radically, and was often not known with any precision in advance;
    d. The uncertainty about the information on which decisions was colossal; and
    e. The changes in scientific advice could rapidly lead to a change of decision or operation.

66. This unprecedented increase in the speed, scale and uncertainty around decision taking had an impact on how Government went about trying to make the best decisions. For example:

    a. Full minutes of meetings were often replaced by action points, as even the note-takers were so time constrained; and
    b. There was much more use of technology, especially WhatsApp and Zoom, and many more informal phone calls.

67. One example is the relationship between the Department and devolved health bodies. The formal structure of decision taking was through the 'Council of Nations'. In normal times, since most health measures are devolved, there is little urgent business but during the pandemic a much more co-ordinated UK-wide response was required. So, at the start of the pandemic, I visited the three devolved nations, and with my counterparts we instituted both a weekly Zoom meeting and a WhatsApp group.

68. An assessment of all papers and communications show that during the pandemic my entire Department did whatever we could to save lives.

69. A major challenge within Departmental decision making until November 2020 was that senior figures in No. 10, including the Prime Minister's Chief Adviser, were in fact not aligned with the Prime Minister, yet issued instructions, often to junior officials, as if they had the Prime Minister's full authority. Even after the formation of the COVID(S) and COVID(O) structures in May 2020, this caused very significant problems, in particular in the testing programme. The full extent of the issues within No. 10 were not apparent to me during the pandemic and have only recently come to my attention and into public knowledge.

70. Within the areas of Department's responsibility, there was little change in formal accountabilities, with the exception of the abolition of PHE, and also the requirement placed on NHSE to agree significant decisions or spending with Ministers in advance, lessening their formal independence. Decision making became much more collective and cohesive. In normal times, the NHS is operationally independent, and operates with infrequent external engagement – for example with PHE or local councils, other Government Departments or agencies. However, the pandemic required much more cross cutting engagement. Furthermore, the NHS was affected by decisions outside its

normal field of operation; for example, decisions on non-pharmaceutical interventions ("NPIs") affected NHS capacity as they would impact on the number of people in hospital with Covid-19. NHSE leadership therefore became much more collaborative and engaged across the wider health sector, and across Government. This improved the operation of the NHS, and enabled, for example, its exemplary delivery of the vaccine rollout.

71. PHE likewise had a more cross-cutting remit in the pandemic and advised across the whole of Government and more widely on the implementation of Covid-19 rules. Despite the exemplary performance of many of its staff, its impact on decision making was undermined by its structure as a body responsible for both non-communicative public health, as well as communicable diseases, and its focus on the former in the run up to the pandemic.

72. In practice, I put in place regular meetings of all relevant health agencies as well as the Department, to bring together the response. These started in January 2020, and continued in different formats throughout my time in office. As we built institutions that had not pre-existed in response to the virus, like NHS Test and Trace, the cast list changed, but this regular meeting of the leaders of the many parts of the health system was incredibly important for co-ordinating the response across the Department and its agencies.

73. In a similar way, while the formal role of scientific and clinical advice did not change, the scale and nature of it did. The Department's corporate statement at paragraph 32 sets out very clearly the nature of clinical advice, and its role, which became much more important due to the nature of the crisis. Scientific advice was given to me as Secretary of State by the CMO or DCMOs, and the Government's Chief Scientific Officer ("CSO"), in formal meetings, including up to Cabinet level, in informal meetings, on the phone, by message, and embedded in formal advice.

74. Overall, decisions were generally collegiate and the Government's best collective attempt to reach the right answer, in the right timeframe, based on as much information as we could get. We constantly questioned and queried the decisions we were making, from all angles, to try to make them better. As new information became available, we queried prior decisions to check if they were still appropriate and were fully prepared to change them if we thought that best. Inside the Department we constantly questioned the best way to make decisions and were self-critical in constantly striving to improve.

75. The bringing in the best of academia and industry to work on fighting the pandemic worked well, as it did with other external leaders on other areas of policy, such as Dido Harding, General Sir Gordon Messenger, Paul Deighton, Kate Bingham, Camilla Cavendish, and many others. In some cases this was done in conjunction with No10, in some cases we did not need nor seek their clearance. I was a strong supporter of the recruitment of external capability, and was personally involved in persuading the most senior external recruits to take on responsibilities, for example for PPE supply, vaccine procurement, test and trace, border quarantine, and others.

76. We put in place both formal structures of accountability and progress reporting, and regular discussions to ensure action was aligned. These structures worked best where they reported through the Department, to ensure the best possible alignment. For example, the Vaccine Taskforce reported both to me and the Secretary of State for BEIS, who chaired a formal Ministerial Board to give oversight and democratic approval for its decisions. On the deployment plans for the vaccine, this worked efficiently because we kept these plans within the Department and its agencies, and only reported to the Cabinet Secretary and then Prime Minister once the plans were fully prepared – and so avoided the inappropriate political interference from No. 10 that had been the hallmark of the testing programme. As a result the vaccine rollout was one of the most effectively delivered programmes in the pandemic, despite being one of the largest logistical exercises in peacetime. When the structures for external leadership did not work, that was generally as a result of muddled lines of accountability with the Prime Minister's Chief Adviser and some others in No. 10 trying to centralise power to themselves, resulting in undermining the teams' ability to perform their roles. No decision in Government is straightforward, and often there is no single clear answer, but second guessing from aggressive personnel outside of the formal line of accountability causes huge problems. After November 2020, many confused lines of accountability were straightened out, and Government operated much better. For example, by winter 2021 the UK had one of the largest testing capacities in the world. The lesson for future is very clear: clear Cabinet accountability and formal Government decision making at pace is best.

77. While the Government was criticised at the time for engaging with the private sector on areas such as testing, vaccines and PPE, on the contrary harnessing the skills of the private sector was vital in our response to the pandemic. We could not have achieved

the expansion of testing, the roll-out of the vaccine, without the support of the private sector.

78. Contracting with the private sector also changed. Normally contracting with the private sector follows slow processes to ensure the best possible value for money. However, emergency procurement rules pre-existed and were used effectively where we had to speed up buying. When the pandemic hit the UK, we needed a significant and rapid expansion of procurement in many very sensitive areas, including testing, ventilators, pharmaceuticals, PPE, hospital equipment, and other areas.

79. Given that global demand for these products rose dramatically, there were significant challenges in procurement. The Government triggered the emergency procurement rules to speed up purchasing, issued public calls to arms, and put in place a Cabinet Office team to support with procurement. We were inundated with offers for support from businesses and private individuals who wished to help in this effort. For example, Rachel Reeves MP on behalf of the Labour Party responded with proposals. As Secretary of State I was not involved in the awarding of contracts, which was led by officials, largely in the Cabinet Office. Every contract that was awarded was decided, priced and signed off by the civil service, independently of ministers. This was confirmed by the National Audit Office in its report, 'Investigation into government procurement during the COVID-19 pandemic'.

80. Overall, my experience was that every single person who worked in my Department and countless people across Government and its agencies worked incredibly hard. The daily routine completely changed for us all; we just worked on the pandemic round the clock. My team and I worked every day with the one overriding mission of saving lives in the face of a virus which we knew very little about.

**CONTEXT FROM MODULE 1**

81. Finally before describing decisions I was involved in chronologically, in order to provide context I have in very large part reproduced below paragraphs 15 – 22 from my Module 1 statement on ways of working, because I understand the Inquiry is not cross-disclosing witness statements between Modules.

82. I served as Health Secretary from 9 July 2018 to 26 June 2021 under two Prime Ministers, Theresa May and Boris Johnson. When I was initially appointed, as with

previous Ministerial roles, I was given a series of 'day one' briefings by officials within the Department to alert me as to its ongoing work.

83. My daily work was heavily diarised and run by my Private Office. Before the pandemic, I would hold regular – usually weekly – meetings on the areas of responsibility I wanted to drive hardest. For example, in late 2019 I would have regular weekly meetings on:

    a. The NHS – with Simon Stevens on the management of the NHS;
    b. Technology – improving health technology and use of data;
    c. People – improving the way the NHS recruits and rewards staff;
    d. Prevention – driving the agenda to prevent disease, not just react to it;
    e. Media – to consider communications, including public health communications;
    f. Ministers – to stay in regular contact with Ministerial colleagues; and
    g. Cabinet – chaired by the Prime Minister in No. 10.

84. I would also hold regular meetings on ad hoc topics, such as delivering on manifesto commitments, securing Departmental finances, hosting visiting dignitaries, making statements in Parliament and other speeches to drive forward progress, responding to questions in Parliament, undertaking media appearances, attending cross-Government meetings such as Cabinet Committees or COBR, delivering a myriad of specific projects, like access to Orkambi (a drug to help those with cystic fibrosis), or making visits across the UK and occasionally overseas to represent the Government and listen and learn.

85. In addition to meetings, many decisions were made through paperwork. The primary method of decision making throughout my period as Health Secretary – including in the pandemic – was the formal Departmental submission: a detailed note from the Civil Service, considering an issue from all angles, that would usually put forward options for decision. Cross-Government matters were largely dealt with through formal letters setting out a Department's position, to seek a cross-Government agreed position. Normally I would receive around twenty submissions or letters per day, typically in my evening red box (my 'box'). On top of each submission, Private Office would attach a one-page note which included:

    a. the date of submission;
    b. the deadline for response;
    c. a summary of issue and decisions needed, and any interaction with other relevant work;

d. the view of the Junior Minister responsible for that area; and
e. any views from Special Advisers.

86. I split my box into five files:

a. Constituency matters relating to my role as MP for West Suffolk;
b. urgent matters (I always completed this file overnight);
c. routine submissions for decision (I usually completed this overnight);
d. reading materials not for decision; and
e. diary questions and invitations.

87. My box would typically take an hour to ninety minutes each day. In addition to this, I would talk to colleagues in person and on the phone, and use email and messages in a fairly limited way. Sometimes I would write on a submission itself and then photograph the submission with my notes and send to my Private Office when this was the most efficient way of sending back my views.

88. All major decisions were made and documented in the formal way through submissions within the Department and letters between Departments. This is the entirely standard way Government operates, and given the sheer scale of the number and size of decisions, in normal times it works well.

89. Discussions on WhatsApp are best thought of as like an informal discussion, like the conversation that happens around a formal meeting, rather than the meeting itself. Any significant decision was taken in a formal way, based on a submission, even if it had been preceded by a discussion or in principle decision on WhatsApp beforehand. Looking only at WhatsApp messages alone gives a highly partial and skewed account of what happened. Actual decision making was much more formal, whether on paper or in formal meetings.

90. During the pandemic my ways of work changed in the following ways:

a. I would wake at 6am and spend half an hour checking urgent overnight messages and news;
b. Most days, my driver would collect me each day at 07:50 and I would arrive at the Department of Health and Social Care at 08:20;

c. I would have back-to-back meetings throughout the day, in the Department, 10 Downing Street or Parliament, usually going back home at around 7-8pm, but often later into the evening;
d. I would have a short time to have dinner with my family before going back to my home office to continue working until around 11 o'clock at night. I always tried to get to bed by midnight;
e. Across Government we used WhatsApp far more frequently, as there were fewer in-person meetings across Whitehall, and the necessary speed of decision taking increased radically. Decisions that previously may have been made in a meeting scheduled several weeks hence would be discussed by WhatsApp and formally taken at urgently convened meetings. WhatsApp presented a very effective, socially distanced way of communicating directly with people;
f. I spoke regularly to the Prime Minister by phone to keep him abreast of developments;
g. A weekly G7 call with my Health Minister counterparts was set up each week to discuss how the pandemic was evolving overseas. Ah hoc bilateral international discussions became more frequent;
h. I set up a weekly 'Four Nations' call with my Scottish, Welsh and Northern Irish counterparts to ensure we had as coordinated a response as possible across the UK; and
i. Administratively, the Permanent Secretary at the Department Sir Chris Wormald, diverted his entire attention to Covid-19 on 22 January, delegating the day to day running of the Department for non-COVID purposes to David Williams, who was appointed Second Permanent Secretary of the Department on the 6 March.

## CHRONOLOGY FROM MY POSITION AS HEALTH SECRETARY

## 1 JANUARY 2020 – 16 MARCH 2020: THE INTERNATIONAL SPREAD OF COVID-19

*Emerging Reports of Covid-19 and Preparatory Decision Making*

91. My first recollection of the virus is reading a news-in-brief story on New Year's Day about a mystery pneumonia outbreak in China. Reports of novel diseases are not in themselves that unusual, but I recall asking my Private Office to put together a briefing and I made a mental note to raise it when back in the Department, which I did.

92. On 5 January there was more in the newspapers about the new disease in China, with fifty-nine people reported as infected, seven of whom were apparently seriously ill with breathing problems. There were also reports of concerns in Hong Kong and Singapore about the new virus, including a suspected case in a three-year-old Chinese girl who had recently been to Wuhan. I asked my Private Office for a full briefing on 6 January, which was to be my first day back in the Department after the Christmas recess.

93. On 6 January I had a meeting with the new CMO, Professor Chris Whitty, and his team to talk about mandatory flu jabs (MH2/11 - **INQ000233736**). I took advantage of having so many experts in the room to ask what was known about the new disease in China. I recall that the CMO and his team told me that they were across it but that there was not much to go on; he explained that they were trying to get whatever information they could out of the Chinese and the WHO. We talked about the chances of the virus coming here.

94. The CMO's view was that the Department needed to be vigilant, as it generally was in respect of monitoring novel infectious diseases. That notwithstanding I recall asking to see the emergency plans that were put together after the Whitehall pandemic preparation exercise known as Exercise Cygnus that had taken place a few years ago under my predecessor, Jeremy Hunt MP. I asked about the need for a vaccine, and options for its development. I was advised that creating a new vaccine takes many years.

95. On 7 January I asked to speak to the CMO again about the new disease. Overnight it had emerged that the novel disease was not a strain of influenza but a coronavirus. My recollection is that the CMO explained that a new coronavirus was not good; the UK had stockpiles of flu antivirals, and I had signed off updating the pandemic flu vaccine supply plans in 2018 (**MH2/11a - MH2/11d** INQ000184107; INQ000184108; INQ000184109; INQ000184110), but there was no vaccine against a coronavirus. The CMO told me that Singapore and Hong Kong had started screening all arrivals from Wuhan for symptoms; mainly fever and coughing. At this time there was no evidence of human-to-human transmission, which I was told was the critical tell-tale sign of a potential pandemic, but this was early days and too early to tell.

96. On 9 January I received my first written briefing about the virus from the Department in the form of an email to my Special Adviser ("SpAd"), Jamie Njoku-Goodwin (MH2/12 - **INQ000233737**). Given the limited information not much was known, but the plans for an influenza pandemic would have to be adjusted because the new virus appeared to have

a much longer incubation period. I was, however, reassured that, at that time, the six known coronaviruses were not transmitted by people without symptoms i.e., asymptomatically. I recall also being also told that this novel disease did not appear to affect children. However, I also remember being informed that there was a possibility that domestic animals may be what scientists call a 'reservoir' of the disease, with cats being a particular worry.

97. My briefing also set out that PHE, the body responsible for tracking and protecting us from pandemics, wanted to publish some generic infection control advice on the next day. I agreed, as I thought that the more information we could publish, the better. PHE was also categorising the new virus as a 'high-consequence infectious disease' ("HCID"), which meant that anyone treating patients who might have it would need to wear hazmat suits. The UK had huge amounts of protective equipment stockpiled for a potential flu pandemic. Lastly I was told that PHE was working to develop a test for the virus and that they could do this once China had published the genome.

98. Later in the day we had the first vote of the year in the House Commons. I spoke to the Prime Minister ("the PM") in the voting lobby and I told him about the new disease. I remember the PM telling me to keep an eye on it. Raising matters with the PM in the voting lobby was an effective way of putting a matter on his radar, as well as going through the formal process of inter-Departmental communication.

99. I learnt about the first death from Covid-19 in China on 11 January (MH2/13 to MH2/14 - INQ000233738 ; INQ000182320 ). The victim had apparently died two days previously. The Chinese Government also published the genetic code of the virus, although they had apparently held the data back for two days. With the genetic code the work on developing tests for diagnosing the disease and the development of a vaccine could begin in earnest.

100. The WHO published its first analysis of the disease on 12 January. The initial data showed that Covid-19 had a lower mortality rate than Severe Acute Respiratory Syndrome ("SARS") but was much more infectious. I discussed these data with the CMO, and he advised that this meant that if it were to spread, the total number of deaths would be much higher. I remember thinking that a 'low mortality but highly infectiousness' disease was going to be difficult to explain to the public. On the same day I spoke to Gordon Sanghera, chief executive of Oxford Nanopore, which designs tests based on genetic sequencing. Mr Sanghera stated that his company could develop a test in a matter of days. I believed this to be true as I had seen their excellent testing devices.

101. On 13 January the New and Emerging Respiratory Virus Threats Advisory Group ("NERVTAG") held a teleconference on the virus in the morning. NERVTAG is a group of eminent scientists specialising in novel respiratory illnesses chaired by Sir Peter Horby, the University of Oxford specialist. Sir Jonathan Van-Tam, deputy CMO, attended for the Department and fed back to me. I wanted NERVTAG's advice on whether we should start screening people at airports. The advice from NERVTAG was not to start screening at airports as they believed that this would only slow the virus getting to the UK slightly. At that time I recall being very concerned about why the Chinese Government was letting people leave the city of Wuhan. One thing that reassured the scientists was that there had never been a coronavirus known to transmit without symptoms. (MH2/15 and MH2/16 - INQ000233740; INQ000023107).

102. I met Sir Chris Wormald and the team to think through how the Department should handle what I wanted to be a very science-driven response, albeit with wider issues to consider. The clear advice from Sir Chris was that the Government should be guided by the science. Being guided by the science does not mean blindly following each scientific recommendation, but rather taking the science as the starting point. In this meeting we agreed that PHE should put out more guidance, saying the current risk to people in the UK is still 'very low' and advising anyone visiting Wuhan to wash their hands and 'minimise contact' with live birds and animals in the markets there. We also went through what we had by way of contingency plans to be prepared if this disease became worse. I was informed that every local authority and every NHS organisation in the country had a pandemic preparedness plan that was ready and waiting. I recall asking to see a selection of these plans to make sure that they were useful.

103. At this point the response to the disease was still essentially within the remit of the Department, i.e., we were concerned with considering hospital capacity, nursing numbers, any legislative changes that might be needed, testing, the very early work on a vaccine, etc. I was, however, conscious that the rest of Government would be required to swing into action if the disease became more of a threat.

104. On 14 January I issued a statement about the benefits of modern vaccines and the dangers of listening to misleading information, to counteract misinformation being spread by Andrew Wakefield, the former doctor who got struck off for scaremongering over the measles, mumps and rubella vaccine. I did not want his ideas to be getting any public

traction, particularly not at a time when a new vaccine for the novel coronavirus might be required.

105. PHE had, by this time, come up with a diagnostic test for Covid-19, which was remarkable given that China had only published the genetic code three days previously.

106. During the afternoon I went to the CMO's office to discuss the latest development; I recall that we discussed what was known about the virus and he stressed the importance of the R-number: the average number of secondary infections produced by a single infected person, which determines how fast an infectious disease spreads. The CMO and I discussed a vaccine, with him outlining that there are effectively two types: ones that are 'pandemic-ending' and prevent people getting ill and passing on the virus; and the others that are 'pandemic-modifying', meaning it helps prevent illness but does not stop the disease in its tracks. The expert advice was that with something spreading as fast as it was in China, it was best not to count on eradication.

107. On 17 January I called the Prime Minister directly to warn him of the risk from the emerging virus. I called him directly on a number of occasions during January (on 22, 29 and 31 January) to try and impress upon him my concerns as to the potential impact from the virus.

108. By 17 January there had been a second coronavirus death in Wuhan: a 69-year-old man. He had died two days before, but news of it had only just been made public. The USA had introduced health screening for arrivals from Wuhan at airports including San Francisco, New York and Los Angeles. I was uncomfortable about how little we were doing at the borders in the UK and raised it again with the PHE team. However, the clinical advice I received was very clear that action at the border would not make any significant difference. The CMO explained that he thought the virus had a 50:50 chance of escaping China. He further explained that if the virus got out of China in a big way it would likely 'go global'. Even with a low risk to any one person, a very large number of people would likely die.

109. On 20 January I received a further formal submission setting out the Department's incident response (MH2/17 - INQ000106901). The submission set out measures in the UK, including NHS capacity and port health measures, and provided a reassuring situation update:

*"1. Following increasing international interest and news over the weekend that the number of confirmed cases of Wuhan novel coronavirus… has increased… we have established a DHSC-led incident.*

*2. An incident team has been set up and we have initiated daily sitrep calls with key delivery partners, the devolved administrations and other Government Departments.*

*3. We have engaged the Cabinet Office Civil Contingencies Secretariat (CCS) who are keeping No.10 informed. Both CCS and No.10 are content with our response so far, and we remain in close contact as this is a very quickly evolving situation."*

110. In light of the developments, the decision was taken by the CMO, in consultation with his counterparts in the Devolved Administrations, to raise the risk level to the public from very low to low. The CMO discussed this with me informally in advance, and I was formally notified in a submission from Emma Reed (the Department's Director of Emergency Response and Health Protection) on 21 January 2020; the submission provided me with an update on developments in Wuhan and sought my agreement, which I provided, to a package of proposed port health measures (MH2/18 - INQ000106897). Paragraph 10 of the submission reflected the little known about the virus and the need to keep measures under review:

*"As this is a new emerging infection, scientific understanding of this disease is evolving rapidly. The measures set out here will be regularly reviewed to assess their effectiveness in identifying cases and in light of the emerging global picture."*

111. I was reassured by paragraph 13 of the submission, which stated that:

*"The NHS is well-prepared for emerging infectious diseases, and has being putting in place plans for this novel disease."*

112. I provided my approval of the port health measures at 20:27 on 21 January (MH2/19 - INQ000233742).

113. PHE also agreed to contact travellers who had come back from Wuhan in the past fourteen days to check if they have had the latest public health advice, i.e., to go into isolation if they were experiencing any symptoms. At this time I was uneasy that the Government was not doing more at the borders, but the expert advice was still adamant that it was not worth the cost. There were reports of people still moving in and out of Wuhan for Chinese New Year with local authorities holding public banquets for 40,000 people at the weekend. I recall suggesting that we ask the Foreign Office to exert diplomatic pressure to make the Chinese authorities see sense but I was told this would be futile.

114. SAGE, which was chaired by the CMO alongside Sir Patrick Vallance as the Government's CSA, met on 22 January to discuss the virus. SAGE backed NERVTAG on not screening at airports due to the risk that so many false positives and false negatives would render the whole exercise meaningless. The advice from SAGE was that leaflets, posters and announcements over the tannoy were the appropriate response and that anyone who had been to Wuhan and felt ill within fourteen days should get tested.

115. However, on advice from SAGE the decision was made that we needed plans in place to isolate anyone suspected of having the virus and to track down anyone they had been around so we could see how they were feeling. At this time England had a limited contact tracing programme (run by PHE) for rare outbreaks. PHE assured me that its contact tracing system was the best in the world, as rated by the WHO.

116. The CMO came into my office in between meetings to take me through SAGE's conclusions; he explained that the R-number was clearly above 1, meaning the disease was spreading exponentially. I ensured that the SAGE minutes were available to No. 10, so that they could see the same scientific advice I was receiving. I also called the Prime Minister to update him personally.

117. At this time there were three flights a week from Wuhan to the UK. PHE announced on 22 January that there would be health officials at Heathrow asking people coming off these flights if they were feeling OK and handing out advice leaflets. I remained concerned that this was too little but accepted the expert advice. No adequate explanation was given as to why these Enhanced Monitoring Arrangements were only being applied at Heathrow, not at other airports where flights from China arrived directly, and I requested their expansion to all relevant airports as soon as possible.

118. Events in China then overtook our concerns about travellers from Wuhan, as Beijing put the entire city into quarantine, meaning that there would be no more transport in or out, including planes, trains and buses. However, by this time I was aware that there were cases in Beijing, Shanghai, Hong Kong and Macau, Thailand, Korea, Singapore and Japan – as well as the case in America.

119. With that in mind I called the WHO director general, Tedros Adhanom Ghebreyesus to try to encourage him to declare a public health emergency of international concern ("PHEIC"), which is a mechanism of ratcheting up the global response. I was told that a PHEIC could not be declared during this week. The reasons given were unsatisfactory: I was told that one of the people who was needed to sign off such a decision was apparently stuck on a long-haul flight.

120. In light of ongoing developments, my view was that the Government needed to call a COBR emergency committee meeting to inject urgency into the Whitehall system. COBR meetings are important because their conclusions are automatically taken as agreed Government policy, and so their decisions run across Whitehall and therefore the chair is in a powerful position to get other Government Departments to act. I requested we call a COBR meeting, but was told No. 10 was unpersuaded, and concerned about how it would be communicated. The purpose of calling the meeting was to co-ordinate preparations, not for communications purposes.

121. Sir Chris Wormald told me that he was now working 100 per cent on the Department's response to the new coronavirus and that he had delegated everything else to his deputy, David Williams.

122. On 23 January No. 10 agreed my request to make a statement to the House of Commons about Covid-19. The CMO came to my office to go over the text of my statement and to help me prepare for any questions. He repeated his assertion that there was a 50:50 chance the Wuhan quarantine would not work and we would face a global outbreak. His visit left me sobered, particularly given that about 300,000 people had apparently poured out of Wuhan by train just before the quarantine deadline. Unbelievably, the Chinese authorities had only recently started closing roads out of the city and the city's health system was reportedly swamped; they had started building an emergency hospital.

123. The CMO's warnings were weighing on my mind when I stood up in the House of Commons. I wanted to set out the facts and show that the Government had got a grip without causing unnecessary alarm. I therefore focused on the proportionate, precautionary measures that the Government had been taking, emphasising the 50:50 chance that the virus would come here.

124. At this stage No. 10 were still saying that calling COBR would be alarmist. I instructed my team to push back with my request. The Department instigated daily situation reports which we made available across Government to promulgate what little information we had as widely as reasonably possible.

*The First COBR and the Dialling up of Work on Testing and Vaccines*

125. On 24 January the first British people were directly affected by the virus. They were on a cruise in south-east Asia on the Diamond Princess and there had been an outbreak of the virus on board. I charged Emma Dean, my policy SpAd, and Emma Reed (as Director of Emergency Response and Health Protection) with preparing the Department's response.

126. I was permitted by the Cabinet Office to convene a COBR meeting, which was held at 12:00 on 24 January. There were four items on the agenda: (1) Current situation updated; (2) UK Escalation Triggers and Response Options; (3) Communications and Parliamentary Handling; and (4) Next Steps. The first agenda point was accompanied by a Commonly Recognised Information Picture ("CRIP") slide pack and the second by a paper titled 'UK Escalation Triggers and Response Options'. As the Chair I was provided with a brief. Minutes were taken and action points were then circulated (MH2/20 to MH2/25 - INQ000056200; INQ000056162; INQ000056222; INQ000056207; INQ000056214; INQ000056161). A number of decisions were made, including the trigger levels and actions as set out in the paper, and that it would be for the CMO to advise as to when those trigger points had been met.

127. On 25 January the Prime Minister's Chief Adviser messaged me directly to enquire: *"To what extent have you investigated preparations for something terrible like Ebola or a Flu pandemic? Are we ready for Ebola or a Flu pandemic?"* I was surprised that his question did not mention the coronavirus outbreak, but responded to explain the background of the response, which he acknowledged.

128. Following COBR, the Foreign and Commonwealth Office ("the FCO") advised against all travel to Hubei province, of which Wuhan is the capital. I recall believing that we needed to go further, and cover far more of China, and that we should withdraw any British citizens from Wuhan. I tried to raise these points with the FCO through private office, but I was told that travel advice is a Foreign Office matter. Not satisfied with this, I called Dominic Raab as the then Foreign Secretary; and following discussion he was happy to order the evacuation and said that he would look again at the travel advice.

129. Testing at this point was focused on travellers coming back from Wuhan. Having developed one of the first tests, I was not satisfied with the degree of urgency to expand capacity. I asked PHE to go faster, and to use the private sector, including people like Gordon Sanghera. I enquired about testing all those returning from Wuhan. I was advised that, due to the proportion of false negatives, the tests were worse than useless for those without symptoms. I saw this as a critical issue; if the tests did not work on people without symptoms, we needed ones that did.

130. Further on 25 January, I heard that Professor Robin Shattock from Imperial College London said that from the early vaccine work that he already had two candidates that would be ready to test on animals in the next month. The CMO was cautious, saying that the development of a successful vaccine could take years. I called for a meeting on Monday 27 January to go through everything. It seemed to me that vaccines were obviously the way out for all of us.

131. On 26 January I read a report from China of the possibility of asymptomatic transmission, which I found particularly worrying (MH2/26 - INQ000183872). The case definition (a clinical statement of the best known understanding of the virus and the disease it caused) included an assumption of no asymptomatic transmission. I asked officials for advice on this for the next day's meeting.

132. At this stage PHE was adamant that a coronavirus could not be passed on asymptomatically and that tests did not work on people without symptoms. I wanted to use the meeting to push them on both of those critical points and to leave them in no doubt that we needed to expand testing.

133. Later on 26 January fellow Member of Parliament Owen Paterson messaged me to put me in touch with Peter FitzGerald, boss of Randox, the biggest UK testing company, based in Northern Ireland. Randox believed that it could create a test in three weeks that

could produce a result within two to three hours. However, to develop it, they needed samples of sputum containing the virus. I knew PHE had access to some through its international work and my view was that they should share it. I emailed Mr FitzGerald asking for more details.

134. On Monday 27 January I heard reports that arrivals from China were coming through Heathrow without being screened. I wanted people arriving back from Wuhan to be quarantined, not just screened. While I could not overrule clinical advice, but I could insist that we plan for the worst case scenario, not the central assumption.

135. Prior to the meeting starting at 09:45 through my Private Secretary I communicated my view to officials and the CMO that we should be working on a worst case scenario basis (MH2/27 - INQ000233743). At the 09:45 meeting I set out my view that we should instigate a travel ban from China. The response was that this was an FCO matter. Dissatisfied with this I asked the CMO to talk to the FCO. The CMO is formally the adviser not just to the Health Secretary but to the whole Government, and so my view was that the FCO machine should listen to him. I also got an update on getting UK citizens out of Wuhan; it was thought that there were 200–300 there. I made it clear that my view was that anyone we bring back to the UK should go into quarantine. I received legal advice that any quarantine should be voluntary. I recall thinking that this was unacceptable. With officials we brainstormed solutions, and came up with the proposal that quarantining on return should be a condition of getting on the flight. I therefore asked for further advice about making this happen. PHE also advised the need to track down everyone in the UK who had come back from Wuhan in the previous fourteen days to ask them to stay at home and contact the NHS if they had any symptoms. PHE estimated there were 1,460 individuals in this category.

136. I also outlined my concern that I had heard that the virus was transmissible asymptomatically. The CMO reported that the global scientific consensus was still that asymptomatic transmission was unlikely. The CMO also indicated that the measures taken by China appeared to be having some effect and that the R-number was likely to fall. We also briefly discussed vaccine development and I indicated that we should pursue every option possible but the right officials were not in the room and so I called another meeting for the next day to go through it and what we could do to accelerate it (MH2/28 - INQ000106067).

137. Peter FitzGerald from Randox then got back to me with the technical details of what Randox needed in order to develop a test. I asked PHE to be helpful to him and all those who could help expand testing capacity.

138. At the Permanent Secretary's suggestion, I also asked for the 'reasonable worst-case scenario' for this disease in the UK so that we could interrogate the numbers, and called a further meeting for the next day to discuss the reasonable worst case scenario and its consequences.

139. Further on 27 January, Germany confirmed its first case of the virus with a patient who reported feeling ill on 23 January and seemed to have caught it from her parents who had been to Wuhan and tested positive even though they showed no symptoms. I spoke to Jens Spahn, my opposite number in Germany, who I trusted. He told me that the evidence of asymptomatic transmission was tentative but that the German authorities were worried and keeping a close eye on it.

140. Amidst all of this my team was still getting calls from No. 10 and being dragged into meetings about how we were going to deliver manifesto commitments. I had to delegate; whilst I wanted these commitments to happen, I had to prioritise. At this stage, whilst the risk level was still 'low', the response to Covid-19 was the first thing on my mind from when I woke up and the last thing I thought about when I got to bed.

141. When I refer to risk levels in this statement I am referring to what I was told the risk to the public was at that time, as opposed to the risk in the future, by the Department's scientific advisers. In the early days of the pandemic, as details of the virus were scarce, the basis for the assessed risk level were naturally limited. As far as I am aware, the Government as a whole understood the risk level to be a statement of 'current' risk to the public rather than a prediction of future risk; this was certainly very clear to me. In considering this issue, and in fact everything else at this time, it is vital to recognise the context of very little information about the virus. When read back with hindsight, knowing what happened, it is very easy to forget the lack of data in January 2020.

142. On 28 January my senior team met in the early afternoon in my office to go through the reasonable worst-case. The CMO informed everyone that although there was currently no sustained transmission outside China, in the reasonable worst-case scenario as many as 820,000 people in the UK may die. Although the risk of death to each individual was low, the transmission was so high that almost everyone would catch

it, in up to three waves, each lasting about fifteen weeks. I understood that we were looking at the risk of an epidemiological human catastrophe on a scale not seen in the UK for a century (MH2/29 - INQ000233747).

143. I asked what we needed to do to accelerate a vaccine. Professor Van-Tam explained that developing a vaccine normally takes five to ten years, but that there was a team in Oxford working on an Ebola project that could be switched to the new disease. He further indicated that if everything was fast-tracked, a vaccine could at best be developed in a year to eighteen months. I responded that I wanted it by Christmas. Professor Van-Tam set out how the Department could fast track progress.

144. I would say that the mood of this meeting was grimly determined; together we went through the other problems the Department had to deal with: testing (again I pushed PHE on expansion and harnessing the private sector), asymptomatic transmission (I was told that a paper was being prepared and would be provided to me later that day) and how people would respond if the Government had to ask them to change their behaviour. We also started to think about how the social media companies could help; my SpAd, Jamie Njoku-Goodwin, had spoken to Twitter and had been told that it was going to change its algorithms so that when people searched for 'coronavirus' and various other key terms they would be directed to the UK Government guidance page (MH2/30 - INQ000233746).

145. On the same day the Foreign Secretary relayed a request from the Chinese Foreign Minister for us to put goggles, masks and other equipment on the flight out to Wuhan (MH2/31 - INQ000233745). I agreed because we wanted to set a high standard for international cooperation and I thought that the UK was bound to need help from others further down the line. The Government said that it would offer any spare seats on the flight back to non-British nationals who needed to get out, but that they would have to get straight home from wherever they landed in the UK without transferring to other airports. This was not my proposal but I was happy with it.

146. I called the Prime Minister on 29 January to provide him with a further update, including of the worrying meeting about the reasonable worst case scenario the previous day. I found Prime Minister's Questions ("PMQs") on 29 January surreal: not a single question about the virus was asked. On reflection, this was perhaps unsurprising with the focus of the country on our impending departure from the EU and the current risk level still at low. I stood by the Speaker's chair thinking that every single question being asked would be rendered irrelevant within a few weeks.

147. Following PMQs the CMO asked to see me, and proposed four elements for our response to the virus: first, we try to contain isolated outbreaks, then we try to delay the spread. If containment is unsuccessful and the virus spreads to the general population, we move on to mitigating and slowing its effects; and throughout we research for treatments and a vaccine.

148. Once again I pushed PHE about asymptomatic transmission; the paper I had been provided with said almost nothing and did not even contain a provisional finding. I could not understand why it was taking so long to get an answer on this issue, not just in the UK but around the world. I called Tedros Ghebreyesus again to have another go at persuading him to declare a PHEIC (MH2/32 - INQ000233748); my sense was that he was terrified of upsetting Beijing. I asked him about unofficial reports from China that there was asymptomatic transmission and he played it down, said that it was a translation error, and claimed to be impressed by the Chinese authorities' transparency. I found this response surprising.

149. On 29 January I chaired a further COBR, for which I was provided with a brief. We went through the reasonable worst-case scenario and ministers agreed to work on plans to handle that situation, should it occur. FCO briefed COBR on the Wuhan evacuation plans. COBR agreed to increase reasonable worst case scenario planning using the pandemic flu assumptions in the National Security Risk Assessment ("NSRA") (MH2/33 to MH2/37 - INQ000056146; INQ000056164; INQ000056166; INQ000056226; INQ000056163).

150. On 30 January the evacuation flight left. Ahead of its departure we had to decide what would happen when the evacuees landed at RAF Brize Norton. PHE proposed they should be asked to isolate at home for two weeks. My strong view was that they needed to go into quarantine. PHE explained that they were worried the Department might be judicially reviewed if a quarantine was insisted upon. I repeated the previous suggestion that the Government make it a contractual condition of their return flight that they agree to go into quarantine on arrival. Whilst I was told that any such contract would not be legally enforceable I asked PHE to go ahead. In the end this approach worked well, and while we did strengthen the powers we had to enforce quarantine, including through the drafting of emergency secondary legislation, these powers were not in the end necessary.

151. On reflection, this policymaking is a good example of the interaction of scientific advice, operational action, and Ministerial decision making. I was guided by the scientific advice, but felt that it was not cautious enough, and would not be reassuring to the public, so on this occasion I did not follow it.

152. The Permanent Secretary advised that we needed to "win the war against the virus and the war for public confidence". Both were important, and both underpinned my decision to take a more precautionary approach than the central scientific advice. Creative policymakers developed a solution that clinicians and lawyers were content with, and the NHS in turn developed operational options for quarantine.

153. As I was on a visit to Porton Down (the UK's Defence and Science Technology laboratory) to see its high-security testing and vaccine production capabilities, I asked Jo Churchill, my consistency neighbour and minister responsible for public health, to go up to the former nurses' quarters at Arrowe Park Hospital, where the evacuees would be accommodated, to make sure it was comfortable. She insisted on packs of toiletries and more towels being provided. Alarmingly, she also messaged me to say that the passenger numbers on the plane manifest did not tally with the numbers the FCO had given the Department, so it was not exactly clear how many people were arriving. To my mind, nothing exemplifies the fundamental lack of information about the start of the pandemic better than the fact that the Government did not know how many people were on the evacuation plane. This is not a criticism: huge efforts were being made in the face of enormous uncertainty.

154. The learnings from Exercise Cygnus meant that the Department had a draft Bill ready. I asked the Permanent Secretary to work on the legislation to adapt it to the information we had learned about the virus and its spread to date.

155. Crucially on 30 January the WHO finally declared the virus a PHEIC, which meant that all countries around the world could (and should) work to the same principles. The WHO advised every country to bring in proper surveillance, isolation, contact tracing and prevention to try to slow the spread. The WHO also mandated that countries, including China, must share full data about their cases with it.

156. Following the WHO's announcement, the four UK CMOs in England, Scotland, Wales and Northern Ireland met and decided to raise the risk level to the public from low to moderate. In my view it was vital that all parts of the UK moved in lockstep, and the co-

ordination of clinical advice from the four UK CMOs played an incredibly positive role to this end throughout the pandemic.

157. On 30 January I received PHE's audit of the PPE stockpile: it said that there was no clear record of what was in the stockpile and that some kit was past its best before date. I instructed officials to work out what we needed fast and to buy in huge quantities. A 'supply chain cell' was set up to address the issue and I understand that it met for the first time on 1 February 2020 (MH2/38 - INQ000233750).

*The Arrival of the First Covid-19 Cases in the UK*

158. On 31 January Covid-19 arrived in the UK. I got a call from my Private Secretary at half past midnight to tell me that there were two positive cases: a Chinese student and his father who had flown in from Wuhan to visit him. After they reported ill on Wednesday night and then tested positive, the first case protocol was put into action, and worked seamlessly. As set out in the first case protocol (MH2/39 - INQ000106073), the CMO made the announcement, as we judged he would be the most assured and reassuring voice for the public, knowing that many people would be understandably concerned.

159. Also on 31 January I spoke to the Prime Minister, and briefed Cabinet on the first cases, the reasonable worst case scenario of 820,000 deaths, and the actions taken so far.

160. On 31 January I received a submission requesting I note the CMO's recommendation to launch a rapid research call (through the National Institute of Health Research and in conjunction with the Medical Research Council), which was intended to strategically source, fund and manage research to better understand the disease and develop interventions to prevent, control and treat it (MH2/40 - INQ000057497). This call would also help to fund crucial vaccine research.

161. On 1 February I found out that the Chinese authorities had ordered people to stay indoors and was only letting them out to get what they need to survive. In Hubei, only one person per household was allowed out every two days for food and other essentials. Funerals were banned and bodies just had to be dealt with at the nearest crematorium straight away. I found this terrifying.

162. At this stage there were nearly 12,000 confirmed cases of the virus worldwide. Of those, 259 had died, all in China. Spain had had its first case, the United States was up to eight cases and numbers were growing in Australia, Japan, Singapore and across east Asia. Further, on 2 February, the first coronavirus death was reported outside China: a 44-year-old man in the Philippines.

163. On 3 February at the old Royal Naval Hospital in Greenwich, the PM gave what was supposed to be a historic speech on Brexit; he touched on the virus, warning against rushing to close borders as this could be used as an excuse to put up unnecessary trade barriers. The speech was completely overshadowed by other events, however: in Wuhan, the army had taken over delivery of medical supplies. SAGE reckoned that the epidemic was still growing exponentially, probably doubling in size every four or five days. SAGE considered it possible that as few as one in twenty cases in China were being identified, which would mean the real size of the epidemic is 200,000–300,000 cases.

164. Given the signs the virus was taking hold outside China, SAGE had also looked again at travel bans. Their view remained that there still was not much to be gained and that, should the pandemic go global, the country would not keep the infection out. The benefit would have been to buy time, but the evidence suggested reducing imported cases by half would only hold the epidemic up by about five days. To gain a month, the country would have needed to cut international travel by at least 90 per cent, which would have required draconian measures, far beyond those seen in China. The PM was clear that the country had to follow the science and the science was clear: travel bans were not worth it. The Government did, however, move to recommend against travel to China.

165. One example of the challenges of following scientific advice is where the scientific advice is not clear. For example, it was very hard to discern the value of face masks for reducing the spread of the virus. The Department asked NERVTAG to look into their impact. NERVTAG's response was that there was no evidence either way that the general public wearing masks would make any difference. My view was that if they did not really help, I did not want to impose them on people. I was advised that there was a furious global debate on this question. Apparently, scientists could not agree at all because the way the virus was transmitted was not yet then understood. At this stage, the best advice was that health and care workers should wear fluid-repellent surgical masks but not the full respirator kit. This demonstrates the scale of the uncertainty under which we were making decisions. Many very significant judgements had to be made

based on very little hard data, and scientific advice that was not clear for entirely understandable reasons.

166. I wanted the UK to be first in the world to develop a vaccine. It was a huge ambition and at the time I could not be sure we could pull it off, but I firmly believed that everything should be thrown at it. The Government pledged £20 million for the international research effort. I talked to the team again and emphasised the need to shorten every possible process, for example manufacturing before approval, and shortening approvals as much as possible subject to not lowering safety standards. I supported Professor Van-Tam's recommendation that trials should be done in parallel, not in series, including beginning laboratory trials as soon as possible, then going straight onto Phase 1 clinical trials. Such an approach was unprecedented in the field of vaccine development.

167. In my statement to Parliament on 3 February, I had thought it best to include details of the evacuation plan for the next week. I was about to go into the debating chamber when my team received a call from FCO officials. They had been provided with an advance copy of the speech and were insisting I take out references to the plan. I did not think that it was worth a fight, so I deleted the section concerned and did not think anything more of it until later that evening when I discovered that the FCO had announced exactly the same thing themselves from Beijing. Whilst this might seem like a minor matter, it typifies the problems in ensuring joined-up governance, which is particularly important when trying to respond to a pandemic.

168. I also had a call with the G7 nations on 3 February 2020, for which I received a briefing in advance (MH2/41 - INQ000233749). The briefing highlighted possible areas for discussion including: quarantine, a donor offer from the G7 to China, technical experts to support the WHO and/or China, face masks and PPE and travel advice. The briefing also noted that the Government had that day pledged £20 million to develop new vaccines to combat new diseases and to advance a Covid-19 vaccine into clinical testing as quickly as possible, which we discussed.

169. I met with Jens Spahn, who was over from Germany, on 4 February; Germany was following our lead in giving more money to vaccine research. He asked whether we might do it together to show Germany and the UK cooperating post-Brexit. We also talked about what sort of social restrictions might be needed if the virus took off, although SAGE still had not made any such recommendations.

170. I also met with the PM on 4 February. This was principally to discuss manifesto commitments, but the meeting began with a short update on the coronavirus (MH2/42 - INQ000106093).

171. At this stage, SAGE had still not confirmed asymptomatic transmission. The data suggested that people could be infectious for as long as two weeks after they first had symptoms and that they were sick, on average, for between two and three weeks, although some were suffering for far longer.

172. At PMQs on 5 February there were still no questions about Covid-19. The Department, however, was focused on how to protect those understood at the time to be most vulnerable from the virus. Jenny Harries, the CMO's other deputy, was running the process. First the Department had to define what conditions made a person particularly vulnerable, which was a job for the clinicians, though at that stage the Department still did not know much about the virus and was aware that it would have to adjust its approach as better data was received from abroad.

173. The next step was then to identify everyone who had those conditions. Such a task was not easy because NHS GP data is segregated and held by two private businesses, which could be very tricky to deal with. The Department then needed to check that the data made sense, which meant GPs looking down the lists the system produced. Finally the Department needed to actually make contact with those individuals, but the NHS' data of people's contact details was not good enough. Because the data was inevitably going to be imperfect (for example, some people still had their medical records on paper) the Department then needed to have a system that allowed people to self-declare that they had one of the conditions and get their GP to vet whether they should go onto the list or not. Even two years previously in 2018 such an undertaking would have been completely impossible. Thankfully, NHS Digital had been making big strides, as a result of which the task was at least theoretically possible.

174. I was provided with a briefing on the Pandemic Influenza Emergency Bill (MH2/43 - INQ000049353), setting out how the Bill could be adapted to respond to a coronavirus. Given the length of time it normally takes to frame and draft legislation, it was extremely helpful that the draft Bill had been produced in advance, following Operation Cygnus.

175. I had another meeting on the vaccine with the CMO, Professor Van-Tam, the Permanent Secretary and Lord Bethell, then the Department's Lords Whip, and as such a junior member of the Ministerial team, who I wanted involved in the vaccine mission.

176. At 16:45 on 5 February I chaired a further meeting of COBR, again receiving a brief. The meeting discussed the current situation, options for limiting transmission, planning for a reasonable worst case scenario, communications strategy and next steps (MH2/44 to MH2/49 - INQ000056167; INQ000056148; INQ000056149; INQ000056168; INQ000056215; INQ000056147).

177. I was provided with a submission on 7 February containing the latest information on the current state of research into coronaviruses and the likely costs and timelines of developing a vaccine for large scale testing in an outbreak setting (MH2/50 and MH2/51 - INQ000233751; INQ000233752). I met the team to push further work on vaccine development. We went through everything we needed to do to get things moving as fast as possible. The CMO provided a reality check on how long it might take and the potential dire consequences of not doing everything by the book. Teams at the University of Oxford and Imperial College were already making great progress and I understood that the first trial doses should be available in a matter of weeks. My view was that the Government should get them manufacturing straight away so that if the trials came good, the country could vaccinate as fast as possible. I recognised that the pressure if and when a vaccine was found to work would be immense.

178. Meanwhile Home Office officials were worried that the Government may not have the power to enforce detention, even for seventy-two hours. Departmental lawyers thought that the Government only needed regulations under the Public Health (Control of Disease) Act 1984 ("the 1984 Act"), rather than a whole new Act of Parliament, but Parliamentary counsel were clear that they could not draft anything until there was cross-Government agreement as to approach. With Cabinet Office also involved I called a meeting on the afternoon of 7 February to resolve outstanding issues, and with the help of the Home Secretary the Department was given a green light to draft the regulations. To their credit, Parliamentary counsel spent the weekend writing them. By this point the response to Covid-19 was becoming all-consuming.

179. Over the weekend on Saturday 8 February there were further problems at Arrowe Park, where one of the evacuees was threatening to leave; Jenny Harries dealt with the situation. I was also told that a skier who had returned to Brighton had infected all of the

other Britons he had been holidaying with. Whilst they were still in France, the Department was working with the French authorities to track them down. I thought this clear evidence of the high transmissibility of the disease was an ominous sign.

180. I spent much of the weekend on the phone to officials working on the quarantine regulations. We used a little-known emergency procedure meaning the powers became law the moment I signed them as Secretary of State, and the regulations were then approved by Parliament retrospectively. The new regulations had to be physically signed and so my PPS, Natasha, came round to my house with the various documents on Sunday evening. The regulations became The Health Protection (Coronavirus) Regulations 2020 ("the Coronavirus Regulations").

181. I hoped that the Coronavirus Regulations would remove any ambiguity over the legal basis for quarantine, and with it the problems we had had with Arrowe Park. A second quarantine centre was added at Kents Hill Park hotel in Milton Keynes to accommodate more overseas returnees. In her capacity as Public Health Minister, Jo Churchill visited the centre. It was a good job that she did as I was told that the CMO had been using his personal credit card to pay for the extras to make the lives of the returnees comfortable. This demonstrates the lengths members of the team were willing to go.

182. By Monday 10 February there were eight confirmed positive cases in the country, all contracted overseas, including two GPs. Half were linked to the man in Brighton. I called the PM to tell him that the virus could go either way: China might manage to contain it, but more likely it would not. In respect of the new Coronavirus Regulations, whilst the Department was worried about how they would be received there was no great criticism; I think that it helped that we had explained the detail of them to the Shadow Health Secretary, Jonathan Ashworth, who approached the issue with professionalism and seriousness of purpose – as he did throughout the pandemic.

183. On 11 February the disease was given an official name by the WHO: 'Covid-19', standing for 'coronavirus disease 2019'. By this point, 1,100 people had died in China, out of nearly 45,000 confirmed cases.

184. At this point SAGE had started working on what lockdown options might have the biggest impact, if needed. The options were set out on an A3 sheet of paper prepared by Cabinet Office officials for ministers to consider; it was dry scientific analysis, but shocking nonetheless. SAGE considered that it would not, at that stage, be effective to

stop large public gatherings because those events, for example large sports matches, are one-off occurrences that will only ever comprise a small proportion of contacts people have with others. Rather, people gather more closely and frequently in pubs and restaurants, and religious services and family gatherings presented the biggest risk of all, as they involve much closer contacts than anything in public, and often involve older people. We also considered schools and whether the Government might have to shut them too. Since the disease barely seemed to affect children, it was hard to see how that would benefit them directly, but if children were found to pass it on we considered that we might have to. Another measure we considered was household isolation: the idea that if one family member got Covid-19, the whole household has to isolate. Nothing like that had ever happened in the UK before.

185. Unhelpfully, No. 10 had been briefing far too definitively that there would not be any flight bans. I thought that this was a big mistake because the reality was that the Government may have to take measures at the border.

186. On 11 February I briefed Cabinet on the extent of the virus, including the UK cases, and the CMO's advice that there was a 50:50 chance of the virus coming to the UK. I asked each Department to ensure adequate focus on preparations. Cabinet took note, and the decision was taken in principle to go ahead with the emergency Coronavirus Bill as a piece of Health Department legislation. On 12 February I was provided with a submission setting out possible additional measures to include in the Coronavirus Bill following the meeting that I had had with officials on 7 February (MH2/52 - **INQ000049364**

187. On 12 February we held an exercise in COBR to rehearse what the Government would do if the virus ran out of control. The Civil Service is good at putting such exercises together, and if everyone plays their part, they can be very useful. There was, however, a flaw with this exercise: there was a reshuffle scheduled for 13 February and most Government Departments had sent junior ministers, many of whom were about to be moved. Nevertheless, there were about thirty of us seated in two rows around the big COBR table: we were presented with scenarios that unfolded as the exercise progressed. We role-played how we would do our jobs in two months' time if the very worst-case scenario happened and there were hundreds of thousands of people dying. We were asked to imagine that the Government was reacting to the calamity. We considered questions like: where in Hyde Park would the burial pits be? Who would dig them? Have we got enough body bags? I recall thinking that there was no way that the

Government could let the country get into a position where half a million body bags were needed.

188. Perhaps the worst part of the exercise was agreeing a protocol to instruct doctors which lives to save. In the exercise, the NHS had become overwhelmed, so there were not enough doctors to treat all patients. We were asked to consider questions including: do we treat the young, because they have more years to live, or the old, because they are more vulnerable? Are all lives saved equal, or is each year of expected life equal? These were horrific decisions, presented in such a bald, matter-of-fact way.

189. Going through these questions, and the administrative requirements for handling death on such a scale was frightening. I could tell from the looks on colleagues' faces that the gravity of the situation had hit everyone and I resolved that I never wanted to have to make these decisions for real: the Government must ensure the NHS was not overwhelmed and ensure this did not happen. Of course, at a policy level the NHS already takes the view that drugs are cost effective if they cost less than £30,000 per year of quality life saved, but asking doctors to choose between who to treat and who to leave is a dreadful scenario. I reflect now that this exercise was instrumental in focussing my mind on the absolutely critical requirement to stop the spread of the virus, not just manage its impact. One of the successes of policy during the pandemic was that the NHS was never overwhelmed.

190. On 13 February the CMO presented the Government's position on Covid-19 on the Today programme. The Prime Minister's Chief Adviser was still banning ministers from appearing on it; it struck me that now the country was in a crisis, this approach was beyond ridiculous. The Government needed to be able to clearly communicate to the public about the virus. A benefit of the CMO's statutory independence was that the Prime Minister's Chief Adviser could not stop him from communicating however he chose, so he was able to explain the Government's focus on containment and isolation while numbers remained low, although he made clear that the preparations for the next phase were underway.

191. On 13 February SAGE came to the view that China had failed to contain Covid-19. However, they recommended against shutting things down here, and advised that travel restrictions within the UK would not help unless they were draconian and fully adhered to, while school closures would have to last weeks to do any good. Instead, in line with

the long established pandemic preparedness plans, SAGE backed campaigns to encourage people to behave responsibly.

192. On Saturday 15 February I heard that Wuhan had been put into what the Chinese called 'wartime controls', with the authorities going house to house taking sick people off to quarantine centres.

193. I also received a submission on 15 February regarding the potential extraction from British nationals from the Diamond Princess cruise ship (MH2/53 - INQ000049380). The submission provided me with an update on the situation and invited me to recommend to the Foreign Secretary that the Foreign Office put pressure on the Japanese authorities, where the Diamond Princess was then moored in Yokohama Harbour, to provide appropriate on-shore isolation facilities for British nationals on board. The submission suggested that should that pressure not prove successful, then the Government should consider extraction, but noted that there were problems with such an approach.

194. On Tuesday the next week, PHE told me that the country's current approach of tracing all contacts of anyone who was infected was unsustainable. I was advised by PHE that they could only cope with five new cases a week, which would on average mean 800 contacts. I was told that this could be increased to fifty cases, but it was clear to me that if we were to keep using the PHE tracing method it would be completely hopeless once numbers started multiplying. I found this infuriating since only a few weeks ago PHE had told me they had the best system in the world. I asked for advice on how we could scale up, but I wished PHE had told me weeks ago.

195. There was at least better progress on other scientific fronts. Professor Van-Tam told me that of the nine confirmed UK cases, the genome of seven had been sequenced. That meant that we had the genetic data to understand exactly what the virus was made of, which helped with testing, treatments and of course vaccine development. Various antiretrovirals, including Lopinavir and Ritonavir, were being trialled to see whether they could be useful. Patients in China were being given an antimalarial drug called hydroxychloroquine, but there were no trial results of its effectiveness to justify its use. Professor Van-Tam and Professor Peter Horby at the University of Oxford were putting together a clinical trial called RECOVERY to test treatments for Covid-19 in hospitalised patients. My role as Health Secretary in these trials was to ensure that they were funded and to protect them from pressure to call the results before they were clinically valid.

Professor Van-Tam was very excited about and proud of how fast RECOVERY had been put together.

196. On 18 February I chaired a further COBR meeting, for which I received a briefing in advance (MH2/54 - INQ000049389). The briefing provided a general situation update, as well as specific updates on the Diamond Princess and the international response. The briefing also covered the proposed draft legislation, planning for a reasonable worst case scenario and lessons learned from the previous ministerial exercise and communications strategy. In respect of the reasonable worst case scenario, and reflecting the little that was known about the virus at this point, I was informed by the briefing that:

> *"20. SAGE advises that the reasonable worst-case scenario for pandemic flu continues to be an appropriate planning scenario.*
>
> *21. SAGE are regularly reviewing emerging evidence about the coronavirus epidemic and will advise if and when the RWCS should change as more information about the virus and the outbreak becomes available.*
>
> *22. During the first phase of the epidemic with a small number of cases it is possible to do contact tracing. When there is sustained transmission within the UK contact tracing will be no longer feasible or useful. At this stage it is likely the NHS and Social care systems will be able to cope with strain. However as transmission becomes much more widespread the systems will come under increasing strain and actions like re-prioritisation of services will need to take place."*

197. The meeting considered the current situation, legislation, planning for a reasonable worst-case scenario, lessons from the ministerial exercise, communications strategy and next steps (MH2/55 to MH2/58 - INQ000056170; INQ000056150; INQ000056171; INQ000056227).

198. At this stage I was still having to spend far too much time on cruise ships. Whilst on 19 February the first 400 or so passengers of the Diamond Princess were finally released I was asked in a submission on 18 February to consider whether to quarantine individuals returning from it in accordance with the Coronavirus Regulations (MH2/59 - INQ000049387). Whilst this work was ongoing, so too was work to protect the most

vulnerable, now formally called 'shielding', which was proceeding at pace led by Jenny Harries.

199. I had a call from Owen Paterson that evening asking about Randox. He indicated that apparently PHE were refusing to engage. I got straight on the phone to PHE again to find out what was going on; it turned out that Randox had not been sent what they needed, despite me instructing them to do so three weeks ago. This left me furious and caused me to question my confidence in PHE's ability to act at the urgency and scale required.

200. On Wednesday 19 February there were discussions about what would be in the battle plan: was the Government really going to tell people we might shut schools or whole cities? My view was that we might have to do this. We had to prepare people and my view was that for something as big as this it would be better to have a formal Government document than briefings to the media. Evidence from China and Hong Kong the next day suggested that social distancing measures were slowing the outbreak there.

201. At the end of the week on 21 February, South Korea reported its first death and it cracked down hard. They closed primary schools and community centres, sealed off nursing homes and banned rallies in Seoul.

202. Media reports of hospitals in Lombardy, Italy were extremely worrying. The fact that the health system was overwhelmed in a major European country was of enormous concern. The Italian Government took dramatic action, quarantining 50,000 people in eleven municipalities, called Red Zones. Schools were shut, sports and cultural events cancelled. Anyone breaching the rules could be fined €206 or get up to three months in prison. This, in another European country, shocked me, and also showed what might be needed in the UK.

203. By this stage, there was enough data from around the world for our experts to modify the worst-case scenario assumptions we had based on influenza. Professor Neil Ferguson from Imperial College gave an update on the four specific questions that the Government had asked him to look at:

1. What proportion of the population could be infected with coronavirus?
2. What proportion of those will develop symptoms?
3. What proportion of the symptomatic will need hospital care?
4. And how many will need respiratory support?

204. His preliminary assumption was that 80 per cent of the population would get infected. Of those, 50 per cent would get sick, and, of those, 4 per cent would go to hospital for an average of six to ten days. He thought that a quarter of hospital patients could need ventilators, which would create a massive supply issue. NHS hospitals were not generally full of ventilators; normally only a small minority of patients have serious breathing problems. Professor Ferguson's estimated death rate was very tentative but could be around 2.5 per cent. All of his predictions were on the assumption that the Government did not take any mitigation measures and that there were no treatments or vaccines, but the numbers still looked horrible. No matter how fast we accelerated the development of a vaccine, there was no hope that it would be ready in time. At this stage all of the data seemed to be pointing to the worst-case scenario.

205. By 22 February thirty UK and two Irish citizens from the Diamond Princess had arrived at the Boscombe Down Ministry of Defence base in Wiltshire where they were then bussed straight to Arrowe Park. The Government had now quarantined a total of 273 people from four flights. After the initial problems, the system was working well. Four of the passengers tested positive, and I felt vindicated about going hard on quarantine. If the Government had simply let them disperse after bringing them back to the UK there was no guarantee that they would have stayed at home and the country might have had multiple instances of community transmission.

206. On Sunday 23 February I took a call from Jens Spahn about Italy. We discussed the potential need for Germany and the UK to take the same sort of extraordinary measures the Italian Government had taken.

207. At this point, without consulting the Department, the Prime Minister's Chief Adviser organised a daily 8 a.m. meeting in No. 10 for SpAds and officials. Frustratingly, he refused to invite Ministers, and timed the meeting so that it clashed with my morning meeting and involved many of the same people. He made it very clear that he expected his morning meeting to be the decision-making meeting, and set out to those present that many decisions did not need to be referred to the Prime Minister, who held a further meeting, to which I was usually invited, at 9:15am. This created immediate practical problems; I did not want to insist on my team getting into the office an hour earlier so we could hold our meeting ahead of his, and I also did not want everyone to have to repeat meetings when they were so busy, but it was critical that sensible people were at the Prime Minister's Chief Adviser's meeting, as his decision making was known to be erratic.

208. From this moment, protecting the Department from irrational requests, demands, and decisions from No10 became a significant part of my job. Motivating the team became harder because of the way in which the Prime Minister's Chief Adviser operated. My view was and is that large teams are better motivated by a positive and collaborative approach. From all my experience I knew this was even more important in times of crisis.

209. On 24 February I was provided with a submission regarding the Emergency Coronavirus Bill and possible additional Departmental measures to be included (MH2/60 - INQ000234329). Annex A to the submission set out measures that I had previously discussed and approved with officials at the meeting on 7 February, whilst Annex B contained those additional proposed measures, including temporary mandatory vaccination to prevent staff absences over the winter period and quarantine powers to reduce the risk of spreading the virus. The submission provided policy guidance on each of the suggested additional measures.

210. I also spoke to the Canadian Minister for Health, Patti Hajdu, on 24 February after she requested a call. I was provided with a briefing in advance, which outlined that it was expected that we would discuss Covid-19 and material transfer agreements (MH2/61 - INQ000049430).

211. Following the call with Minister Hajdu, I spoke with my counterpart in the US, Alex Azar. Again, I was provided with a briefing in advance, including about matters to do with the Diamond Princess (MH2/62 - INQ000049432). A readout of the call was subsequently circulated (MH2/63 - INQ000049462).

212. On 25 February an issue in Tenerife was drawn to my attention where hundreds of British tourists were stuck in a hotel that had gone into quarantine. By this point I was clear that the Government needed to stop these repatriations: my view was that the state should not become the travel agent of last resort.

213. On 26 February I was provided with a submission on whether more time could be found to allow for further Parliamentary scrutiny on the draft Coronavirus Bill (MH2/64 - INQ000049446). The submission noted that:

> *"We have consulted policy and legal officials and Parliamentary Council* [sic.] *to understand the implications of introducing the Bill in the previous week.*

*There is a significant quantity of work required ahead of introducing the Bill, relying on a wide range of stakeholders across the four nations. Introducing the Bill significantly earlier than planned risks undermining these work streams which could risk the Bill at both the drafting and parliamentary stages."*

214. At 15:00 I chaired a further COBR meeting with four items on the agenda: current situation, public order, communications and next steps (MH2/65 to MH2/71 - INQ000056173; INQ000056172; INQ000056152; INQ000056151; INQ000056174; INQ000056216; INQ000056201). At the meeting the Home Office presented a paper on behavioural insights that noted that people were more likely to be altruistic if an outbreak was widespread, but that this situation could change if individuals deliberately provoked tensions and/or if closures and long hospital waits led to perceived unfairness.

215. On 27 February I met with No. 10 SpAds to discuss the coronavirus and particularly preparedness of domestic response, supply and communications. A read out of the meeting was subsequently circulated (MH2/72 - INQ000049457). After that meeting I met with the Sir Chris Wormald to discuss governance structures for the response to the coronavirus. The note of that discussion (MH2/73 - INQ000049458) records that:

*"SofS outlined that he will be leading the response to Coronavirus as SofS of the Health and Social Care system and will also be leading the coordination across Government to support* [other Government Department] *ministers to consider the impacts on their services (for instance schools, businesses). SofS decided as chair that he would like to step COBR up to twice a week.*

*The Governance structure is as follows:*

- *Twice weekly COBR – M meetings, chaired by SofS;*
- *Twice/three weekly COBR – O meetings;*
- *A designated Junior Minister from every Department that works on Coronavirus;*
- *All DHSC junior ministers to have a role to play on Coronavirus;*
- *Daily meetings with the health system (PHE, DHSC, NHSE officials);*
- *Daily conversations with the CMO;*
- *Some PM oversight, he's open to discussion but perhaps a weekly call with the PM could be useful;*

- *A weekly press briefing that will be led by SofS and CMO (joined by lead officials depending on situation)."*

216. I spoke to the then Secretary of State for Transport, Grant Shapps, who supported my position on the evacuation (or lack thereof) from Tenerife. The FCO similarly agreed and the Government announced that there would be no more rescue flights. This position was reflected in a submission I received on 26 February (MH2/74 - INQ000049447), which I signed off to formalise the decision.

217. In my red box that evening there was a copy of the draft battleplan I had commissioned. It set out that we might have to lock down, close schools and have everyone in a household with a case isolate at home. It was an extraordinary document, but it was necessary for getting people ready for what might have to happen. The drafting of this document was an example of the civil service at its best and in supplying comments and feedback, I commended my team for the quality of their work. (MH2/75 and MH2/76 - INQ000233753 | INQ000233754). I reviewed the plan and my comments, indicating that broadly I thought it was in a very good place, were communicated the next day (MH2/77 - INQ000049465).

218. In terms of the Government machine, I suspected that the hardest part may be dealing with the devolved Governments. I recall thinking that it was madness that the devolved Governments would be taking their own lead on domestic public health policy; that kind of devolution is all very well for running the NHS and fighting obesity, but not for responding to a pandemic. Unfortunately, there was not much I could do about it: the devolved Governments had these powers, as set out in the 1984 Act.

219. When originally enacted, the decision takers would have been the Secretaries of State for Scotland, Wales and Northern Ireland, all sitting in the same Cabinet. Those who framed the 1984 Act could not have foreseen how health policy would be devolved, but it was nonetheless frustrating. After much negotiation, my team managed to get the devolved Governments to back the joint action plan, providing the Department put the emblems of Scotland, Wales and Northern Ireland on the front of the document. I respect the fact that health services are devolved, but a pandemic does not respect boundaries no matter how historic.

220. In the plan we set out scenarios ranging from mild pandemic to severe prolonged pandemic as experienced in 1918. Measures as set out in the plan would need to be

mixed and matched depending on the course the virus took. At the peak, the predictions were that a fifth of the workforce could be off sick, which would have many knock-on effects. The plan said that life should continue as normally as possible, though of course it was impossible to say at this stage how normal that would be. It also set out some of the stark new powers to allow *"medical professionals, public health professionals and the police to… detain and direct individuals in quarantined areas at risk or suspected of having the virus"*. The plan also identified what the country needed to do to protect the NHS, including getting retired medical professionals back into service and making sure that people who did not need to be in hospital could leave. Penny Mordaunt, then Cabinet Office Minister responsible for policy on handling deaths, decided to include the precautions from the theoretical exercise that had taken place two weeks previously: namely that councils needed to review their capacity in morgues and crematoriums to deal with a possible increase in bodies. It was difficult to get No. 10 to agree to publish the document.

221. I felt the document was very important to publish to prepare the public for what might have to happen.

222. On 28 February I received the sad news of the first British death from Covid-19: a man who had been on the Diamond Princess. He died in Japan, but I felt it was a wake-up call for the UK as a whole. The Department also confirmed the first case of the virus passed on inside the UK: the patient was a man from Surrey who had not been abroad at all in the recent past. While I was getting more and more worried, No. 10 were still trying to stop the PM from saying anything publicly about the virus. The Downing Street machine had been pushing back all week on him chairing a COBR meeting, so, seeing no other option, I decided to short-circuit them and called him directly. I felt like the country really needed Prime Ministerial authority now. I recall telling the PM that he had to show that he was engaged on this and that he had to chair a COBR meeting and overturn the ban on appearing on the Today programme. A few minutes later, I recall receiving a call from No. 10 asking me to return to London immediately for a formal meeting.

223. I pushed for an immediate COBR to agree the action plan, but once again I was rebuffed – this time I was told that the Cabinet Office needed to give the secretariat time to get the correct papers ready. This was unfortunate. Had the COBR system been running the response up to this point, they would have been prepared. I did succeed in persuading the PM to give a short interview at No. 10 that evening to underline that the

virus was the Government's top priority. A brief readout of the meeting was subsequently circulated (MH2/78 - INQ000233755).

224. On 29 February I received a message from Oliver Letwin saying he thought that we needed to close the borders: all air and seaports. I asked the CMO, who knew Oliver from his time responding to Ebola, to call him to explain why the advice was still against closing the borders. I received a submission of the same date dealing further with the issue of 'medevac'; the submission invited me to approve a general approach of no evacuation due to infection with Covid-19 and no further repatriation flights (MH2/79 - INQ000049469).

225. There were three more confirmed cases in the UK, taking the total to twenty-three. Two had travelled back from Italy recently and the third from Asia. So far a total of 10,483 tests had been administered, but PHE's capacity was still growing far too slowly. Later that evening I received a message from the CMO warning me that there had been a series of new cases, including a British doctor who had caught Covid-19 while overseas. His colleagues had all been taken off duty and luckily he had not been seeing patients.

226. In advance of a PM chaired COBR meeting scheduled for 09:00 on 2 March, a paper on the Coronavirus Bill and its provisions was circulated (MH2/80 to MH2/82 INQ000106140; INQ000106141; INQ000052276. I raised a concern as to the time limit proposed to be placed on the Bill of six months, which I did not consider to be long enough; I asked officials to revise the duration of the Bill to be two years (MH2/83 - INQ000109109).

227. On 2 March, prior to the PM chaired COBR meeting, I met with officials working on the response to Covid-19. We discussed various matters and I thanked them for the tremendous amount of work they had done over the last two months, including at weekends (MH2/84 - INQ000049485). I then went to COBR at 09:00. The main room and side rooms were packed with ministers, officials and SpAds. The key business was signing off the action plan, which the civil service had turned round in record time. I spent the afternoon speaking to media editors to pre-brief them in confidence and also spoke to various social media companies. Everyone I spoke to was very reasonable and seemed to appreciate that they had a part to play in responding to the crisis (MH2/85 - INQ000049493).

228. Later in the day I had another call with Tedros Ghebreyesus. We discussed how the UK might be able to help the WHO. I urged him to declare a global pandemic, which would have been a major step up from a PHEIC, but he demurred. He indicated that he thought containment was working in China and that the whole situation might still be OK. I was surprised as I thought this was wholly unrealistic, and wondered whether this complacent attitude was due to pressure from the Chinese. Meanwhile Sir Patrick Vallance estimated that there was a roughly one in five chance of the reasonable worst-case scenario happening in the UK. Even though he did not have the data to give more than an impression, I still thought that was high.

229. I was briefed that SAGE had updated the reasonable worst-case scenario with the latest international data and reduced the maximum number of deaths from 820,000 to a still horrific 520,000 out of 53.5 million people showing symptoms. Around 390,000 of those might be in critical care with such bad breathing problems that they need ventilators. The numbers were huge and it was clear to me that there was no way the NHS would cope; it was difficult enough getting a number of how many beds the NHS had available, but on any estimate it was an order of magnitude less than 390,000.

230. I also received word that Care Minister Helen Whately was worried about preparations in care homes. She messaged me during the afternoon to say that there was a growing nervousness about the capacity of the system to cope. She had only been provided with two existing pandemic contingency plans in the sector: Hertfordshire and Essex, and her opinion was that those were inadequate. The Essex document apparently stated that providers were required by the Care Quality Commission to have plans in place to provide safe care in the event of a pandemic and that during a flu pandemic, directors of adult social services would need to know the effectiveness of providers' plans, emerging risks and capacity to meet demand. The plans were subsequently shared with my Private Secretary on 4 March (MH2/86 to MH2/88 - INQ000233756, INQ000233757, INQ000233758).

231. Late that evening, Sir Simon Stevens circulated a worrying confidential alert saying that one of the twenty-two new cases identified was a man at Withington Community Hospital who was already seriously ill in the ICU with cancer and diabetes. The patient was in a critical condition and needed to be moved to another hospital because the unit had to be decontaminated. As many as thirty-six doctors and nurses who had been looking after him had been sent home to self-isolate. There was a similar problem with an elderly lady at King's College Hospital in south London. She needed to be transferred elsewhere but might not survive the journey. I saw this as just a foretaste of the crises

hospitals would soon face on a daily basis and was reminded that staff (un)availability was going to be at least as big a problem as beds.

232. In a disturbing sign of the kind of pandemic protectionism I thought we might be about to see more of, India then banned the export of certain key ingredients for painkillers. Steve Oldfield, who was in charge of NHS supplies, had been doing an industry ring-round to check what stocks the country had. He had been brought in to prepare for Brexit, and thanks to his work the Department had both a stockpile of medicines as well as an exceptionally good understanding of what medicines we had in the country and what the supply chains looked like. He confirmed that there was no immediate issue, identifying around 500 million paracetamol in the country's stocks, but that the Department would need to keep a very close eye on matters.

*The First Covid-19 Death in the UK*

233. On 4 March, NHS England declared Covid-19 their highest grade of emergency, a Level 4 alert. This meant that Sir Simon Stevens took command of all health service resources in England. Sir Simon discussed this decision with me in advance and I was happy with it. Guidance for hospitals told them to assume they would need to look after Covid-19 cases in due course. In addition, a rule was introduced that everyone in intensive care with a respiratory infection must be tested for Covid-19. It was understood that there would be too many patients to treat on specialist Covid-19 units, so the Department had said that people could be cared for in wider infectious disease wards.

234. At this point SAGE had advised that we were around 4 weeks behind Italy on the epidemic curve. Italy indicated that they would close all schools and universities, while Germany declared an epidemic and shifted from containment to mitigation.

235. I had further meetings with the PM and officials to discuss the way forward and the latest data from SAGE; I had been clear the day before that we needed to dramatically increase testing capacity and protect vulnerable people, which we discussed (MH2/89 to MH2/93 - INQ000049512; INQ000049513; **INQ000087584** **INQ000087585** INQ000049516).

236. At 17:00 I chaired a further COBR meeting for which I received a brief. Item 3 on the agenda was non-pharmaceutical interventions and the director of GO Science gave an update on the proposals. The minutes note that the biggest variable (in determining what

non-pharmaceutical interventions would be effective) noted by behavioural scientists was public compliance with the interventions. At this stage, based on work by SPI-B, it was still thought that the public might not comply with draconian measures. I made the point at the meeting that the UK should take a Four Nations approach and stick to the science (MH2/94 to MH2/97 - INQ000056202; INQ000056225; INQ000056158; INQ000056218).

237. Additionally on 4 March the Department's officials prepared a response from me to a letter dated 2 March from the leaders of the House of Commons and the House of Lords concerning the passage of the Coronavirus Bill through Parliament. The letter asked for, *"…an assurance that there has been robust testing of each measure to ensure that there are no alternative existing powers available to the Government."* (MH2/98 to MH2/100 INQ000049506; INQ000049502; INQ000049508). The response indicated that:

> *"…when coordinating the measures to be included in this legislation from the Department and other Government Departments, we outlined strict guidance as to the high-threshold that emergency legislation necessitates. Included in this were questions to officials on rationale for intervention, timing and urgency and whether other policy options had been considered."*

238. On Thursday 5 March the UK recorded its first deaths from Covid-19. This was obviously a significant and worrying moment. The Department had a carefully set out protocol in place, managed by lead crisis official Emma Reed, for how to handle such sensitive news. The death was that of a woman in her seventies who had been in and out of hospital with various conditions. She had tested positive for the virus, although it was not yet known whether it was the direct cause of her death. Later in the day a man in his eighties who had recently returned from a cruise sadly died in Milton Keynes after testing positive for the virus; again, it was not known what role the virus had played in his death.

239. Following my 09:00 meeting with officials and subsequent call with the PM (MH2/101 - INQ000049525), at a hearing in the House of Commons, the CMO indicated that the country may soon need to move from 'contain' to 'delay', banning large events, closing schools and working from home. SAGE advised the Government to plan for that in one to two weeks. It is perhaps useful here to record here that I did not, as Health Secretary, attend SAGE, but the CMO, who co-chaired the meetings with Sir Patrick Vallance, gave me a run-through of the key points so I did not have to wait for the official minute. What

I valued most from the CMO was his unedited advice on what the very best scientific evidence was.

240. I had further communication from Helen Whately to say that the PPE supply to care homes was inadequate. I told her that the Department had to get PPE to wherever it was needed, not just hospitals. The challenge was logistics; NHS Supply Chain, the company that delivered PPE to hospitals, had never seen so much demand and were really struggling.

241. I also spoke to Alex Azar again; during the call we discussed the move from 'contain' to 'delay' and the approach in the US (MH2/102 - INQ000109112).

242. Among the myriad decisions, I was provided with a submission dated 5 March detailing the recommended changes to provisions in the Coronavirus Regulations when transferred to the proposed Coronavirus Bill. The submission set out two key policy questions for my consideration: not including a provision for the Secretary of State or a registered public health consultant to apply to a Justice of the Peace for a Part 2A order under the provisions of the Bill and not introducing a maximum time limit on the period for which an individual could be isolated (MH2/103 - INQ000049523).

243. Alok Sharma, the Business Secretary, found another £4 million from our various science budgets for research to accelerate vaccines and rapid tests. Our technical team had started talking to Sir Patrick Vallance, David Halpern and PHE about a phone app to help people avoid coming into contact with anyone carrying the virus. It was apparent that other countries would be looking into this too.

244. At this point the PM signed off David Williams' promotion to Second Permanent Secretary of the Department. I strongly supported this proposal from Chris Wormald. It had taken several weeks to get the sign off from the Prime Minister, so with the help of private office in No10 I personally oversaw the Prime Minister's approval by raising it at the end of a meeting on the coronavirus response. This appointment was helpful in ensuring that the Department could continue to deliver on other priorities, such as the Government's manifesto commitments, and gave David additional authority and responsibility as the Department's responsibilities expanded.

245. I was also provided with a submission detailing the acute capacity in the independent sector, as well as how that capacity was assessed by the NHS (MH2/104 -

INQ000109119). At a meeting with officials we discussed the challenges posed by Covid-19 to social care (MH2/105 to MH2/107 - INQ000233759; INQ000233760 INQ000049530).

246. By 7 March it was clear that there was a crisis looming with ventilators. It was apparent that the country had nowhere near enough. Whilst it would have been great to boost domestic manufacture these were not easy machines to manufacture and they also needed to be operated by trained staff, otherwise they can do more harm than good. I was conscious that if the worst came to the worst, the Department might need to put out advice on how to care for a critically ill relative at home, which would no doubt be a terrible prospect for most people.

247. I had a constructive discussion with Jeane Freeman, the then Scottish Health Minister. Coordinating the Government's response with the devolved administrations was going to be critical, and we agreed that I should go to Scotland soon to discuss matters in person. There was no formal mechanism for co-operation across the four nations among Health Ministers. Co-ordination existed at CMO level, and also at First Minister level, but I felt the lack of health minister co-ordination was a missing piece of institutional infrastructure. Given the devolved nature of health policy, but the cross-border impact of the pandemic, this was clearly critical, so as UK Health Secretary, I took the lead in discussing this with my counterparts in the Devolved Governments, leading to the weekly calls which took place throughout the rest of the pandemic.

248. At a Downing Street press conference on 9 March, the CMO warned that within the next ten to fourteen days the Government would advise anyone who has even mild symptoms of Covid-19 to self-isolate for a week. At this point, the number of cases was still so low that it was very unlikely a cough equalled Covid-19, but I was aware that it would not be long before that changed. The advice to us as Ministers remained that it would be an error to bring in lockdown measures too quickly.

249. In my box that evening was a scientific briefing containing a dire warning about how bad hospital bed shortages could get. It starkly suggested the NHS could have a deficit of 150,000 beds and 9,000 ICU spaces.

250. Health Secretaries are usually tightly constrained to health matters, but the pandemic was starting to drag me into all sorts of unexpected fields of Government. For example the Government was being criticised for allowing outdoor events to go ahead whilst gatherings of 1,000 people or more had been banned in seven German states, and there

were variations across Europe. In Ireland, they had cancelled parades for St Patrick's Day for the next week. Scotland was considering banning large gatherings, which would have undermined the UK-wide approach the Government was trying to follow. At its 10 March meeting SAGE was not in favour of banning large events, suggesting that they posed a relatively low risk to the public, but they agreed to review the matter (MH2/108 - **INQ000109125**). The central scientific argument was that large events were not actually where most infections are passed on, and if the country locked down too early it may not be sustainable as people may not put up with restrictions for long.

251. When it came to older people, the science was at least unambiguous and the Department was now advising anyone over seventy to be extremely careful. The SAGE minutes for 10 March record that social distancing measures should apply to those 70+.

252. I was briefed by the CMO on the readout of the SAGE meeting. SAGE estimated that the UK probably had 5,000–10,000 cases, up to twenty times the recorded figure. I was advised that the UK was four-five weeks behind Italy on the epidemiological curve. Transmission was thought to be well under way in both hospitals and beyond. Analysing samples was a research priority, and there was frustration at the speed with which PHE were carrying out this work. I asked Duncan Selbie, the Chief Executive, to produce plans for how he would get testing up from 1,000 tests a week to 10,000.

253. Panic buying was starting to spread to pharmacies at this point. A friend told me that the Boots she was in was almost out of paracetamol with shoppers grabbing items. I considered that retailers needed to get a grip before we run short of basic items. Italy locked down the entire country.

254. In terms of meetings on 10 March, I attended a morning meeting with the PM (MH2/109 - INQ000049577), the usual meeting with officials (MH2/110 - INQ000049570) as well as speaking to my counterparts in Wales, Scotland and the Republic of Ireland (MH2/111 to MH2/113 - **INQ000049568**; INQ000049567; INQ000049573). At the PM meeting we decided that I would chair a COBR meeting on 11 March, solely with the purpose of getting sign off for the Coronavirus Bill.

255. On 11 March I chaired the COBR meeting, for which I had been sent a submission dated 10 March regarding the introduction of an 'Emergency Coronavirus Bill' (MH2/114 to MH2/116 - INQ000049578; **INQ000106177** **INQ000106178**, as planned. The submission set out the final proposed clauses to be included in the Bill. Agreement in

respect of the Bill was reached. I produce an example of how I used to work by annotating submissions (MH2/117 - INQ000049602), in this case the submission on the Bill, which in this case was shared directly by my Private Office in the interests of time (MH2/118 - INQ000049601).

256. On 11 March the Chancellor set out his first Budget. Unlike other Departments, the Treasury do not need to agree policy across Government – they merely need to agree with No. 10. The Chancellor set aside £12 billion for fighting the virus, and made clear there was more to come. Crucially from my point of view, he promised the NHS would get whatever resources it needed to get us through the crisis.

257. At 15:00 I had a call with other European Health Ministers, chaired by Jens Spahn, for which I received a briefing in advance (MH2/119 - INQ000109128).

258. Tedros Ghebreyesus then finally declared Covid-19 a global pandemic. At 7 p.m. I updated the House of Commons with the Government's response to the WHO announcement. I was able to confirm that Parliament would be kept open, with modifications to the way we worked to make it as safe as possible. The Speaker agreed that it was vital that democracy kept functioning. I asked the CMO to phone him to advise on risks and precautions.

259. After my statement I went to No. 10 to see the PM. On my way into his office I passed the Prime Minister's Chief Adviser, who was sitting at his desk a couple of yards from the door to the PM's outer office. I recall that he looked ashen-faced and he asked if I had seen the latest modelling. I indicated that I had and that it matched the data coming from hospitals on the ground. He finally seemed to be seeing what the country was facing. The PM indicated that he would hold a press conference on 12 March, i.e., the next day.

260. At 08:15 on 12 March I met the Shadow Health Secretary and Shami Chakrabati, the Labour health spokesperson in the Lords, to take them through the Coronavirus Bill (MH2/120 - INQ000233764). I wanted to ensure they knew what was in the Bill, and had the opportunity to raise any concerns in private in advance. Given Baroness Chakrabati's career as a civil liberties campaigner, I was concerned that she may find it difficult to agree to the Bill, with the very significant curbs on civil liberties. However, she in fact pushed for more powers, and more draconian measures. I took on board as many of their points as I was empowered to do without unravelling the agreement that was being reached across Government.

261. Also on 12 March I received a message from David Cameron (MH2/121 - INQ000233763), saying that I needed to explain in more detail why the Government was not already introducing restrictions that we said we might need soon. I told him that it was down to clinical advice, namely that the Government should not go too soon for fear that people would only put up with measures for so long, and the fact that what we would have to do would be so huge. I did my best to get this message across on the Sunday media round, using my slots on *Sophy Ridge* and *Andrew Marr* to talk about the action plan the Government was about to release, elements of which had been pre-briefed to the media.

*Increased Government Intervention in Response to the Increasing Spread of Covid-19*

262. Early on 12 March the CMO called me to say that the country needed to raise the risk level from moderate to high. He also indicated that he thought the Government should move from the 'contain' phase to 'delay'. I understood that he had come to these conclusions after discussions with his Scottish, Welsh and Northern Irish counterparts and they were all in agreement. The plan was to announce it at a press conference. The CMO was very straight with me and my team about what this meant: he explained that everyone was going to get infected and that the question was whether that happened before or after the vaccine had been developed. The decision to move to the delay phase was recorded in a protocol document (MH2/123 - INQ000049539) and announced by the PM at the press conference that evening.

263. At the same time I was advised by PHE that they should stop all contact tracing. They advised that the growth in tests and contact tracers could never rise exponentially and that there was then so much spread that contact tracing would not be worth the effort. Their estimates of how many people would be needed to do the job were all based on carrying on exactly as before, which I found infuriating, as it was clear that a large-scale contact tracing operation would have to operate differently, in a mechanised way.

264. After the press conference we had a debrief in the PM's study next to the Cabinet Room. We talked about the likely need for as many as 300,000 ventilators; and decided to launch a national ventilator challenge.

265. On the way back from Downing Street I called Sir Simon Stevens to discuss NHS capacity. He had previously explained that the pandemic was likely to hit the NHS

workforce very hard, meaning that there would not be enough staff to expand the number of beds, and that therefore there was no point in trying to scale up. I had been sceptical of this argument and decided to overrule it; staff ratios would have to be stretched to ensure everyone could access treatment. Whilst of course I accepted that that might bring problems, I considered it to be far better than the alternative of turning sick people away from hospital. Simon agreed and said he would come back to me as soon as possible with a plan.

266. Over the next twenty-four hours, from the evening of 12 to evening of 13 March, I visited Edinburgh, Belfast and Cardiff to build relationships with the three devolved Health Ministers and establish as effective co-ordinated working as possible.

267. On the afternoon of the 13 March I joined the G7 Ministers call, which was very alarming. Counterparts in other countries were extremely worried, and several, including Roberto Speranza in Italy, detailed the very extensive actions they had taken to slow the spread. Later the CMO talked me through SAGE's latest discussions, which significantly strengthened the case for immediate action. The committee thought that there were far more cases in the UK than previously believed, that we were now just two weeks behind Italy on the epidemiological curve, and that household isolation and shielding of the elderly should come in sooner rather than later, even though there were trade-offs including the effect on peoples' mental health. SAGE now thought that far heavier measures may be needed to make sure case numbers stay within NHS capacity and they were examining options. I spoke to the Prime Minister and reinforced my view that we needed to lock down immediately.

268. I found it extraordinary how detailed the advice on practicalities became. The scientists reckoned that a safe distance for people to stay away from each another would be two metres, which I understood to be well beyond the maximum range droplets can travel in a normal conversation. There was still no evidence that avoiding handshakes removes the risk of infection, but SAGE now acknowledged that it was a minor sacrifice and worth advising against it as a signal. Much more important, SAGE said, was handwashing and avoiding touching the eyes, nose and mouth in case of infection from a contaminated surface.

269. The wider world seemed to me to be moving faster than the official advice. The Premier League had by this stage voted to suspend games, the London Marathon had been postponed and various summer music festivals were being cancelled. Government

polling showed there was significant public concern over the UK not doing things other countries were, such as banning big events, which 73 per cent of people then supported. I drew from this that the people were onside and that the Government should get on with taking such measures.

270. Sir Simon Stevens called to propose postponing all non-urgent operations from 15 April to free up 30,000 beds. To me this really hammered home what was coming. All those people waiting for surgery, many in pain, would now be deferred. Simon said that frail, elderly patients who did not need urgent treatment would need to be discharged, either to their home or to care homes. He told me that he had spoken to the PM about it and was determined to make it happen. The NHS was doing all it could to increase bed numbers and to keep them above the projected figure for peak infections. Simon was also making progress on my instruction to build emergency hospitals and said he would update me on 14 March.

271. I am aware that on 13 March, Helen Whately was provided with a submission detailing the development of an Ethical Framework for Adult Social Care that had been developed by the Office of the Chief Social Worker to support ongoing response-planning in respect of Covid-19 (MH2/124 - **INQ000049614**. The framework provided a set of ethical values and principles to be considered when taking decisions or developing policies at local, regional and national levels. Minister Whately was asked to review and agree to the publication of the framework on 19 March to coincide with the introduction of the Covid-19 Emergency Bill to Parliament.

## 14 MARCH 2020 – 1 JUNE 2020: INCREASED SOCIAL RESTRICTIONS AND THE FIRST LOCKDOWN

*The Decisions to Implement Social Distancing Measures*

272. On Saturday, 14 March I attended No. 10 to discuss the action that was necessary. The Chancellor, the CMO, Sir Patrick Vallance, the Prime Minister's Chief Adviser and Director of Communications, Lee Cain, were present. Sir Patrick told everyone that while we had thought we were four weeks behind Italy on the epidemic curve, it was now thought that the UK was two weeks behind, which meant there was no time to lose. We struggled at the meeting with enormous issues that no one had faced before. The data pointed to our reasonable worst-case scenario of over 500,000 deaths becoming a reality unless the Government stepped in hard and fast. There were 342 new confirmed cases,

taking the total over 1,000, to 1,140. In just three days, the numbers had doubled. On 13 March, eleven more people had sadly died, taking the total to twenty-one. They had all had serious underlying health problems, but we were advised that would not be the case for long.

273. The PM set out the case for and against each option. The CMO and Sir Patrick talked through the science. The Chancellor, the PM and I debated the options, and the Prime Minister's Chief Adviser intervened whenever he thought things were going off track, as by this stage he was strongly in favour of lockdown. Lee Cain advised on communications, which were evidently going to be extremely important. A readout was subsequently circulated (MH2/125 - INQ000233765).

274. The streets were empty and people were cancelling engagements, which indicated that a decision to lock down the country would be supported. Because the number of deaths, at 21, was still relatively low, many were concerned that the public might not accept the draconian measures that were needed. But the reality of peoples' behaviour made me convinced that with the right communications about helping others, the public could be persuaded. Many people were understandably frightened. Retailers released a joint letter asking people not to buy more than they need, as panic buying continued.

275. After everyone had had their say, we collectively made the decision to close large swathes of society. We did not recommend closing schools at that stage. We went over the proposals, how to do it and what would be shut, including whether this would be done regionally since we had been advised that London was ahead of the rest of the country, and gave instructions to the civil service to work up the details ahead of another meeting at 5 p.m. tomorrow to finalise matters.

276. As I left the meeting and walked back towards the famous No. 10 front door, I recall phoning the PM to tell him we had made the right decision and to reassure him that this was absolutely necessary. He picked up the phone and invited me back up to his office. I went back to the smaller study next to the Cabinet Room, where I found him with the Prime Minister's Chief Adviser, Lee Cain and his private office staff. The Prime Minister's Chief Adviser had a whiteboard full of numbers flowing from cases to hospitalisations to deaths, with predictions with question marks next to them and then a chart depicting hospital capacity. These figures had been in various briefing papers over the previous few days. He was doing exactly what I had called the PM to do: hammering home the

point that lockdown had to happen to protect NHS capacity and prevent it from being overwhelmed.

277. Afterwards I went back to my office to work on a piece for the next day's Sunday Telegraph, setting out that herd immunity was not and never had been the Government's policy, and setting the scene for the Monday's announcement. I agreed the newspaper piece with the Prime Minister's Chief Adviser and talked to the PM about exactly how to set out the Government's position during interviews on television the next morning.

278. Sir Simon Stevens briefed me about hospital capacity; including the excellent idea of converting the ExCel Centre in East London into an overflow hospital. Sir Simon had put a team onto it. He explained that London hospitals were already starting to see worrying increases in Covid-19 patients so we could not act soon enough.

279. On Sunday 15 March, I woke at 5:30 and spent the morning broadcasting, to prepare the public for the action we had agreed in principle to take, and setting out the strategy. Ahead of the 5pm meeting to agree the finer details of the measures, I spoke to the CMO. We were worried that the individual measures we had discussed the morning before would not be enough, and agreed that we would try to persuade the Prime Minister to say that everyone had to stop all unnecessary social contact.

280. By the end of the meeting, we had agreed to a package of restrictions, and that the PM would ask the public to end all unnecessary social contact for the foreseeable future. Whilst no one called it a lockdown, that is what it was. It was a relief to be taking these essential steps, but it still felt surreal and to this day I am still somewhat disbelieving that we took the steps we did. It is hard with hindsight, and having experienced two lockdowns, to recall just how radical and unprecedented a step this was. It felt utterly momentous.

281. I was provided with a submission dated 15 March following the COBR meeting on 11 March and the meeting I had attended at No. 10 on 14 March which sought formal clearance of the draft Coronavirus Bill (MH2/126 – INQ000106229).

282. Following the meeting on 15 of March, the package of proposed announcements were put to a COBR meeting on 16 March 2020 to get formal agreement on the restrictions and to ensure that the devolved administrations were in agreement (MH2/127 to MH2/130 - INQ000233770, INQ000056182; INQ000056184; INQ000056210). The

measures which were finally approved included: a stay at home policy; social distancing guidance; and guidance on the additional precautions that should be taken by those who were believed to be vulnerable to Covid-19. There was remarkable unanimity among those in attendance with everyone recognising that the measures had become necessary and could not be delayed. Once the package of measures had been signed off at COBR, the CMO, the Prime Minister's Chief Adviser, Lee Cain and I worked with the PM to finalise the language of the public announcement.

283. At 5pm, the Prime Minister made his televised announcement to the nation, explaining that without drastic action we would lose control of the spread of the virus, which could double in speed every five or six days (MH2/131 - INQ000086753). He informed the public of the gist of the new measures that we had agreed, namely: asking those with symptoms to isolate at home for 14 days; stopping non-essential social contact and all unnecessary travel, including working from home; and 12 weeks' of shielding for the most vulnerable members of society. He also explained that London was a few weeks' ahead of the country in terms of the speed of spread of Covid-19, and that it was particularly important for Londoners to follow this guidance. Crucially, he asked everyone to stop all unnecessary social contact – the broader behavioural change that was needed.

284. Immediately after that announcement, I made a statement in the House of Commons (MH2/132 - INQ000176653). Before setting out the package of restrictions, I explained that the virus' spread was accelerating in the UK, that 53 people had sadly died, and that the Government's action plan was designed to protect the NHS, as well as safeguarding the most vulnerable. I was also able to provide further information that the PM's announcement had not been able to cover, namely: the planned increases in Covid-19 testing to 10,000 per day; the purchase and production of additional ventilation equipment; the emergency Coronavirus Bill which was to be brought to Parliament later that week, giving the Government the ability to take control of essential services if required; and increasing communications so that the public had the best information available to them at any given time.

285. We considered using the Civil Contingencies Act 2004 ("CCA"), but it was inappropriate for two reasons: first, it could only be legally binding for "unforeseen" events, and there was legal uncertainty over whether that applied to the circumstances of the spread of Covid-19, and in any event it could only be used for 30 days, and any lockdown was likely to last longer than that. Lockdown decisions were in no way delayed by not using the CCA: the restrictions that were first introduced were made under new

regulations under the 1984 Public Health Act and not the Coronavirus Act and, in any event, as set out earlier in this statement the Government was acting on the scientific advice not to lockdown until it was necessary and unavoidable given that the period of compliance was likely to be short (and also recognising the significant impact on society at large).

286. Following my Commons Statement it became apparent to me from the questions that I was asked in Parliament (MH2/133 - **INQ000233767**) that, in the absence of a Government mandate that hospitality businesses must close (rather than Government advice on best practice), that sector would experience significant financial hardship without being able to claim on any relevant insurance policies (though Government was later advised, at the time of the lockdown, that a relatively small proportion of businesses were likely to have insurance policies with the relevant coverage). Similarly, my discussions with backbench MPs in other settings revealed that their main worry was the collapse of small businesses as a result of the Government's guidance.

287. In a Cabinet meeting on 17 March the Chancellor proposed a £330 billion package of loan guarantees, and £20 billion of direct funding by way of grants and tax cuts, which was an astonishing and unprecedented amount of public money (equating to 15% of the UK's then GDP) to be used in response to a national emergency: (MH2/134 - **INQ000233772**). This proposal – which was approved unanimously - was not only indicative of the scale of the potential crisis we were facing, but also a recognition that we were asking the public to put their livelihoods on hold to save the health of the nation.

288. Between Monday 16 March and Wednesday 18 March, in addition to attending a high number of meetings to deal with the crisis, I worked on the content of the Coronavirus Bill and on practical issues relating to the Government's Covid-19 response.

289. At this point, I was taking many decisions extremely quickly. For example, I was provided with submissions regarding: the introduction of a statutory instrument for service prioritisation in primary care to authorise the prioritisation of certain services which deviated from normal arrangements (MH2/135 - **INQ000109168** international engagement on Covid-19 (MH2/136 - INQ000049661); and temporary changes to national terms and conditions for NHS staff aimed at supporting mobilisation during the pandemic response (MH2/137 - INQ000109175). These are just three examples of the dozens of submissions I received each day which proposed significant policy changes to cope with the pandemic and its consequences.

290. It quickly became clear that one failure of preparation was that the stockpile of PPE was not spread across the country, local stockpiles were almost non-existent, and little consideration had been given to the rapid distribution of PPE in a crisis. I was told that the warehouse which held a very significant stockpile had only one main door, which slowed the distribution of PPE.

291. Alongside the Government guidance to the public, the NHS changed its protocols for PPE. I accepted their proposals for new PPE guidance. However, we also knew that the consequence of the new guidance would be to further radically increase demand for PPE. The Department therefore had to take additional action to try and speed up PPE distribution to NHS trusts, some of which had already reported shortages.

292. I spoke to the Secretary of State for Defence, Ben Wallace, to ask if the armed forces could be utilised to assist in distributing PPE. As a result, on 18 March 2020, it was formally announced that 20,000 military personnel would be designated part of the 'Covid Support Force', designed to assist public services in their response to Covid-19, which had an immediate impact on the distribution of PPE to NHS Trusts around the country. It was disappointing that the Government had to commit additional resource on these matters: while it was right for PPE distribution to be treated as a priority, I felt that this could and should have been adequately considered and planned for in advance, bearing in mind that the PPE stores were supposed to be an emergency resource (and designed as such).

293. Formal responsibility for PPE distribution rested with individual institutions – whether NHS hospitals, Primary Care (which is contracted by the NHS, not run directly) or care homes, which are mostly private sector. Prior to the pandemic, the official NHS supply chain only supplied the main hospitals, while primary care and social care provided for themselves. However, given the global shortage, it became extremely clear that individual organisations would not be able to provide for themselves. I therefore insisted that primary care and care homes be given PPE deliveries from our national stocks. Although this was a departure from normal arrangements (as care homes were private entities and not normally supplied with stocks by the Government), I was aware that care homes desperately needed PPE because their stocks were not designed to cope with a pandemic; this is another area where preparedness fell short. We responded as fast and as widely as possible, including giving free PPE to care homes as well as the NHS. I

would recommend that all health and social care facilities are required to keep an appropriate store of PPE for the early stages of any future emergency.

294. While we had been buying PPE in anticipation of these problems since January, the procurement of additional PPE became exceptionally difficult at this time, as many other countries also began purchasing in very large scale. These difficulties were exacerbated by our public procurement rules, which required the Government to make purchases at the bottom quarter of the market pricewise. Whilst those were eminently sensible rules for ordinary times (respecting that public money needed to be spent carefully and with an eye on value for money), this restriction put the UK on the back foot as global prices for PPE soared.

295. When I found out about this bottleneck I indicated that any PPE that could be found should be purchased, irrespective of its price point: my view was that we needed everything we could get. After consideration, HMT signed off the move to emergency procurement procedures, which were designed for this eventuality. Significant cross-Government effort, led by a combination of Cabinet Office, NHS England, FCDO and DHSC staff, went into the efforts to purchase extra PPE. The Prime Minister made a public call for help from those who could buy or produce PPE, and a system was put in place to handle the many responses we received from this call to action.

296. I cannot comment on individual purchase decisions as I was not involved in any contracting, pricing, or purchasing decisions – these decisions were made by civil servants, largely from the Cabinet Office. With hindsight I would simply say that emergency procurement rules need updating to protect the reputation of those who respond to a Prime Ministerial call to action to do their duty in the national interest. The only alternative to buying expensive PPE was not to buy PPE, which would have cost lives.

297. On 15 March, the Cabinet Office established the 'C-19 Secretariat' and a committee structure dedicated to Covid-19 decision-making, which stood in the shoes of the Civil Contingencies Secretariat (MH2/138 - INQ000233766). This new structure improved the speed of decision making, and replaced the informal No10-led process which had been deeply unsatisfactory. With hindsight, although an improvement, having four separate MIGs in place did not work as well as they could as all issues were cross cutting, and their replacement in May 2020 with the COVID(S) and COVID(O) committees speeded and strengthened cross Government decision making further.

298. On the evening of 17 March, the Prime Minister and I attended a meeting with public sector health officials and representatives from private sector companies and organisations (including Amazon, Boots, Roche, Thermo Fisher, Altona Diagnostics, and Randox) that could potentially assist with our Covid-19 testing efforts. From an early stage, we recognised that regular, mass testing across the country would be pivotal to the successful navigation of the pandemic, enabling the country to minimise spread as well as providing data that would be central to planning. This echoed the advice from the WHO to "test, test, test". At the meeting we discussed, among other things: testing capacity; the barriers to expanding it; and what steps the public and private sector could take to break these barriers and accelerate testing (MH2/139 - INQ000233771).

299. During the meeting, the NHS and PHE were unable to give convincing plans for scaling up their testing capacity. I therefore decided that the Department would lead on the testing programme, rather than PHE. From a very early stage of the pandemic, I followed and scrutinised the UK's testing programme and capacity, and had been constantly pushing for its expansion. I was lucky to have many allies on this challenge. Sir John Bell, University of Oxford Professor of Medicine also saw expansion of testing as critical and I remember him talking about a world in which mass DIY testing would be available on demand and it would be perfectly normal to get up in the morning and do a coronavirus test before going to work.

300. Based on the advice at that meeting from both public and private sector testing providers, it was agreed that PHE and the NHS would carry on expanding as much lab capacity as they could, but that the Department would also set up a mass-scale testing programme, alongside the existing system, for antigen tests, another for antibody tests and a strand for surveys to find out how many people have it and have had it. These different strands of testing were referred to as the four 'pillars' of testing. Lord James Bethell, who had recently been promoted to Parliamentary Under Secretary of State at the Department, was given overarching responsibility for the strands of testing work within the Department.

301. The following day (18 March) Oxford University scientists based in China[2] announced that they had developed a rapid test for Covid-19, which produced a result in half an hour. The same team were exploring the validation of the tests in the UK, and their

[2] At the Oxford Suzhou Centre for Advanced Research ("OSCAR").

incorporation into rapid devices which could allow for very large scale personal testing, for example, at airports or even at home.

302. The Department's remit at this time was vast: in addition to our usual business, we were the lead Department for the response to the pandemic, and were therefore at the centre of Government decision making in response to the pandemic, which was necessarily vast and fast-paced. The Department's remit also resulted in it becoming involved in matters or decisions that were normally the remit of other Departments, but required a fast and decisive response; for example, working with the FCO on the expatriation of UK citizens.

303. During this period, the Department had also worked further on guidance for those most vulnerable to Covid-19. This programme, called "Shielding", was vital for the protection of the most vulnerable. We recognised that the Government and NHS needed to take urgent steps to identify and assist those who were required to shield, and that communicating with those being asked to shield would be extremely sensitive, as they were many of the most worried about the disease.

304. Data held by the DWP and NHS identified a significant number of the most vulnerable people in the country who needed to shield for twelve weeks. However, there were difficulties in linking data to enable us to contact those individuals and give them the help they needed. This frustrated me, as I felt that data and privacy concerns, whilst important, could not be given priority ahead of saving the data subject's health or even life. I made it very clear, both to NHS Digital, and at meetings of the Health MIG, that I wanted this issue to be sorted urgently. I was ultimately required to issue four notices under Regulation 3(4) of the Health Service (Control of Patient Information) Regulations 2002 on 1 April 2020, which directed the NHS to share the relevant data for these purposes. These had a very significant positive impact on the ability to deliver services, and one lesson from the pandemic is that this sort of data sharing should become the norm to improve and save lives.

305. Robert Jenrick and I drafted a letter to the 1.5 million individuals identified to be vulnerable and who were required to shield, to explain what they needed to do, and the steps that we were taking to support them, including arranging food and medicine deliveries: (MH2/140 - INQ000233778).

306. Soon after the advice that we gave the public on 16 March, a series of additional decisions were made to expand restrictions. Following a SAGE meeting on 18 March, due to increasing concerns about the transmission of Covid-19 it was proposed that schools should be closed (MH2/141 to MH2/144 - INQ000056050; INQ000056058; INQ000056123; INQ000056188). This was discussed at a COBR meeting at 4pm on the same day (MH2/145 - INQ000056211), and agreed by Cabinet. Closure of schools was an option that had been set out as a last resort, and following the scientific advice that it was necessary, there was a consensus on following that scientific advice.

307. We obviously considered the arguments against doing so, including the impact on children's educations, on parents who may not be able to attend work as a result, and on the economy. The Cabinet decided on the recommended option: a partial closure whereby schools would remain open for children of key workers, and for children who were deemed to be vulnerable for non-medical reasons, for example, children who had Education, Health and Care Plans, or who were receiving the support of social services (MH2/144 to MH2/148 - INQ000056188; INQ000056211 INQ000056196; INQ000056187; INQ000056185).

308. On 18 March 2020, we also discussed the potential of additional restrictions in London that could amount to a legal lockdown (MH2/149 to MH2/151 - INQ000056052; INQ000056056; INQ000056062). However, it was identified that there was a strong argument for extending any additional restrictions beyond London, given that the rest of the country was behind London and would only follow in time, and in light of data suggesting that there was not enough compliance with the Government's advisory measures. By 19 March, there was a strong consensus that additional restrictions were required, and that the decisions to be made were (a) the extent of those restrictions, and (b) whether they would apply to London or to the entire nation (MH2/152 - INQ000056262). In each case, these considerations were based on scientific advice, and we followed the central proposal of that advice.

309. On Friday 20 March, the Prime Minister was given advice at the 9.15am Strategy Meeting as to measures to increase compliance, and whether mandatory restrictions were required. At that meeting, I pressed the case for further action, and we came to a clear consensus that a legally enforced lockdown was necessary. The Prime Minister decided that additional advice and planning should be undertaken ahead of a COBR meeting that afternoon, where the final decision would be taken: (MH2/153 to MH2/154 - INQ000056065; INQ000056265).

310. A paper entitled 'Social Distancing Measures' (MH2/155 - INQ000106263), was discussed at that Strategy meeting and later at the 4pm COBR meeting (MH2/156 to MH2/158 - INQ000056159; INQ000056198; INQ000056212). That paper set out the scientific advice that the numbers of infections were continuing to rise, that some people were not complying with the guidance measures, and that a number of businesses posed high risk of spread due to close contacts.

311. The scientific data in the Covid-19 Dashboard (MH2/156 - INQ000056159] also indicated that if we did not impose more stringent measures, within the coming weeks the number of people in critical care with coronavirus would outstrip the NHS' critical care capacity by tens and then hundreds of thousands. By contrast, stringent measures for 5 months followed by a relaxation would only cause a resurgence of the virus later in the year. That resurgence was still predicted to exceed hospital capacity by tens of thousands, and so in my mind would require action later. It was clear to me that we needed to suppress the virus, and then keep it suppressed until a vaccine could prevent a second peak.

312. Based on scientific advice, the decision was therefore taken at COBR on 20 March that it was necessary to introduce enhanced measures which mandated the closure of food and hospitality venues (MH2/158 - INQ000056212]. It was recognised that there would be significant economic consequences, both for businesses and employees, and that financial support would be required as a result of this decision.

313. On the same day, these measures were announced to the general public. Accordingly, on Saturday 21 March 2020 I enacted the Health Protection (Coronavirus, Business Closure) (England) Regulations 2020, which gave effect to that decision and enforced the closure of food and hospitality venues. Equivalent legislation was introduced in the devolved nations. The Chancellor also announced details of the furlough scheme on 20 March 2020.

314. Alongside those meetings, the Coronavirus Bill was working its way through Parliament, and had its first reading on 19 March. The bill gave the Government broad powers to take steps to protect public health in the face of the pandemic, including: banning or restricting gatherings; controlling or suspending public transport; ordering the closure of businesses; detaining those suspected of being infected; close education; and

relaxing regulations and laws to accommodate the pressures that were being faced by the NHS and hospitals.

315. The Cabinet recognised that the powers in the Bill were extremely broad: the intention at that time was, if possible, to limit its use to what was necessary and proportionate, as guided by the scientific advice at the time, but it was recognised that we needed a legislative framework in place for the worst-case scenario. The bill was providing a mechanism to take measures quickly when things escalated in order to protect the public. Despite its breadth, the Bill was received positively at its first reading, which I took to be a recognition by all political parties that these measures were needed urgently.

316. I established other groups to further the Government's Covid-19 response. For example, on Friday 20 March I chaired the meeting of the Covid-19 Testing Daily Working Group, which met most days until June 2020, when Dido Harding took over day-to-day responsibilities for test and trace. That meeting's sole focus was the rapid expansion of our testing programme, including matters such as: technical evaluation of testing and resulting data; exploring avenues for new methods or forms of testing; and opportunities to expand through the public or private sector. I also attended the Cabinet Office's first daily Covid-19 procurement meeting, which was chaired by Lord Agnew. Since the Cabinet Office was the lead Department for procurement, and Cabinet Office officials were in the lead on the contracting, it was appropriate that the Cabinet Office minister led that group, and I delegated further attendance to my junior Minister (MH2/159 to MH2/160 - **INQ000233774**; **INQ000233775**

317. Over the weekend following the enhanced social restrictions (21 and 22 March), a number of important discussions took place at C-19 Strategy Meetings, including on PPE, NHS bed capacity, the impact on non-Covid-19 healthcare, shielding, and food supplies (MH2/161 to MH2/166 - INQ000056064; INQ000056086; INQ000056263; INQ000056085; INQ000056266).

318. A draft of the Department's "battleplan" was approved by the PM on 22 March 2020, and was broken into 7 key areas of work (which changed and developed over time), as listed below. I exhibit a copy of the various battleplans that were created during my tenure as Secretary of State as (MH2/167 - **INQ000234336**

a. Resilience (NHS and social care);
b. Supply;

c. Testing;
d. Technology (which included new treatments and vaccines);
e. Social distancing;
f. Shielding; and
g. Cross-cutting.

319. Over that weekend, new data in relation to Covid-19 spread suggested that intensive treatment unit ("ITU") capacity in London could be overwhelmed in as soon as nine days, and that this increase was likely to stem from Covid-19 cases already in circulation which could not be halted and that, therefore, there was no capacity within the system for new cases. In addition, the modelling suggested that roughly 75% of the public needed to comply with the social distancing measures to successfully avoid the NHS becoming overwhelmed, but that compliance was estimated to be at around 45% (MH2/168 – **INQ000056087** ). By the evening of Sunday 22 March, it was confirmed that Greater London's ITU beds were 80% occupied (MH2/169 - INQ000056103). This data demonstrated the need to rapidly enforce social distancing, which further supported the need for a legal lockdown rather than the advisory approach that had previously been taken.

320. At two C-19 Strategy meetings on the morning of Monday 23 March, the committee discussed this issue further, based on a paper which posited a number of alternative options to enhance social distancing (MH2/170 -**INQ000089938** In our discussions we weighed up all of the possible options that would meet our stated goals of protecting the NHS and saving lives. In light of the rapid increase in cases which had arrived earlier than anticipated, the unanimous view was that the best option appeared to be the imposition of a formal lockdown on the country as soon as possible. The Prime Minister determined that the final decision would be taken at COBR that afternoon.

321. At the strategy meetings on 23 March we also discussed where we were up to with the ongoing wider response to the pandemic. Those strategy meetings also discussed and progressed the various ways in which the Government could and would expedite its response to the virus, including boosting the capacity of the NHS, increasing NHS staff levels, and progressing Operation Nightingale – the plan to expand NHS capacity (MH2/171 to MH2/174 - INQ000056102; INQ000056098; **INQ000087338** INQ000056096).

322. Later that day, after the Coronavirus Bill had all of its remaining stages in the House of Commons,[3] a COBR meeting was held at 5pm to discuss the social distancing paper and the measures that were needed. At that meeting we decided that: all citizens should be instructed to stay at home except for a small number of essential activities; non-essential shops would be closed; non-household or work-related gatherings of more than two people in public would be banned; and all social events would be banned (MH2/175 - INQ000056199). I spoke in favour of the proposal, which garnered unanimous support. We discussed the timing of the measures. NHS England preferred one or two days notice to prepare NHS 111 for the inevitable influx of questions, and the Mayor of London recommended bringing in measures immediately. I confirmed that should it be deemed necessary we could have the requisite legal documentation put together imminently, and that the emergency Parliamentary procedure used in February for quarantine meant we could seek Parliamentary approval in retrospect. In agreement with the First Ministers of the devolved nations, which included representatives from all major Parliamentary parties, the Prime Minister agreed this approach.

323. A further question of timing was how long to put the measures in place for. Given the significant impact that those restrictive measures would have on health, quality of life, and livelihoods, the lockdown was restricted to an initial period of three weeks, at which point there was to be a review and further announcement. However, the sense of the meeting was that we all knew it would likely be longer, not least as we had already warned those especially vulnerable to Covid-19 who were shielding that we expected that advice to remain in place for 12 weeks. The measures agreed at COBR were also agreed on a Cabinet call and announced by the PM at 8.30pm that evening (MH2/176 and MH2/175 - INQ000056259; INQ000056199), and were implemented by the Health Protection (Coronavirus, Restrictions) (England) Regulations 2020, which came into force on 26 March 2020.

324. Some have argued retrospectively that lockdown was not necessary. In my view, this is plain wrong. If we had not locked down at this point, there is no doubt that the NHS would have been overwhelmed, and hundreds of thousands more people would have died. The evidence that we considered at the time of making the decision to lockdown was clear that this was necessary:

[3] The Coronavirus Bill had its readings in the House of Lords between 24-25 March 2020, before being given Royal Assent on 25 March 2020, the same day that the majority of its provisions came into force.

a. The number of cases were doubling every five to six days, and the relationship between cases recorded and future deaths was clear in the data;
b. NHS ITU capacity was very nearly overwhelmed in London, and would have been had we locked down even a few days later;
c. People were not following guidance enough to prevent growth in cases faster than subsequently seen. It was not possible to have any confidence whatsoever that R would have been reduced to below 1;
d. Later, when we did relax measures as case numbers became low, case numbers soon began to multiply again, from mid-July onwards, leading to the second wave during the autumn.

325. In my view, comparisons with countries like Sweden are not valid. The UK's population is over 10 times more dense than Sweden, so the comparison of the raw number of deaths per 100,000 is invalid. Furthermore, Sweden had ten times as many deaths as its geographically similar neighbours Norway and Finland. In the end, Sweden did introduce statutory measures, such as closing schools, travel bans, and vaccine passports. I have seen no credible evidence to support the case that Sweden achieved a better outcome, and reiterate that in making the decision to lockdown we acted on the science and the scientific recommendation to us at the time that this was what was necessary to protect the NHS and save lives. In my view, it is absolutely crucial to learn the lesson from the pandemic that the UK should swiftly reject any argument that lockdowns are not necessary in circumstances such as those which faced us during the Covid-19 pandemic; otherwise the consequences of the next pandemic will be disastrous.

326. On 24 March 2020 the first Nightingale Hospital was announced and I visited the London ExCel Centre to observe its rapid military construction (which ultimately resulted in being completed within an astonishing 9 days, opening on 3 April 2020). The specifically designed hospital would provide an additional 500 beds and ventilators for Covid-19 patients (MH2/177 - **INQ000233779**

327. At the Covid-19 Strategy meeting that morning, the PM agreed that the Department, the NHS and the MoD should work together to construct nine additional Nightingale Hospitals, to be made operational as soon as possible as it was recognised that the London surge was likely to be replicated across other cities in the UK (MH2/178 - INQ000056105).

328. Although we hoped that this additional capacity would not be needed if the lockdown measures worked, both the high R number (which was then between 2 and 3) and the high incidence of cases which had arrived much quicker than anticipated made it essential that we had additional capacity and contingency within the NHS to plan for the worst. In the end, the Nightingale hospital in London was used, and saved lives, but thankfully never reached capacity. The same strategy meeting also sought to accelerate the other essential limbs of our Covid-19 battleplan, including: PPE and ventilator supplies, raising a call for arms for private businesses to help us, ramping up testing, and beginning to investigate and trial treatments and vaccines.

329. Later that day I gave the daily televised briefing, launching the NHS Volunteers' Scheme. The scheme asked local communities to help those shielding, whether through deliveries, transport to medical appointments, or even a telephone call to anyone that was lonely or needed to be checked up on. We were aiming for 250,000 volunteers to join the scheme, but within a day over 405,000 volunteers had signed up. Like many other pivotal moments during the pandemic, the public demonstrated the lengths that they were willing to go to in order to help and look after others in the community. Throughout the pandemic I lost count of the number of times I was moved by the impressive, thoughtful and heart-warming acts of the British people.

330. Around this time, the updated data that Government had received from the NHS (MH2/179 and MH2/180 **INQ000233783** **INQ000233784** predicted that the peak of the virus would be in April, and that our country would experience 65,000 deaths and 320,000 hospitalisations by September 2020. This was a reduced figure as a result of the restrictive measures that we had taken, and we were advised that if the restrictive measures were lifted after six months, then another, larger peak would take place later in the year, resulting in an additional 90,000 deaths. In my mind this reinforced the vital need for a vaccine to prevent this second peak.

331. The NHS data was subsequently echoed by SAGE's updated advice on the reasonable worst case scenario, which projected that the peak of the virus and the number of deaths would take place in April, and would slowly decline after that. The data predicted that if people abided by the measures, the peak would take place that coming week (the first week of April), with an expected 1,900 deaths that week, but that non-compliance could result in as many as 2,700 deaths that week: (MH2/181 - **INQ000233787**

332. All of the data underlined to me the need to maintain the speed and pressure on the vaccine development efforts, and the importance of the continued expansion of the UK's testing capacity so that we could limit spread and accurately monitor the peak and the R number.

*Increases in Testing Capacity*

333. We increased testing capacity to 10,000 per day by the end of March. Throughout, tests were prioritised on clinical need. In the first instance, this meant for patients with symptoms. As we built capacity, we devised a priority scheme for the roll out of tests as they became available, starting first with NHS staff, ambulance staff and nurses in social care along with their household members with symptoms. This clinical prioritisation recognised the risk that individuals faced, as well as the risk that they posed to vulnerable individuals within their care (MH2/182 - **INQ000233780** That first group of key workers was estimated to require 250,000 tests per week in England, which would require approximately 36,000 tests per day before tests could then be provided to the next priority group.

334. With the testing system not scaling as fast as we needed, I set a target to carry out 100,000 coronavirus tests a day by the end of April. This target was the subject of a lot of criticism, including off the record press briefing from No.10, who made the accusation that this was a publicity stunt. This is categorically wrong and shows a complete failure of mindset. I set this target to galvanise the whole system to deliver more tests. Especially given the wide range of people who needed to come together to deliver this extraordinary effort, I needed to make the target clear and public. This was an intentionally ambitious target which stretched the whole system. At the end of March, just over 10,000 tests were carried out, and I was asking the system to times that by ten in 30 days. Huge numbers of people went out of their way and delivered against the odds to expand testing, in a way they simply had not before. Even on the final days of April, we were unsure whether we would hit the target, but what we did know was that testing capacity had massively increased, showing this target was an unqualified success.

335. Professor John Newton and Lord James Bethell worked incredibly hard to lead this system, often with No.10 intervening in ways that made it harder to achieve. This is why it was so important that the Departmental team was completely aligned with clear lines of accountability, so we could avoid the same issues that were occurring across Government. Professor John Newton's blog (MH2/183 - **INQ000233805** sets out the

important context of how the team achieved this in the face of very little capacity from the start. The UK entered the pandemic without the diagnostics capacity needed to deal with outbreaks, and by 18th May 2020 everyone aged 5 and over with symptoms of Covid-19 was eligible to be tested.

336. The test developed by Randox was approved by the Medicines and Healthcare Products Regulatory Authority ("MHRA") on 27 March, providing an additional 1,400 tests per day using three new hub labs set up specifically for the pandemic through the work of a partnership between Government and industry. I am aware that there was subsequent criticism of the Government's decision to award Randox a contract for testing, but without them and thousands more businesses stepping up to help in the national effort to increase testing, many more people would have unfortunately died. It was vital for Covid-19, and will be vital for future pandemics, that when businesses are called upon to help convert their supply chains to support a particular goal, they step up. I fear that the criticism that many businesses have faced during and since the pandemic will lead to businesses and people deciding to not go out of their way to help in the next pandemic.

337. Some have argued that faster procurement processes were not the right way to award contracts. This argument, in my view, completely underestimates the scale of the challenge we faced at the time. In the face of a novel pandemic where we did not have an adequate capacity to fall back on, we were in urgent need of tests. As Health Secretary at the time, I faced two choices: to operate a business as usual procurement process which can take months to be completed, leading people without the tests they needed, or to create a faster process which continued to be decided, priced and signed off by the civil service. My aim, and the aim of most countries around the world, was to rapidly scale-up testing in the early months of the pandemic. There was a truly global scramble for these vital items and without this faster process, many more people would have died.

338. In addition to testing being provided by the private sector, the NHS and PHE expanded their existing systems as fast as they could, and contributed significantly to hitting the target. Concurrently, work was undertaken on developing testing for antibodies that could indicate immunity (MH2/184 **INQ000233786**. At this stage, the scientific picture was uncertain as regards immunity, and how long it might last: the advice we were given was that immunity was expected following recovery from Covid-19, but that the length of time

for antibodies to develop, and how long they would protect a previously infected individual, were uncertain (MH2/185 and MH2/186 **INQ000233788** **INQ000233790**

339. Antibody testing was especially important in disproving the false predictions by anti-lockdown voices such as Sunetra Gupta, who said that over half of the population may have been infected by the 24 March (MH2/187 - **INQ000233777** This was proven categorically wrong with only 6.78% testing positive for antibodies in the Covid-19 Infection Survey later published on the 28 May (MH2/188 - **INQ000233813**

340. Partnerships with the private sector were reached appropriately and effectively, and were critical in the minimisation of unnecessary transmission, and in the way that the UK kept cases under control during the first lockdown. I had no oversight of the contractual arrangements themselves. However, the testing system we built ultimately enabled the easing of restrictions, relative to what would otherwise have been needed, and undoubtedly saved lives.

*Asymptomatic Transmission*

341. As stated earlier in this statement, on 27 January, I raised concerns with officials about the reports of asymptomatic transmission occurring in China and asked the Department to gain clarification from China on whether asymptomatic transmission is occurring, and to scenario plan accordingly **MH2/28** **INQ000106067**

342. On 2 April the WHO restated their position that there had been no documented asymptomatic transmission of Covid-19 (MH2/190 - **INQ000234308**). The failure of the global scientific community to accept the likelihood of asymptomatic transmission was a source of great frustration to me. That scientific consensus determined the "case definition", which I could not overrule. I was briefed on why they held this view: because no previous coronavirus exhibited asymptomatic transmission, and because the evidence for it was anecdotal not clinically validated, the scientists concluded that the existing view had not been disproved. Although our guidance documents at the time cautioned that further work was required to understand whether asymptomatic transmission was possible (rather than positively stating that it did not occur), with hindsight I should have insisted on the likelihood and dangers of asymptomatic transmission, despite the formal scientific position. However, the formal case definition of Covid-19 excluded asymptomatic transmission, and all the advice to me from PHE, based on the WHO's global advice, was based on this assumption.

343. Asymptomatic transmission is a prime example of a concept that could not yet be formally determined (as the scientific view was constantly adopting, developing and changing to reflect the emerging evidence), but where precautionary measures should have been taken until the science could demonstrate that this was no longer a risk: in my view we should have assumed, until proven wrong, that these types of risks existed, and should have taken measures to reflect that assumption, rather than waiting for "evidence", which was inevitably going to be delayed in the context of a novel emerging virus.

344. I have reflected on why I did not over-rule this advice, and insist on a reasonable-worst-case assumption. The reason is that I felt that on such a scientific question, I could not have carried the system with me. Obviously with hindsight I should have tried to do so.

345. On 3 April 2020, the day after the WHO's announcement, the US Center for Disease Control published a study which demonstrated that asymptomatic transmission was likely to be occurring, with over 50% of residents in one care home having been asymptomatic but tested positive for Covid-19 (MH2/191 **INQ000233785**). The minute I heard this news, I instructed the Department to review all of our guidance.

346. Following the CDC's evidence, PHE began their own study which supported the American evidence. That was presented to NERVTAG on 24 April 2020 and further evidence was presented to SAGE on 12 May 2020 and informed Covid-19 response plans. But even before this official advice was given to Ministers, we took the decision to act on the assumption of asymptomatic transmission after seeing the CDC evidence, and on the 15 April, as we were ramping up testing capacity and with this growing evidence of asymptomatic transmission, we decided that all patients being discharged from hospitals into care homes should be tested. This was extended to asymptomatic care home staff on 28 April.

347. With hindsight I regret not acting on the assumption of the worst case scenario that asymptomatic transmission was occurring. While the official advice I was receiving from the WHO said that asymptomatic was unlikely, for the next pandemic I would advise Ministers to act on the basis of the worst case scenario until proven otherwise.

348. The Department constantly updated its advice to hospitals and care homes on this issue (and other connected issues) based on the scientific advice that we received at the

time. The Department's guidance is listed in further detail in the corporate witness statement provided by Sir Christopher Wormald. In summary, the guidance in relation to discharging patients to care homes was:

a. Operational hospital discharge guidance published on 19 March to explain the need to discharge patients swiftly and the process for doing so (MH2/192 - **INQ000115314**;
b. To try and assist care providers, we decided to provide specific guidance on the issue of accepting residents discharged from hospital, and published updated care home admission advice on 2 April 2020 (MH2/193 - **INQ000233798**);
c. On 6 April 2020, following an increase in the sourcing of PPE, the Department was able to deliver PPE free to approximately 58,000 care providers (which included care homes but also extended to other organisations including hospices and community care organisations);
d. On 9 April 2020 PHE published guidance for stepdown of infection control precautions within hospitals and discharging Covid-19 patients from hospital to home settings (MH2/194 - INQ000106344);
e. On 15 April the Department published the adult social care action plan on 15 April 2020 (MH2/195 - **INQ000233794**, which detailed advice on how to minimise the risks and transmission of Covid-19 in care settings, along with the support that central and local Government would and could provide to care providers, including in the event of outbreaks of Covid-19. In part thanks to the 100,000 target, we were able to announce in the action plan that all hospital patients would be tested for Covid-19 prior to admission to a care home. This had the dual benefit of freeing up hospital capacity, while also giving care providers the risk mitigation that they understandably wanted and needed. Importantly, our action plan still advised that those discharged into care with a negative test be isolated for 14 days to guard against the risk of a long incubation period and false negatives. In addition, the action plan announced that there was now sufficient capacity for all social care workers who needed a Covid-19 test to access one; and
f. As of 28 April, testing capacity had been built up sufficiently to enable all residents and staff (including those that were asymptomatic) to be tested.

349. By mid to late April, over 25% of care homes had declared a Covid-19 outbreak and the infection rate was considered by PHE to be higher than in the general community. It

was recognised that yet further measures were needed to control the spread of the virus and to protect vulnerable residents as well as care home staff.

350. The Department began work on a further intensive support package, led by Helen Whately as the Social Care Minister throughout April and into early May, (MH2/196 and MH2/197 - **INQ000233797** **INQ000233804**

351. The support package was published approximately one week later (MH2/198 - **INQ000233812**) and included: increased access to direct sources of national support in the form of funding, PPE and testing; local authorities providing support, including step down or quarantine facilities to prevent infection risk where necessary; additional funding for local authorities to support care providers, which the Department requested local authorities to urgently direct to care providers; training in infection control; assistance from PHE Health Protection Teams ('HPTs') upon an outbreak being declared, including mass testing and tailored infection control advice; support from the NHS including access to medical equipment and infection control to prevent Covid-19 positive patients from being discharged into care homes and additional staffing.

352. Those enhanced support measures resulted in an update to the admissions care home guidance on 19 June 2020: (MH2/199 - INQ000106486).

353. Clinical experts, such as Jenny Harries and data released since this time have shown that the seeding of infections in care homes came from care home staff rather than from hospital discharge. A summer 2020 report (MH2/06 - INQ000058526), supported by a later May 2021 PHE report, has shown that approximately 1.6% of care home infections came from hospital discharge, contrary to common criticisms (MH2/05 - **INQ000234332**

354. This does not detract in any way whatsoever from the incredibly diligent work of care home staff, who were going to extraordinary lengths to support vulnerable elderly people. Recognising the risk of transmission from staff is not a criticism of care home staff, as I was unreasonably accused of in December 2022 when outlining this fact – not least because the central problem was that asymptomatic transmission meant people would often simply not know they were transmitting the virus, and could not be expected to know.

*Decision-making in relation to PPE*

355. I have read and agree with the account of the Department's decision making in relation to PPE as set out in Sir Christopher Wormald's first Module 2 statement at paragraphs 205-218. Similar to the difficulties with scaling up testing, the main issue we faced with PPE in this time period was the fact that there was a global scramble for these items. This led to a lot of countries struggling to provide PPE to the frontline. As an illustration of just how difficult it was for many countries at this time: China - the UK's principal supplier of PPE - announced restrictions on exports which were effective from 1 April; France and Germany banned PPE exports altogether; and the EU tried to continue with procurement processes but saw two rounds of procurement calls go completely unanswered. Indeed, this led to countries directly trying to out-bid each other for PPE. One example of this was when the United States concluded a purchase of gloves from a supplier with which, only hours before, we had been engaged in commercial discussions.

356. The PPE shortages did not ease throughout April, despite the Government throwing all of its efforts and resources at this problem; the global supply chain simply could not match the worldwide demand, notwithstanding the rapid expansion of production. On 10 April, the Department published a PPE plan, setting out the efforts being taken to address the need for critical PPE (MH2/200 - INQ000106347). As well as directly providing PPE from Government, we also provided the social care sector with information on where PPE could be obtained across the UK (MH2/201 **INQ000233796**).

357. The Prime Minister suggested to me that we bring in Lord Deighton to lead on PPE efforts, and I was delighted at the idea. I called Lord Deighton and, along with the help of others in No10, we persuaded him to come in to lead on PPE procurement, based in the Cabinet Office. Lord Deighton had previously served as Chief Executive of the London Organising Committee of the London 2012 Olympic Games. He was appointed as a voluntary advisor on 19 April 2020, and was responsible for PPE purchasing decisions thereafter. This arrangement proved to be a success, and resulted in the appointment of other leading public and private sector individuals to head up strands of the Government's response in the months ahead.

*Government Decision Making When the PM was Ill*

358. When the Prime Minister was in hospital, the Government worked incredibly effectively. The Cabinet rallied around the First Secretary of State (Dominic Raab), who did an effective job at managing the Government in this time of instability. This was overlapping with when the Prime Minister's Chief Adviser was also self isolating, and the proper lines of accountability were respected far more in this time.

359. This time was a very good example of how the state can operate in a time of crisis when convention is respected, Ministers do not play politics, and advisers do not leak Government decisions to the media in order to get their own way or exert disproportionate influence on decision-making in the name of their boss without their boss' approval.

360. As the Prime Minister recovered from his illness, I attended a remote meeting on 24 April, at which he appeared online accompanied by the Prime Minister's Chief Adviser and other advisers. During that meeting I was bombarded with questions on the Department's work on PPE, testing, and other key areas of response. The Prime Minister was largely silent. The starting point for questions from his advisors appeared to be based inaccurate media reports, rather than having read any Government documentation, and I was able to answer them to the PM's satisfaction. I felt that a great deal of energy had been wasted on both my part and that of those on the other side of the link, which could have instead been deployed in our Covid-19 response.

*April 2020 Expansion of Testing, the Testing Taskforce and the UK's Covid-19 Testing Strategy*

361. The Department held weekly meetings devoted to the expansion of our testing programme. On 7 April, I requested that those meetings become daily given the importance of delivering in this area at the speed I wanted. At the first daily meeting on 7 April, the Department formalised the five operational pillars of the UK's Covid-19 testing strategy, with each pillar having a lead individual and supporting staff dedicated to its delivery:

1 – NHS swab testing for those with a medical need and critical key workers;
2 – Commercial swab testing for critical key workers;
3 – Antibody testing to determine immunity;

4 – Surveillance testing of samples to understand the virus and develop tests and treatment; and

5 – A national diagnostic effort to create mass-testing capacity.

These pillars would become central in our mission to ramp up testing.

362. I also established the Testing Taskforce to sit alongside the daily meetings, which was intended to bring together ministers and experts and other leaders in the healthcare sector to help drive progress and creative solutions across the five pillar (MH2/202 and MH2/203 **INQ000233789** **INQ000233791**. I chaired the taskforce, which met three times per week.

363. On 7 April, Cambridge University, AstraZeneca and GlaxoSmithKline had also announced the opening of their new, joint venture testing centre which was estimated to bring an additional 1,000-2,000 tests per day, with that figure increasing daily through to 30,000 tests per day by the first week of May.

364. By this time, PHE had advised Government that the testing capacity required to cover all key workers was 750,000 tests per week (or approximately 110,000 tests per day): (MH2/204 **INQ000233793** ). NHS and social care staff were prioritised within the key worker cohort, recognising both the risks to them and to the vulnerable people they work with from their high risk of contact with the virus.

365. Dedicated focus to each of the five pillars of the testing strategy was essential to the successful operation of our testing strategy, as there were a significant number of logistical challenges to expanding testing capacity beyond those associated with actually creating the capacity; for example, ensuring that supply met demand in the appropriate locations and sectors and was not under-utilised elsewhere.

366. I was frustrated by reports of tests being under-utilised, given the widespread need and desire to access tests, and repeatedly sought to make clear that any 'spare' tests should be re-distributed to ensure that capacity was fully utilised. For example, by 28 April (by which time access to testing had been extended to all key workers and to those aged 65 and over) testing capacity had reached 73,000 per day, but the take up was much lower at circa 43,000.

367. Reports of under-utilisation included reports that NHS staff were avoiding taking tests to as they did not want staff to test positive and then be required to stay at home, impacting staffing levels. I was astonished to hear this, bearing in mind not only the impact on staff, but also on vulnerable patients in hospital for reasons other than Covid-19. I discussed this problem repeatedly with Simon Stevens.

368. At that time, all tests were processed within a laboratory. Although the tests could be delivered and administered at home, they were then sent off to the appropriate laboratories for results. The Department eagerly awaited the arrival of home-testing kits which would accelerate the UK's testing capacity, the speed of results and the easing of restrictions, but as of April 2020 home-testing devices had not been approved by the MHRA.

*Lack of Population Immunity and Increased Focus on Vaccines*

369. On 9 April 2020, I received the unofficial and unconfirmed results of a Government-commissioned serology survey from Professor Van-Tam. The survey was intended to estimate the proportion of people who had previously contracted Covid-19, and would therefore give us an indication of the levels of immunity in society. The result was devastatingly low at 5%. Given the number of deaths already, this fact meant that the only viable strategy was to suppress the virus until the vaccine could deliver immunity safely to the population.

370. It became clear at that stage that the level of exposure to Covid-19 (and, therefore, suspected immunity) within society was not as high as had been reported anecdotally by news outlets, and that any question of relaxing restrictions for relaxing a large section of society with acquired immunity was out of the question. For the avoidance of doubt, and as stated earlier, 'herd immunity' (i.e., the notion that the spread of Covid-19 would be contained once a large proportion of society had developed immunity) was not the Government's policy. It was never the case that Government simply intended to let the virus run its course – or to sacrifice any section of society – in order to achieve immunity and bring an end to the virus' spread. All of the steps taken during the first lockdown were aimed at limiting the spread and impact of the virus, rather than simply letting it take hold. The data shown in the serology report confirmed once more that our decision not to follow the 'herd immunity' strategy that some groups were calling for was the right one.

371. The results of the serology survey only served to emphasise the necessity of developing a Covid-19 vaccine to give people the necessary antibodies, protect society and ease restrictions. It was my view that we needed to suppress the virus, keep the R number below 1, and that this would justify a relaxation of the strict lockdown, recognising that we needed to be vigilant to rising case numbers.

372. I discussed this view with the CMO the following morning, who had reached the same conclusions as me. He also highlighted that the winter and influenza season would have an impact on spread, NHS capacity and death rates. He said that that additional pressure suggested that Covid-19 was likely to be circulating in the UK and posing restrictions or pressures on society until at least Spring 2021.

373. On 14 April, the First Secretary of State, the Chancellor, the Chancellor of the Duchy of Lancaster and I met to discuss our joint recommendation to the PM on the continuation of the restrictions, which had only been implemented for 3 weeks and therefore formally needed reviewing. I presented my view that the R number needed to remain below 1 until we had a vaccine, and that this should inform our approach to the relaxing or tightening of social restrictions both at that stage and going forward. After debating the issue, we made the decision to recommend that the formal lockdown continue for another 3 weeks, and to be re-assessed again at that time, by reference to five tests, which the Deputy Prime Minister announced:

> 1 – The NHS is able to provide enough critical care throughout the UK;
> 2 – A sustained and consistent fall in the daily death rate;
> 3 – Infection rates are falling to manageable levels;
> 4 – Testing capacity and PPE stocks are sufficient to meet future demand; and
> 5 – Changes to restrictions would not risk a second peak of infections that would overwhelm the NHS.

I regarded these tests as a useful framework for considering the factors around the decision.

374. Following consideration in detail by those Ministers closest to the matter, the Deputy Prime Minister called a COBR meeting on 16 April where it was decided that the lockdown measures should be extended for a further three week period (MH2/205 to MH2/207 - INQ000083788; INQ000083790; INQ000083827). This decision was primarily driven by the advice of SAGE that although the R number had decreased, there was a

risk that relaxing measures would lead to the R number rising above 1, and a corresponding rapid rise in Covid-19 cases.

375. We were, of course, aware of the significant impacts of the lockdown, and it was very much hoped that the lockdown could be restricted to what was necessary. There was a recognition that lifting the restrictions too early, and causing a dangerous spike, could result in a further lockdown period and could do more damage in the long term.

376. Professor Whitty gave a cautionary warning in the daily press conference on 22 April, when he advised that the chances of a vaccine within the next year were incredibly small, and that it was wholly unrealistic to expect life to return to normal any time soon, with social distancing restrictions likely to be in place for the rest of the year. Similarly, Ursula von der Leyen (President of the European Commission), had announced on 12 April that vulnerable individuals may need to isolate into 2021 or until a vaccine had been produced.

377. On 17 April the Vaccine Taskforce was established, hosted by BEIS and reporting to the Prime Minister and a Ministerial Board composed of the BEIS Secretary, the Chief Secretary to the Treasury, and me. Its aims were: securing access for the UK population to a Covid-19 vaccine, supporting international access to vaccines, and leaving the legacy of a permanent UK vaccine and biotherapeutic capability, given the hard work that had gone into building these capabilities from scratch in response to the pandemic.

378. I became aware that Oxford's vaccine research required additional funding of approximately £22m, and that a funding request of a similar scale had been made by Imperial College in relation to its own vaccine research, both of which I had no hesitation in prioritising (MH2/208 to MH2/210 **INQ000233799** **INQ000233800** **INQ000233801** My view was that these sums were tiny compared to the lives a vaccine could save and the economic cost of lockdown that could be avoided, and even for the smallest chance of a vaccine working such sums should be paid. I instructed the required funds to be paid. Thankfully, Oxford University themselves had been footing the bill until that point, and the first human trials of the Oxford vaccine began on 23 April, preceded by the welcome news on 22 April that the vaccine was effective on monkeys and had demonstrate a high level of single-dose efficacy and therefore increased the chances of the vaccine successfully working in humans. This episode demonstrates the need, in an emergency, sometimes to use taxpayers' resources in a faster way than normal, on a lower evidential base. With hindsight this expenditure was some of the best value for money in history.

379. If and when a vaccine was created it would then need to be produced at a large scale to guarantee its delivery not only to UK citizens, but to other countries around the world. Along with Oxford University, we were therefore taking steps to identify an appropriate manufacturing partner in advance to prevent delays to a vaccine roll out. On 22 April I received a submission recommending that the Government liaise with Merck, an American pharmaceutical company that Oxford University had a long-standing arrangement with for the manufacture and commercialisation of Oxford's drug innovations (MH2/211 **INQ000233803**).

380. I was concerned to read that a partnership with Merck would result in the UK only being able to "expect" access rights to the first batches of Covid-19 vaccines produced: this struck me as inadequate in circumstances where the British taxpayers were helping to fund the vaccine's development, it was legitimate to have an agreement in place that ensured that the UK was given priority access to vaccines, and thereafter global access, rather than risking vaccines being sold to the highest bidder or otherwise restricted to domestic use elsewhere. I was keen to ensure as much onshore UK production as possible. I was very concerned about a scramble for vaccines once one was approved, and particularly concerned that the US might used their domestic legislation to require access to any vaccine produced. I therefore contacted Sir John Bell at Oxford University, and told him that I could not agree to the Merck agreement. Respecting the fact this was technically an Oxford University contract, not a Government contract, I asked that he look at alternative manufacturers. He readily agreed: (MH2/212 **INQ000233792**).

381. My stipulation was that we needed legal agreement to exclusive access to the first 100 million doses. Subsequent discussions between Oxford University, the CSA and AstraZeneca resulted in the latter agreeing to manufacture the vaccine on the basis that the UK would be given exclusive access to the first vaccines produced onshore, and that AstraZeneca would collaborate with other countries to ensure production of the vaccine at cost, rather than for profit. Sir John Bell, Sir Patrick Vallance and Sir Pascal Soriot deserve significant praise for acting so quickly. Although AstraZeneca had originally proposed access to vaccines for 30 million people, I insisted that it should be for 100 doses to cover all of the UK's population, which AstraZeneca readily agreed to.

382. The vaccine programme is yet further evidence of the learning point from the Covid-19 pandemic to engage with the private sector as well as academia as a matter of priority in a public health emergency of the scale of Covid-19; there are many areas in which the

public sector has superior expertise and skill, but there are equally areas where the skills and daily experience of those in the private sector or academia can achieve more - especially on efficiently reaching scale. A health or other public emergency requires recognition of the strengths and weaknesses of all sectors, and the appropriate co-ordination.

*Getting Past the Peak and the Decision to Ease Restrictions Using the Roadmap*

383. By the end of April, there was a growing consensus amongst officials and the media that we may have been past the peak: admissions to hospitals and ICU on account of Covid-19 were declining consistently across the country, and survival rates for ventilated patients had improved as compared to the start of pandemic. Although we did not want to encourage complacency - which in turn could result in the R number rising above 1 again – the CMO and CSA advised that it was appropriate to inform the public that the UK appeared to be past the virus' peak in the daily press briefing on 30 April 2020.

384. This position was not considered to be inconsistent with the subsequent coverage that claimed on 5 May that the UK's death toll had become the worst in Europe. First, admissions and deaths were declining consistently, notwithstanding the total numbers recorded. Second, it was widely acknowledged that those figures could not be relied upon for comparative purposes, given the differing approaches taken by different countries; in particular, the UK's daily reporting took into account the death of any individual who had received a positive Covid-19 test (without assessing whether or not Covid-19 played a causative role in their death), and captured deaths outside of the hospital setting. Discussing this question was incredibly sensitive. I was acutely aware that every death was awful, and left behind grieving relatives. Yet at the same time, in the UK we took an approach of trying to be as transparent as possible about the number of Covid-19 deaths. Subsequent analysis has shown that in fact the UK did not have the worst death toll in Europe, and had a lower death toll per 100,000 population than many comparators including Italy and Germany, and that within the UK, the death toll was lowest in England as a proportion of population (MH2/01 **INQ000234333**.

385. The approach I took to removing restrictions was that we should try to ensure that, as we removed restrictions, we got the case rate down as low as possible, and tried to keep R below 1. I was acutely aware that if R went above 1, then eventually we would have another peak, and inevitably another lockdown. We were advised again by the CMO of the seasonality of the virus due to people spending more time indoors in the winter

months. Throughout May, June and July the CMO warned that the winter would be more difficult. Much later on, the Prime Minister's Chief Adviser asked us to focus on the winter. I took this as potentially helpful as we would undoubtedly need funding, for example to expand all A&E centres in the country to make them more Covid-19-secure, and his help in persuading the Treasury to spend money on the NHS would be helpful (MH2/213 – INQ000102034).

386. In light of the improvements in the daily data, including the fact that SAGE had advised on 5 May that the R number was somewhere between 0.5 and 0.9, at a meeting of senior ministers on 6 May, and then at a Cabinet meeting on 7 May 2020, discussions were held regarding the UK's steps out of lockdown, which the Cabinet Office had been reviewing. However, SAGE had also advised that the lockdown measures remain in place as there was sufficient scope and risk for the R number to swiftly rise above 1, but that this advice would be revisited following additional evidence from the ONS, which was due to be received late on 7 May 2020.

387. The legal extension of the lockdown measures for restrictions was due to remain in place until 7 May 2020. I was therefore required to make a decision on revoking or extending the restrictions in advance of the new data and advice arriving from SAGE in the days that followed. I agreed that, on the basis of the scientific evidence and advice as it stood, the restrictions remained necessary and I agreed to extend them for an additional three weeks; however, in making that decision I was very much aware that if the updated advice from SAGE was more optimistic and the Cabinet's considered position was that restrictions should be relaxed, there would be no hesitation in making these changes earlier than the three week review timeline, and that this would be my legal duty if my opinion were that the restrictions were no longer necessary. I considered that this was likely, and it was on that basis that I felt able to agree to further restrictions for a short period of time while an appropriate route out of lockdown was agreed on (MH2/214 and MH2/215 - INQ000109348; INQ000109349).

388. I presented this view to the Cabinet, along with my view that since R was below 1, and with Covid-19 rates falling, it appeared that the UK had passed the peak and that Government should therefore consider relaying its approach to easing restrictions to the general public, and that this was to be decided in light of the data due from ONS and SAGE in the days to come (MH2/216 - INQ000106402).

389. Despite there being agreement on that broad proposition, there was a debate among the Cabinet as to the degree of relaxation that should take place in the near future: my view was that the overriding priority was keeping the R number below 1, whereas others wanted to bring the country out of lockdown faster. SAGE had given advice that any steps to take us out of lockdown should be small and incremental so that there could be a proper assessment of the impact on the R number and to prevent a second wave or further lockdown. I agreed with this advice.

390. The Prime Minister decided to propose to Cabinet a move out of lockdown which was cautious and phased, corresponding to the following 'steps' (which did not have fixed dates and would depend on the emerging data at any given time):

> 1 – Unlimited outdoor exercise and a return to work for those who cannot work from home;
> 2 – Phased reopening of shops and the return of primary school pupils in stages, which would take place on 1 June at the earliest;
> 3 - Reopening of the hospitality industry and other public places, which would be July at the earliest and would be dependent on social distancing rules being adhered to in the relevant settings, on the expansion of PPE stocks, and on the success of the track and trace app.

391. Following that meeting, the PM asked me to telephone other members of the Cabinet to identify whether there was any dissent to those proposed steps, while he engaged with the devolved administrations, ahead of the Cabinet meeting on Sunday 10 May, following which an announcement would be made to the public: (MH2/217 - **INQ000233806**. The whole Cabinet was in agreement with the proposed roadmap, which was announced to the public that evening, with the first stage of the roadmap to be given legal effect as of 13 May.

392. This method of decision making was entirely normal. The Prime Minister and Secretaries of State with a direct responsibility for the decision would first be briefed on the facts and options from the civil service, including the clinical, operational, and legal advice. Then the core decision making group would meet, and collectively receive a factual briefing and recommended options. This group changed at different times, but usually consisted of the Prime Minister, Chancellor of the Exchequer, the Chancellor of the Duchy of Lancaster, the Deputy Prime Minister, and me, accompanied by the CMO,

CSA, Cabinet Secretary and various other officials, almost always at an in person meeting in the Cabinet Room.

393. If the decision pertained specifically to one area of policy, for example on schools, then the relevant Secretary of State would typically also be invited. That groups would take an in-principle decision, and if it was highly significant, a Cabinet meeting would be called to ensure the Cabinet were informed and any dissenting views could be taken into consideration before the Prime Minister made a formal decision in Cabinet. If the decision also needed the agreement of the Devolved Authorities, a COBR or meeting of First Ministers chaired by CDL would be called to reach agreement – although as the pandemic progressed this part of the process became more difficult as the First Minister of Scotland tended to confuse messaging by choosing presentational differences, or differences of timing, despite almost entirely following similar policies, based on agreed UK-wide clinical advice. This was unfortunate, and needs addressing before the next pandemic.

*Progressing to Stage 2 of the Roadmap*

394. At this point, a significant public debate erupted about the need for any further restrictions. The argument was made that a significant proportion of the population must have by now been infected, and therefore it was safe to lift all measures. Some academics argued publicly that 50% of the public would have been exposed to the virus. As stated earlier, I had been briefed the unverified results of a serology survey that only 5% of the population had antibodies, (save for in London where c.15% of residents had antibodies). As this data was still being verified we were unable to announce this in response to the calls to lift all measures.

395. The results of this serology survey were formalised and confirmed on 28 May (the finalised national figure being 6.78% of the population with immunity): (MH2/188 - **INQ000233813**. This was very bad news. My conclusion was that there was no prospect, on this basis, of allowing R above 1, because the inevitable result would be another spike and therefore another lockdown. This underpinned my caution around opening up too fast. It was clear that we needed to keep R below one until a vaccine could be widely administered.

396. I asked the Department's chief technology advisor to meet with a data analytics company that with an idea to use anonymised mobile location data to operate a larger

scale tracing app for those who had tested positive for Covid-19. Using this idea, we would be able to locate those who had been tested positive for Covid-19 and inform other individuals who had been in close proximity and advise them to isolate, slowing the spread of the virus.

397. The first deep dive on Track and Trace was held by the C-19 Strategy Committee on 17 April 2020, where I set out the possibility of an app. I believed we could use the app as a critical element of the strategy to keep the R number low and to prevent a second national lockdown. It was agreed that development of the app and its surrounding systems should proceed at speed (MH2/218 - INQ000088664).

398. As had been discussed at the meeting on 17 April 2020, a pilot of the app on the Isle of Wight was announced on 4 May 2020, with approximately 18,000 people having been employed to contact those who might be carrying the virus and giving them instructions to self-isolate. We chose the Isle of Wight as a good place to run the trial, as its self-contained nature would allow us to easily monitor the results. Baroness Dido Harding was appointed as executive chair of Test and Trace to lead these efforts as of 7 May. As a condition of her appointment, No10 officials insisted that Dido formally reported directly to the PM, but in practice she reported to me as part of the Department's senior team, and she and I necessarily liaised extensively given the centrality of the Department's work to the Test and Trace programme. At this point I was then able to disband my daily testing meeting, and shift to a weekly meeting with Dido to track progress.

399. An additional deep dive into the test and trace programme took place on 7 May to consider international comparators and the lessons to be learned from their experiences (MH2/219 - INQ000088574). This was discussed in a C19 Strategy Meeting on 8 May (MH2/220 and MH2/221 - INQ000088578; INQ000088651).

400. The results of the Isle of Wight pilot were presented to the C-19 Strategy Committee on 12 May. The pilot had gone well but demonstrated the further areas of work needed to ensure that the testing platform and its logistical network were not overwhelmed. Simultaneously, testing capacity had continued to expand and was expected to reach 200,000 tests by the end of May, which it did: (MH2/222 - INQ000088653).

401. As of 18 May, we had expanded testing capacity to the extent that, following clinical prioritisation, all people in the UK with symptoms were able to access a test, which was

a significant milestone and was an important foundation for the roll out of test and trace. Prioritisation of access to tests followed clinical advice.

402. We all recognised that the test and trace programme that the Department had developed would be pivotal to the further easing of restrictions, as it would allow us to reduce national restrictions and have in place a responsive system of localised restrictions in light of data as to outbreaks, given the virus' short doubling time and the potential for exponential spread.

403. On 27 May, a senior meeting at No. 10 was held ahead of the announcement about the Track and Trace app launching on 1 June. For reasons I still do not understand, I was not invited to that meeting, which was ridiculous given that the functioning of the app and the performance of the tracing programme was inherently intertwined with the Department's work, and I was accountable for the programme. After the meeting, Dido updated me that the decision had been taken to trial the obligation to self-isolate once contacted by Track and Trace as a "civic duty", and that if people routinely ignored the request it would be made mandatory in law.

404. The Track and Trace app was launched on 28 May 2020, which was the same day that the PM announced that the UK would be moving into Step 2 of the roadmap as of 1 June. Again, notwithstanding and acknowledging that the app was not perfect and took some time to become fully operational, the Department had built the app and the supporting technological systems from the ground up: the NHS had gone from lagging in its use of technology, to pioneering an important app that provided data and advice in real time.

## 1 JUNE 2020 – 31 AUGUST 2020: FOLLOWING THE ROADMAP OUT OF LOCKDOWN

405. By the end of May, the number of cases, Covid-19 patients in hospital, and deaths from Covid-19 were all falling. It was clear R was below 1, and that we could therefore remove some restrictions. My goal was to remove as many restrictions as possible subject to R remaining below 1, for the by now obvious reason that if R went above 1 we would have to reimpose restrictions.

406. On 27 May 2020, I was provided a submission which invited me to consider further easing of restrictions as part of the move to Step 2 in 'Our Plan to Rebuild' (MH2/223 and MH2/224 - INQ000050709; INQ000050710). I was broadly content with the

relaxation to various measures proposed, which included removing the 'stay at home' requirement and permitting gatherings outdoors of up to two households or six people from any household, on the basis of the reduced transmission rate of the virus and the assessment that the Government's five tests in 'Our Plan to Rebuild' could be met (MH2/225 - INQ000106446).

407. On 30 May 2020, I was sent a further submission inviting me to confirm that I was content to make amendments to the Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 to give effect to the relaxation of the measures proposed, which I was (MH2/226 to MH2/229 **INQ000233819**; **INQ000233821**; **INQ000233820**; INQ000106456).

408. On 4 June 2020, I was briefed for, and attended, a COVID-S meeting where we considered and discussed the strategy for coming out of lockdown (MH2/230 and MH2/231 **INQ000233828**; **INQ000233829**) The Cabinet Secretary presented a paper on the strategy, which set out a cautious approach which he characterised as "steady as she goes" (MH2/232 **INQ000233834**). The Committee welcomed and agreed that approach, although the Prime Minister made clear that there was also a need to focus on promoting the economic bounce back. We agreed that the Committee would consider whether the next steps, such as opening non-essential retail, could be taken on 15 June 2020 (MH2/233 - INQ000088234).

409. On 5 June 2020, I was briefed for, and attended, a COVID-O meeting where we considered whether we could open non-essential retail on 15 June 2020 (MH2/234 to MH2/236 **INQ000233830**; **INQ000233832**; **INQ000233833**). The Cabinet Office presented a paper for discussion on compliance and enforcement with Covid-19 Secure guidance for the proposed re-opening, which included the option of making the guidance law and introducing tougher sanctions and offences for non-compliance (MH2/237 - **INQ000233831**). It was agreed that what was required was clearer communication and more muscular guidance on how to achieve a Covid-19 secure environment, alongside strengthened enforcement, rather than a change in the law (MH2/238 - INQ000088792).

410. On 6 June 2020, the Prime Minister and I discussed by WhatsApp what restrictions could be eased on 15 June 2020 (MH2/239 - INQ000129357). He was of the view that we could open up non-essential shops and permit some outdoor hospitality. James Slack and Lee Cain had advised him that it was "too far ahead of public opinion". I agreed it was too soon given that, at that time, the R number was just below 1. I told the PM that

"if we go ahead with non-essential retail on 15 June, we are sailing very close to the wind. My view is that the public are right and we need to hold our nerve." I made this case in a number of fora, including official decision making meetings, but the Prime Minister decided on balance to take the step towards opening.

411. On 10 June 2020, I was sent a submission on the policy options on relaxing shielding following the provision of new clinical advice from the then DCMO, Dr Jenny Harries (MH2/240 - INQ000050886). As the guidance on shielding was expiring at the end of June 2020, and having committed at the COVID-O on 3 June 2020 to provide an update in the week of 15 June 2020 (MH2/241 **INQ000233835**, the submission noted the need to agree a future policy for the cohort of by now 2.2m Clinically Extremely Vulnerable ("CEV") people (MH2/242 and MH2/243 - INQ000050887; INQ000050888). On the basis of the submission and the continued reduction in infection rates, I agreed that those shielding could be advised from 22 June 2020 that they could meet outdoors in groups of up to six people, while maintaining strict social distancing, and from 13 July 2020 shielding measures should be fully eased, in line with the guidance to the clinically vulnerable cohort (MH2/244 - INQ000106470).

412. On 11 June 2020, I was sent a submission with proposals to further relax restrictions in line with Step 2 of the Roadmap (MH2/245 - INQ000109437). It recommended, inter alia, from 13 June 2020, that (i) single occupancy households be able to form a support bubble with another household, which I insisted also included single parents with children under 18, who had been hit especially hard by lockdown, (ii) people be able to visit those in hospitals, hospices and care homes, and (iii) individual prayer could take place in places of worship (MH2/246 - INQ000109438). From 15 June 2020, it recommended the opening up of certain non-essential retail and outdoor attractions. Save for opening attractions which offered visitors physical contact, I approved the recommendations (MH2/247 **INQ000233837**. The Health Protection (Coronavirus Restrictions) (England) (Amendment) (No 4) Regulations 2020 gave effect to those amendments on 13 June and 15 June respectively.

413. I was sent a further submission on 11 June 2020 in relation to the mandatory wearing of face coverings on public transport (MH2/248 and MH2/249 - INQ000106472; INQ000106477). The scientific advice that the Government had received at the start of the pandemic was that there was not conclusive evidence that face coverings offered protection from Covid-19. This view shifted back and forward throughout April, and ultimately on 7 May 2020 a C-19 Strategy meeting determined that face coverings should

form part of the roadmap out of lockdown. It recommended mandating face coverings from 15 June 2020 in line with the Government's earlier commitment to do so (MH2/250 - INQ000106461). The measure was to support the expected increase in travel as lockdown eased and more people returned to work. That reflected SAGE's view that using face coverings in enclosed spaces, where social distancing was not possible, could provide some additional protection to fellow passengers to help avoid the spread of the virus. I approved the recommendation (MH2/251 - INQ000106479). The Health Protection (Coronavirus, Wearing of Face Coverings on Public Transport) (England) Regulations 2020 came into force on 15 June 2020.

414. On 12 June 2020, I was sent an updated submission on the future support packages that would be required as the shielding policy was relaxed (MH2/252 - INQ000106480). Whilst MHCLG had responsibility for the majority of the support package, the Department had responsibility for the medicine delivery service and for the NHS Volunteer Responders programme and the '9 Actions' that the NHS was taking as part of the wider changes to support clinically vulnerable people. In respect of medicine delivery service, the submission recommended continuing the service as it was for the next few months to see whether or not the requirement for pharmacies to deliver medicine increased or reduced (MH2/253 - INQ000106481). That recommendation was subsequently revised to suggest that we extend the service to the end of July only and evaluate at that point. I agreed with that subsequent recommendation (MH2/254 and MH2/255 **INQ000233842** INQ000109449).

*Progressing to Stage 3 of the Roadmap*

415. Following a meeting attended by Departmental leaders with the CMO on 12 June 2020 (MH2/256 to MH2/259 **INQ000233838** **INQ000233841** **INQ000233839** **INQ000233840** I decided that the Department should put in place plans for the reasonable worst case scenario of a second wave in winter. This was something that the CMO and I had discussed earlier in the year, but I was increasingly concerned that the Prime Minister wanted to move too fast on opening up, and that as a result R would go above 1. I repeatedly made the argument that until a vaccine arrived, there was no trade-off between economic considerations and health, because if R was above 1 that would inevitably lead to future lockdowns until a vaccine arrived. I found it baffling that this obvious logic had not been accepted across Government, and I was concerned that many parts of Government did not accept that the vaccine trials were progressing well and a vaccine looked promising.

416. On 14 June 2020, I spoke with the Prime Minister to discuss the current data. The Prime Minister expressed his concern that 1,500 people were still testing positive every day. I shared that concern with the Cabinet Secretary (MH2/260 - INQ000129376). I explained to the Cabinet Secretary that the Prime Minister would need to focus on preparation for winter now. To my mind, at this point, based on advice from and discussions with the CMO, there were three significant future events which presented obvious dangers and for which we needed to prepare: (i) the planned further relaxation of restrictions on 4 July, (ii) the start of the new school year in early September, and (iii) winter, when people spend more time together in confined spaces.

417. On 19 June 2020, I was briefed for, and attended, a COVID-O at which we discussed how a broad range of closed sectors and businesses could safely re-open in line with step 3 of the Roadmap (MH2/261 to MH2/263 - INQ000106487; INQ000106488; INQ000106489). The briefing outlined the progress being made on developing Covid-19 Secure guidance for businesses and strategies for enforcement to ensure compliance with the guidance so as to reduce transmission. At the COVID-O, we decided that the current regulations and enforcement were working, with businesses demonstrating a high level of compliance with guidance, such that the committee should recommend that the existing regime stay in place. It was also decided that MHCLG should work with LAs and HSE to monitor compliance with Covid-19 Secure guidance (MH2/264 and MH2/265 - INQ000088795; INQ000088849).

418. On 22 June 2020, I was briefed for, and attended, a COVID-S which was to consider whether the five tests that had been set in 'Our Plan to Rebuild' were being met to a degree which warranted a move to step 3 of the Roadmap by 4 July 2020; and, if so, what sectors could reopen at that point and what social distancing restrictions would remain in place (MH2/266 and MH2/267 - INQ000106492; INQ000106493). The proposed changes in broad terms were: (i) reduction of social distancing guidance from two metres to one metre (discussed below), (ii) permitting some social gatherings, (iii) re-opening sectors, including hospitality, leisure and tourism and sport, and (iv) reopening certain public and community services. The briefing set out that the changes proposed were at the high end of manageable risk (but not recklessly so) and that the mitigations proposed and enforcements would be key.

419. At the COVID-S, the Cabinet Secretary presented a paper entitled 'Covid-19 Roadmap: Step 3' which detailed the proposed set of measures (MH2/268 -

INQ000088239). I was extremely nervous about this step, as was the CMO, who expressed significant concern, and set out that it would be wrong to imply that we could be free of restrictions during the winter. Following discussion, the Prime Minister decided that the five tests the Government had set were met and that the proposed measures should be implemented (MH2/269 - INQ000088242). We acknowledged that the package of measures was bold and ambitious. It was also recognised that it would be vital to step up all efforts on the Track and Trace system, combined with a credible mechanism for a localised lockdown.

420. Later that day, I was sent a submission in respect of the amendments needed to the Health Protection (Coronavirus, Restrictions) (England) Regulations to give effect to the proposed changes, which had been agreed in principle at the COVID-S (MH2/270 to MH2/272 - INQ000106494; INQ000106496; INQ000106497). I confirmed that I was content in principle to make the amendments to the regulations outlined in the submission and for the social distancing guidance (which fell outside the regulations) to be implemented alongside the other changes on (but not before) 4 July 2020 (MH2/273 **INQ000233855**. The Prime Minister announced the measures on 23 June 2020 (MH2/274 - INQ000106501).

421. We introduced a gathering limit of 30 people (MH2/275 to MH2/277 - INQ000106515; INQ000106514; INQ000106516). It is always a judgement as to where to set such a numerical limit. With hindsight this package of measures was too loose, and case numbers began to rise from mid July.

422. Ahead of the planned relaxation of measures on 4 July 2020, I also sought advice on 29 June 2020 about the potential benefits of mandating the wearing of face masks in other indoor settings such as shops and supermarket (to expand on the requirement to wear one on public transport and in NHS settings) (MH2/278 - INQ000106511). I was provided a submission on 1 July 2020 which noted evidence that there may be some benefit in wearing a face covering in enclosed crowded spaces, although the science remained mixed (MH2/279 and MH2/280 - INQ000106517; INQ000106518).

423. My preferred approach was not to mandate face coverings, but to support their use with stronger guidance and communications (MH2/281 **INQ000233876**. I put the options to the Prime Minister on 7 July 2020 (MH2/282 **INQ000233877**. The Prime Minister's decision was that they should be made mandatory but only in shops and supermarkets from 24 July 2020 (MH2/283 **INQ000233885**. The boundary of what is defined as a "shop"

as opposed to a "café", and other such boundaries, presented very significant communication challenges for almost all future rule changes. For the future it would be extremely helpful to consider which social distancing measures might be used, that ensure boundary issues are well understood in advance.

424. Overall, the first lockdown protected the NHS and saved lives. There was no alternative to lockdown other than to allow the whole population to come into contact with Covid-19 naturally. The idea we could use Test and Trace alone to suppress the virus was wishful thinking. Given only 6.78% of the population had developed antibodies, letting the virus get out of control would have been unconscionable. I estimated as follows: since at the point this survey was taken, over 40,000 people had died, then even without taking into account the lag from cases to deaths, for that 6.87% to reach 100%, the number of people who would die would be above 500,000 (as 40,000 / 0.0678 ≈ 590,000). Depressingly, this confirmed and corroborated the reasonable worst case scenarios from March.

425. Had the first lockdown been introduced earlier, additional lives would have been saved. It is impossible to know exactly how fast the virus was doubling before measures were brought in. If estimates of doubling every six days are correct, then locking down a week earlier would have cut the first peak in half and saved around 20,000 lives. Locking down two weeks earlier would have cut the peak to a quarter and saved over 30,000 lives. This simple but immensely powerful fact is central to the need for a future doctrine of pandemic response, which I set out at paragraphs 66 of my statement for Module 1, and which I have updated below following considered feedback:

> '66. In the face of a potential pandemic, we should develop a doctrine along the following lines:
>
> a. Assess as early as possible the impact of the population gaining immunity to a new disease without suppressing the virus,
> b. If the likely impact in terms of morbidity and mortality is less bad than the cost of measures needed to suppress the virus, then the 'Contain, Delay, Mitigate, Research' framework is appropriate.
> c. If, however, the impact of a disease in terms of morbidity and mortality is greater than the cost of measures to suppress it, then we should act to keep the R number below 1 as soon as possible to keep people safe until a vaccine is developed.

d. Low cost measures to suppress the virus, such as test and trace, should be implemented before high cost measures, such as lockdowns. What measures are needed will not be immediately clear.

d. In practice, if measures to suppress the virus are needed, they should be sooner, stronger, and wider than anticipated. That is the way to save most lives and keep lockdown in place for the shortest period possible. As we discovered in autumn 2020, without a vaccine there is no trade-off between the two.

e. Develop a vaccine and other countermeasures urgently to ensure damaging social distancing provisions are in place for as short a time as possible.

67. In practice this means we must be ready to implement social distancing measures, including lockdowns, if the impact of the disease, unchecked, is set to be greater than the negative impact of such measures. Just as a lockdown will not always be the right response, ruling out lockdowns in all circumstances is completely irresponsible.'

426. As to the release from lockdown, this was always going to be a fine judgement, of allowing as much freedom as possible while keeping R below 1. With hindsight, steps 1 and 2 were clearly justifiable. Step 3 went too far, as cases began rising again shortly afterwards. A better policy would have been to move to a step roughly half way between Step 2 and Step 3, accepted that this was as far as it was possible to go while keeping R below or at 1, and kept those restrictions in place until the vaccine came good. Even this may not have been possible given the return of schools in September 2023 and the onset of winter, with more time spent indoors.

427. By this point I had a high degree of confidence that a vaccine would come good. On 22 April 2020, John Bell had messaged me to say the single dose efficacy of the vaccine on monkeys was amazing (MH2/284 **INQ000233802**). The Oxford vaccine was just one of the numerous vaccines that we were buying in large scale from across the world. I did not expect them all to work – and many either failed trials or could not be manufactured at scale. But by this point I did expect at least one of them to come good Unfortunately this view, despite being fully founded in the advice from Sir John Bell at Oxford University, did not prevail across Whitehall. This had two consequences. First, for those who did not accept that a vaccine was highly likely to come off, the cost of lockdown appeared permanent, not temporary, and therefore harder to justify. Second, those who did not

believe a vaccine would happen focussed undue attention on using mass testing to control the virus. I supported the goal of mass testing to help reduce R, and supported the "Operation Moonshot" proposal (discussed below), but never expected it to be able to replace all lockdown measures, as some hoped for. Test and Trace could only ever be one string in the bow. Unfortunately, expectations for Test and Trace were set far too high, and so its significant contribution to saving lives was seen by commentators as a disappointment, when in fact building such a huge and effective Testing and Tracing capability at such incredible pace was a huge achievement, kept R lower than it otherwise would have been, reduced the need for other lockdown measures, allowed the enforcement of local action in areas of particularly high prevalence, and saved many lives.

*Review of the Two-Metre Rule*

428. On 4 July 2020, the Prime Minister announced that the two-metre social distancing guidance would be changed from "where possible, you should maintain 2m between people" to say that two metres is acceptable or one metre with risk mitigation where two metres is not practically or economically viable.

429. The issue of whether the distance should be reduced had been raised for discussion at the COVID-S on 4 June 2020 because other jurisdictions were operating with shorter distance in their guidance (MH2/233 - INQ000088234). The Prime Minister announced a review of the rule on 14 June 2020 to be chaired by the Cabinet Secretary with a core review panel of the CMO, CSA and HMT's Chief Economist (MH2/285 - INQ000069646).

430. On 15 June 2020, I had a meeting with the CMO and various Departmental officials about the rule (MH2/286 **INQ000233843**. The CMO produced some draft principles for consideration for our meeting on 15 June 2020 (MH2/287 and MH2/288 **INQ000233845** **INQ000233844**).

431. At the COVID-S on 22 June 2020, the Cabinet Secretary presented the findings of the review within his paper entitled 'Covid-19 Roadmap: Step 3', which concluded that the guidance should change to: two metres is acceptable or one metre with risk mitigation where two metres is not practically or economically viable (MH2/268 - INQ000088239). I was cautious about any such change, and made my view clear. However, my view did not prevail. Fundamentally, the issue was not any of the particular individual loosening of restrictions – the problem was that the cumulative relaxations risked R rising above 1,

which is exactly what happened. My strong view was that the idea of a trade-off between economic and health considerations did not exist, and I was again shocked that others who I respected did not understand the dynamic consequences of the exponential growth of a virus with R above 1. Nonetheless, it was decided at the meeting that the two-metre rule change should be implemented, which led to an announcement of the proposed rule-change on 26 June 2020 (MH2/289 - INQ000086727) and the Prime Minister's announcement on 4 July 2020 (MH2/269 - INQ000088242).

*Eat Out to Help Out Scheme*

432. On 8 July 2020, the Chancellor announced the new 'Eat Out to Help Out' scheme. I have no recollection of knowing about the scheme in advance, and despite my serious reservations that R would go above 1, out of respect for the Chancellor and because I regard Government as a team effort, I abided by collective responsibility in supporting it in public.

*Leicester, Local Lockdowns and the Role of Local Government*

433. In early June 2020, thanks to our significantly expanded testing capacity, we had better local understanding of where cases were. One of the discoveries from this new data, increasingly supported by the vital ONS survey, was that it became clear that case numbers remained stubbornly high in some very specific areas. I discussed this problem in the Department, with the CMO, Baroness Harding and others.

434. On 4 June 2020, I attended a COVID-O to discuss local lockdowns (MH2/290 - INQ000088798). Dido Harding presented a paper which focused on three core areas of the Government's response to local outbreaks: (i) the data required to identify outbreaks, (ii) the resources required to enable containment of outbreaks, and (iii) the decision making between national and local levels (MH2/291 - INQ000088718). It recommended that there be a principle of locally owned and led decision making for local Covid-19 prevention actions within a clear national framework and oversight, on the basis that an overly centralised model would not be fast enough to deal with outbreaks in local areas. While there was some agreement that a wholly centralised model was not the best way forward, it was agreed that the Committee should reconvene to consider a more detailed action plan and playbook for local outbreaks (MH2/290 - INQ000088798).

435. On 8 June 2020, I met with PHE in order for them to present me with a full update on local data and the exact location of hotspots. I was particularly concerned about Leicester where there had been a marked rise in cases. The CMO had advised me that it was the type of location where difficulties may arise, due in part to deprived areas and casual employment in production. PHE were not in a position to provide an adequate update. I asked them to return with a proper analysis a week later.

436. Similar to the meeting I had had with PHE on 8 June 2020, I was informed by the Cabinet Secretary on 11 June 2020 that the Cabinet Office had had to cancel a COVID-S meeting with PHE, NHS England and NHS Test and Trace that day because the data that they had produced was inadequate to allow for useful discussion (MH2/292 - INQ000129364). I suggested to the Cabinet Secretary that going forward all data questions should be directed to the Joint Biosecurity Centre ("JBC"), which we had set up for this purpose in May 2020 and which had reached initial operating capability on 1 June, although still not at full operating capability (MH2/292A **INQ000233836**. In the months to June we had worked incredibly hard to improve the data available for decision making. The JBC was an important step forward in this data gathering and analysis, as was the NHS's decision to bring in Palantir, a private company, to make sense of its data for decision making purposes. All this work led to extremely impressive data dashboards which gradually became available from the summer of 2020 onwards.

437. The JBC was established to provide a UK-wide analytical function to deliver insights across the UK by providing evidence-based, objective analysis, assessment and advice to inform local and national decision-making in response to Covid-19 outbreaks, including local outbreak management (MH2/293 to MH2/297 **INQ000233814** **INQ000233816** **INQ000233817** **INQ000233815** **INQ000233818**. I strongly supported its establishment, which complemented existing work in PHE and the Department.

438. I attended a COVID-O on 11 June 2020 to discuss the JBC and local lockdowns (MH2/298 - INQ000088793). A number of papers were presented and discussed at this meeting: (i) the Contain Framework, which set out a framework to support decision makers to develop and deliver plans to control local outbreaks by clarifying decision-making responsibilities, particularly between local and central Government (MH2/299 - INQ000088722); (ii) an update paper on the JBC, which provided an overview of the JBC's data sources and its data operating model (MH2/300 - INQ000088727); and, (iii) an NHS Test and Trace Service – 'Contain' Ambition and Operating Model (MH2/301 - INQ000088728). The Committee decided that further clarity was needed on the balance

of powers between local and central Government and on available data sources and integration (MH2/302 - INQ000088734).

439. To manage the need for local lockdowns, on the advice of the Permanent Secretary, we introduced a new Gold, Silver, Bronze Local Action Committee structure for (i) reviewing the information and analysis provided by the JBC about local outbreaks, (ii) providing oversight of the local containment aspects of the Test and Trace programme, and (iii) escalating any issues requiring national decisions, support and/or intervention (MH2/303 to MH2/305 - INQ000106469; INQ000069650; INQ000106471). I chaired the weekly Gold meetings from 11 June 2020 until my resignation in June 2021. They covered the latest epidemiological briefing and assessment; assurance for containment action underway; discussed the implications of any trends identified; made recommendations to COVID-O and COVID-S and proposed issues to raise, and action to advise for agreement at COVID-O on a weekly basis, or more frequently if needed.

440. On 17 June 2020, PHE provided further data and more comprehensive analysis on Leicester following a multi-agency 'deep dive' (MH2/306 and MH2/307 **INQ000233849** **INQ000233850**. It revealed that there had been a 'rising tide' of cases over the previous two weeks, since the end of Ramadan, easing of national lockdown measures and the celebration of Eid. The most concentrated volume of cases was in the ward of North Evington. Cases were increasingly within the working age adult group. There was a sense that compliance with social distancing was poor amongst that group.

441. On 18 June 2020, I chaired a Gold meeting to review the operational situational report provided by JBC (MH2/308 - **INQ000233846**. The report highlighted Leicester as an area of concern, given the rising tide of cases there. It noted that there had been an outbreak at a food factory where the workforce were from areas with a high density of BAME individuals. It noted that action had already been taken to deploy a mobile testing unit and to provide multilingual public health information, but that action needed to be swifter. It was agreed that a local action plan for Leicester needed to be provided by the following day in order to decide whether action at a national level was required (MH2/309 - **INQ000233847**. I asked for a roundtable with local leaders in Leicester to discuss the situation. I also spoke with the Shadow Health Secretary, about the situation, and by coincidence also the local MP. Nadine Dorries spoke with other local Leicester MPs (MH2/310 **INQ000233848**.

442. On 19 June 2020, I held a roundtable with the local leaders, including Professor Ivan Browne, Leicester's Director of Public Health, Andy Keeling, the CEO for the Local Authority, and Sir Peter Soulsby, the Mayor of Leicester (MH2/311 and MH2/312 - **INQ000233851** **INQ000233852**. We agreed that (i) postcode level testing data should be provided to better understand where within the wards the virus was concentrated, (ii) communications in the correct languages should be targeted at the relevant communities, and (iii) any spare testing capacity should be sent to Leicester to start systematically testing the population in that area (MH2/313 **INQ000233853**. I also made clear after the meeting that we needed to produce a publication setting out the local and national process for local outbreaks (MH2/314 **INQ000233854**.

443. On 25 June 2020, I chaired a further Gold meeting to review the operational situational report provided by JBC (MH2/315 **INQ000233856**. In respect of Leicester, it was noted that work had progressed positively with collaborative efforts leading to additional mobile testing and an agreement to undertake community asymptomatic testing and access to postcode level data. However, the number of cases had not yet gone down, so it remained a watching brief with further data needed on the impact of local action (MH2/316 **INQ000233857**).

444. On 26 June 2020, I was sent a submission about (i) the proposals to delegate powers to local authorities to provide a clear and uniform legal basis for them to implement and enforce intervention as set out in the 'Contain/JBC Framework and Action Cards' and (ii) the options for providing new powers for ministers to impose local lockdown measures in response to outbreaks (MH2/317 and MH2/318 **INQ000233858** **INQ000233859**. I was content with the overall direction and agreed with the recommendations, subject to (i) preferring the option of obtaining powers to close particular settings by 4 July 2020 and then obtaining a full range of powers in a further vehicle thereafter, and (ii) considering that ministers needed the power to implement national-level lockdown measures at a local level, including restricting inter-regional transport and imposing stay at home measures (MH2/319 **INQ000233860**. I emphasised the need to progress at pace with this.

445. On 28 June 2020, PHE provided further data on Leicester, showing a worsening picture (MH2/320 to MH2/324 **INQ000233861** **INQ000233862** **INQ000233865** **INQ000233870** **INQ000233871**.

446. I held an emergency Gold meeting later that day to discuss the situation (MH2/325 and MH2/326 **INQ000233863** **INQ000233864**. It was reported that confirmed cases were primarily from BAME communities and workers within large food processing and other manufacturing plants/factories. It was further reported that there was limited social distancing in retail environments, that testing units were not easily accessible and that health communications were not in the languages used by the local residents (MH2/327 **INQ000233867**. We agreed, on the advice of Jonathan Van-Tam, that Leicester ought not to take Step 3 on 4 July 2020 alongside the rest of the country, but more advice was needed on whether we should go further, for example closure of high-risk workplaces and non-essential shops. It was agreed that these actions should be discussed and consensus reached with local leadership (MH2/328 and MH2/329 **INQ000233866**; **INQ000233868**.

447. Further to that meeting, Tom Riordan and Suzanne Rankin spoke with Sir Peter Soulsby about the situation and proposed actions. While he accepted most of the recommended actions, he considered that Leicester was being unfairly targeted for a delayed 4 July reopening and raised concerned about "rationale, practicality, distraction and community cohesion consequences of such a delay" (MH2/330 - **INQ000233869**

448. On 29 June 2020, I sought advice from Professor Van-Tam on Leicester. His recommendation was that not only should the planned reopening on 4 July 2020 not happen but the recent easing of lockdown on 15 June 2020 should be reversed across the city (MH2/331 **INQ000233872**).

449. I then met with local leadership, including Sir Peter Soulsby, as well as the CMO, Dido Harding, Jonathan Van-Tam and various others to discuss the situation (MH2/332 and MH2/333 - **INQ000233873** **INQ000233874**. Professor Van-Tam was again clear that we needed to act decisively now or we would be forced to have to do more in a few weeks as the situation deteriorated. I was also of that view. While Sir Peter Soulsby expressed scepticism about the data, we decided that the national easing on 4 July 2020 should be delayed in Leicester and all non-essential retail should be closed.

450. I attended a COVID-O later that day to discuss Leicester and recommended that those measures be implemented, which was agreed (MH2/334 to MH2/336 - **INQ000062363**; INQ000088764; INQ000088759). The Committee also agreed that schools in Leicester would only be closed where there was a strict epidemiological need. It was recognised that there had been challenges getting buy-in from the local leadership in Leicester to

the approach being taken and that lessons needed to be learned from the experience to shape future local lockdown policy. I explained during the meeting that we would need to publish a process for dealing with local outbreaks.

451. I attended a COVID-S on 2 July 2020 where the point was made, which I agree with, that the "Government had learnt a lot from the process to lockdown Leicester. That lockdown had won widespread public backing. The Government should be as decisive as possible when making decisions about local lock downs. A playbook was being developed." (MH2/337 - INQ000088245). I set this out in some detail because the dynamics of dealing with Leicester were repeated in other local areas of concern throughout the autumn.

452. On 14 July 2020, I attended a further COVID-O to discuss management of local outbreaks (MH2/338 and MH2/339 **INQ000233881** **INQ000233884**. Dido Harding presented the 'Contain Framework' which set out clear responsibilities at local and national level for responding to local outbreaks. All Upper Tier Local Authorities ("UTLAs") had Local Outbreak Plans in place and in most areas Directors of Public Health were successfully keeping infection levels down. The Contain Framework provided for strengthened roles for Ministers and Governments to intervene when a locally-led approach was insufficient. It set out the Gold, Silver and Bronze structure for monitoring outbreaks and escalating cases requiring enhance support/intervention (MH2/340 - **INQ000233882**

453. The Committee agreed that the Contain Framework should be published on 17 July 2020, but that it should be considered a living document and subject to review to account for any feedback from local authorities (MH2/341 - INQ000088800). I then presented a paper on local lockdown powers with a view to obtaining collective agreement of the proposed new powers for UTLAs to implement restrictions, which were set out in the Contain Framework, and for ministers to impose more potent lockdown measures, such as restricting movement of people or requiring people to stay at home at a sub-national level without bespoke regulations (MH2/342 **INQ000233883**. The Committee agreed the new UTLA powers which took effect from 18 July 2020 and that the ministerial powers should be published in draft regulations as soon as possible to be enacted shortly thereafter.

454. This local lockdown framework remained in place until there were so many local lockdowns that we had to simplify the approach. Combined with the inconsistency of

some local leadership, the confusion of local approaches, tailored to each area, became a significant problem which we tried to tackle in the autumn of 2020. Our experience working with local leadership in Leicester was unfortunately reflected many times during that autumn, when, on occasion, a local leader would try to make political points rather than follow the data, despite the public's support for lockdowns when they were needed. We found that local leadership almost never wanted to implement measures necessary to save lives, but by contrast were often content to accept a decision taken nationally. This made the initial vision of a framework that could be implemented locally much more difficult in practice. Over time we developed a model of effective data sharing, which supported public health professionals on the ground to act locally, under the political cover of a national decision. I reflect on the role of local lockdowns, and a sub-national approach, in more detail below.

*Understanding Vulnerabilities to, and Health Disparities Caused by, Covid-19*

455. On 7 April 2020, SAGE advised that it had identified particular risk factors for the outcome of contracting Covid-19, which were age, gender (men being more vulnerable than women), obesity, and ethnicity. I stressed that this information needed to be published so that those who were at risk of particularly acute effects of a Covid-19 infection were aware of this, and could take precautions accordingly. This was another area where I knew it was pivotal to keep following the emerging scientific picture and to allow that to inform our decision making. However, at this stage the reasoning behind this link was unknown.

456. Just over a week later, I received the news from the 16 April SAGE meeting that it had been identified that black people had a higher risk of being admitted to hospital and of dying, and that a disproportionate number of BAME healthcare workers were dying (MH2/343 **INQ000233795**. I was not present at the SAGE meeting, but received an update from the CMO prior to the circulation of the minutes. I was horrified to hear this and asked the scientists to work hard to find out why this was, and how our decision making could be improved to help mitigate this exacerbated risk.

457. Accordingly, the CMO commissioned PHE to carry out a review into disparities in outcomes and risks from Covid-19. Although this picture had only just emerged and very little was known about why these disparities might exist, both the Department and the broader Government was immediate in reaching a view that all action should be taken to eradicate any disparities, and minimising any particular vulnerabilities, insofar as was

possible. For example, this was noted in the C-19 Strategy meeting on 8 May 2020 (MH2/344 - INQ000088650) and then on 4 June (MH2/233 - INQ000088234).

458. At my request, on 12 May 2020, PHE provided a rapid interim review on the current data already available on ethnicity and health outcomes and the CMO sent me a note on the same (MH2/345 to MH2/349 - **INQ000233807** **INQ000233808** **INQ000233809** **INQ000233810** **INQ000233811**.

459. On 31 May 2020, we received the full review, alongside a separate stakeholder engagement review, which had been carried out by Professor Kevin Fenton, to understand the impact of Covid-19 on BAME communities (MH2/350 to MH2/354 - **INQ000233822** **INQ000233826** **INQ000233824** **INQ000233823** **INQ000233825** The quantitative PHE review showed disparities in the impact of Covid-19 at that time based on age, sex, ethnicity and deprivation. The reviews were published in early June 2020.

460. In response to the findings and recommendations, the Government commissioned further work through the then Minister for Equalities, Kemi Badenoch, to improve understanding of drivers for disparities to inform decision-making. It was supported by the Race Disparity Unit in the Equalities Hub (Cabinet Office). I announced that work on 2 June 2020 (MH2/355 **INQ000233827**. The Department periodically fed into it to ensure we were building in proper responses to protect those who had been disproportionately impacted by Covid-19. The work and progress on the recommendations was periodically reviewed at COVID-O including, for example, on 24 September 2020 (MH2/356 - INQ000090034), 29 October 2020 (MH2/357 - INQ000090185) and 8 December 2020 (MH2/358 - INQ000091044).

461. Risk factors for being particularly vulnerable to the physical and mental health impacts of Covid-19 were not the only disparities that the Government considered. Sadly, the impact of the pandemic and the lockdown did disproportionately affect other cohorts of society.

462. Knowing that certain groups were faced with additional pressures on top of those already existed as a result of the lockdown and the pandemic was something that weighed heavily on my mind when making decisions, but I was a firm believer that the best I could do was to be guided by scientific advice on whether – and if so, how – our decisions could alleviate any additional risks or anguish, and that an effective response to the pandemic overall (i.e. taking decisions early, not relaxing restrictions when the R

number was too close to 1, and thereby minimising the need for future lockdowns) was the key to putting an end to these difficulties.

*Next chapter in 'Our Plan to Rebuild' and Second-Wave and Winter Planning*

463. While the number of infections in the UK remained broadly stable at this point in time, the Government began to turn its mind to how it would respond to a nationally significant increase in infections should local measures fail. The Department had already begun planning for that eventuality.

464. On 2 July 2020, I attended a COVID-S to discuss such contingency planning (MH2/359 and MH2/360 - INQ000088287; INQ000088286). I made clear at the meeting that preparation for winter needed to be a top priority and that the NHS needed to be prepared and, therefore, properly funded, which had been the subject of debate with the Treasury for the previous two months. The Prime Minister said that there needed to be a further roadmap for the next few months given that the previous roadmap had expired on 4 July 2020. He was anxious that there should be powers in place to respond to local outbreaks and that alternative, smarter restrictions should be developed and deployed to avoid another lockdown, which he considered would be a "disaster" (MH2/337 - INQ000088245).

465. On 13 July 2020, I sent the Cabinet Secretary a memo warning that funding issues about the NHS winter budget could not be further deferred and that the NHS needed to be told the financial plans for the rest of the year in order to begin its planning (MH2/361 - INQ000129418). At the time, financial arrangements only extended to the end of July 2020. In particular, I told him that (i) funding for Nightingales and independent sector contracts had to be signed-off or else we would lose the capacity, (ii) additional funding for social care had to be approved or people who ought to be provided care at home would unnecessarily take up hospital beds over the winter, and (iii) the flu vaccination programme had to be signed off. I was assured that I would have the Prime Minister's support and that he wanted to announce the package that Friday.

466. I followed-up with the Prime Minister directly on 14 July 2020 expressing my concern about the speed with which we had released lockdown, cases entering Test and Trace starting to rise and that I was getting limited response on the need to protect the NHS over the winter (MH2/362 - INQ000129422). I advised him that we could not take a risk on releasing lockdown and NHS winter capacity at the same time. He replied on 15 July

2020 saying that he wanted to discuss it (MH2/363 - INQ000129423). We were ultimately able to agree extra funding for A&E capacity, a commitment on measuring waiting times and an agreement to promote use of NHS 111 to take the pressure of hospitals (MH2/364 and MH2/365 **INQ000233886** **INQ000233889**. Minister subsequently agreed a further £3 billion of NHS winter funding which he announced on 17 July 2020 (MH2/366 - **INQ000233891**.

467. On 16 July 2020, I was sent a briefing which formally outlined that a COVID-S would be seeking agreement to publish the next chapter of 'Our Plan to Rebuild' on 17 July 2020 (MH2/367 to MH2/370 - INQ000106526; INQ000106527; **INQ000233887** **INQ000233888**. The Department and I were concerned that that the overall tone and level of ambition of the next chapter underplayed the scale of risk of a second wave. Based on the CMO's advice, we thought the desire to return to normality by November was unachievable. I conveyed those reservations to the Cabinet Secretary prior to the meeting (MH2/371 - INQ000129427). Notwithstanding the concerns raised at the meeting, particularly by the CMO, the Prime Minister was anxious to set a date in November 2020 (rather than waiting until Spring 2021) whereby all restrictions would be lifted, subject to caveats, with the central objective of getting life back to as close to normal as possible by Christmas (MH2/372 - INQ000088249). This was a mistake.

468. On 17 July 2020, I was advised that, in view of evidence that the virus had the potential for transmission beyond 7 days after symptoms start, the CMOs for each of the four nations had agreed that the self-isolation period (for symptomatic individuals with a positive test result) should be increased from 7 to 10 days (MH2/373 and MH2/374 - INQ000106537; INQ000106538). This was discussed at the COVID-S on 22 July 2020 where the change was agreed (MH2/375 - INQ000106541). The change was announced by the CMO on 30 July 2020 (MH2/376 - INQ000106546).

469. At the COVID-S on 22 July 2020, the Committee also decided that indoor swimming pools (including indoor facilities at water parks), indoor fitness and dance studios, and indoor gymnasiums and sports courts could re-open from 25 July 2020 (MH2/377 and MH2/378 - INQ000088251; INQ000088291), further to the Prime Minister's announcement to that effect on 17 July 2020 (MH2/379 - INQ000106536). I signed regulations the same day implementing that decision (MH2/380 to MH2/382 - **INQ000233896** **INQ000233897** **INQ00023389**).

470. On 24 July 2020, ONS data showed that the decline in cases in England was levelling off (MH2/383 **INQ000233913**. The number of cases on the 24 July 2020 was 20,276 but one month later on 24 August 2020 they were 30,330. This showed that the virus was growing again.

471. On 25 July 2020, I spoke with the Prime Minister and said that we needed to shift to a more cautious approach and delay the planned opening of beauty salons and other 'close contact' businesses on 1 August 2020 and to tighten messaging to the public to slow social contact (MH2/384 - INQ000129434).

472. On 29 July 2020, further ONS data showed that the cases had risen dramatically from 2,800 the previous week to 4,200. SAGE advised that R was likely above 1 (MH2/385 - **INQ000233919**. At this point, the Prime Minister's view was appropriately cautious about the risk and likelihood of a second wave (MH2/386 - INQ000102205).

473. We discussed the response to the data at a Gold meeting on 30 July 2020 (MH2/387 **INQ000233920**) and then at a COVID-O later that day (MH2/388 to MH2/392 - INQ000106550 **INQ000062461** **INQ000062459**; INQ000088797; INQ000051409). The data showed that outside Leicester, there were growing belts of higher infection rates across Greater Manchester and parts of East Lancashire and West Yorkshire. We determined, in addition to Leicester, to place much of the North-West into local lockdown, including banning socialising in other people's homes in Greater Manchester, West Yorkshire and parts of East Lancashire. I approved a submission giving effect to the decision to prohibit interhousehold mixing in those areas on 4 August 2020 (MH2/393 to MH2/395 **INQ000233922** **INQ000233923** **INQ000233924**. We also determined to delay the further relaxation of measures planned for 1 August 2020 by at least two weeks.

474. We also discussed whether and how to reintroduce shielding if required, depending on incidence of levels of infection. I had been sent a submission about this on 23 July 2020 which recommended that the power to introduce and pause shielding, at both a local and national level, should be retained as a ministerial decision (MH2/396 and MH2/397 - INQ000051337; INQ000051337). I agreed that the decision on the resumption of shielding (whether at local or national level) should be made at national level and the collective decision was taken at the COVID-O to pause shielding guidance as planned from 1 August (MH2/398 - INQ000106545). There were, however, locations where shielding continued because of increasing Covid-19 rates, for example in Leicester, Blackburn and Darwen (MH2/392 - INQ000051409).

475. On 1 August 2020, the Prime Minister conveyed his concern to me, the CMO, the CSA, the Cabinet Secretary, the Prime Minister's Chief Adviser and Lee Cain about the public's compliance with the social distancing rules and that the Government's communications in respect of the rules had become confused and difficult to comprehend. He sought 'a big reset' in respect of communications involving the reiteration of simple messages, particularly in respect of social distancing and how many people someone could have inside their house (MH2/399 - INQ000102213). He was right.

476. By now, the assumption that anyone who died, having ever had a positive Covid-19 test was increasingly wrong. On 6 August 2020, following publication of a review by PHE and external statisticians into the methodology for recording deaths, the CMOs of each of the devolved Governments agreed that deaths should be published if they were within 28 days of a positive test to ensure consistency (MH2/400 **INQ000233935**). England and Wales also agreed to publish deaths within 60 days of a positive test, although not as a headline measure. This had the effect of reducing the official death toll by 5,377 to 41,239 when it was announced on 12 August (MH2/401 **INQ000233936**. Although, as the CMO explained, because of the difficulty accurately measuring why an individual died, the only real measure is how many people died as compared to a normal year afterwards.

477. On 13 August 2020, I was provided advice on the proposed easing of measures due to take place on 15 August, as delayed from 1 August (MH2/402 to MH2/405 - **INQ000233937** **INQ000233938** INQ000109653; INQ000109658). I was uncomfortable about the easing happening, and argued that it should only occur alongside a stronger compliance and enforcement strategy (MH2/406 and MH2/407 - **INQ000233939** **INQ000233940**). The Prime Minister agreed to that stronger enforcement and compliance strategy, but it never happened as it was subsequently blocked by the Treasury (MH2/408 - INQ000058096). It was also agreed, at my recommendation, that the areas still in lockdown in the North West and Leicester would be excluded from the easing given the heightened incidence levels in those locations (MH2/409 **INQ000233941**. The Health Protection (Coronavirus, Restrictions) (No. 2) (England) (Amendment) (No. 3) Regulations 2020 which gave effect to the easing came into force on 15 August 2020.

*Operation Moonshot*

478. On 15 July 2020, we had received the interim report from a Southampton testing pilot into the use of RT-LAMP saliva tests, which indicated that (i) it was a reliable and

acceptable form of Covid-19 testing at population level and (ii) that it had potential for scale (MH2/410 and MH2/411 **INQ000233898** **INQ000233890**.

479. This report was picked up by No 10 (MH2/412 **INQ000233900**. On 22 July 2020, I attended a meeting with Professor Keith Godfrey, who was running the pilot, the Prime Minister, the CMO, the CSA and others about using the testing to test whole populations with lower sensitivity, higher scalability tests. The premise of population testing was that if you test everyone, and everyone who tests positive isolates, you can control the virus without the need for social distancing for all. I was sceptical of this final part of the premise, but keen to use testing as much as possible to reduce the need for lockdown measures.

480. On 23 July 2020, Professor Godfrey wrote to the Prime Minister seeking support for that program, which he called the Phoenix Program but also described as a 'Moonshot' program (MH2/413 and MH2/414 **INQ000137242** **INQ000233901** As he put it:

> *"Such an approach might allow much more widespread testing in the population and could help control the spread of COVID-19, with less reliance on social distancing. It would make 'test and trace' much more effective in three ways: i) asymptomatic cases would be detected, ii) many symptomatic cases would be detected earlier, and iii) contact tracing would be simpler and isolation quicker. These approaches could be used to protect care homes, hospitals and other at risk sites or could even be expanded for whole-population testing."*

481. On 24 July 2020, I attended a further meeting with the Prime Minster, Professor Keith Godfrey and various others about the program to discuss progress so far, next steps to take it forward and accreditation of the tests (MH2/415 to MH2/420 **INQ000233907** **INQ000137242** **INQ000233908** **INQ000233910** **INQ000233911** **INQ000233912** Part of the discussion centred on scaling to whole population testing (MH2/421 **INQ000233914**. While I was supportive, I was concerned at the time that aiming for whole population testing immediately was too ambitious and that we ought to focus on a city pilot in the first instance (MH2/422 - INQ000129433), particularly in light of a discussion I had had with Gila Sacks, Director of Testing Strategy & Policy, the previous day about scalability (MH2/423 **INQ000233906**). Dido Harding and her team at NHS Test and Trace were tasked at this meeting with taking the program forward.

482. On 2 August 2020, I wrote to the Prime Minister about the proposal to test an entire city in order to test the hypothesis that effective population surveillance, including first detection of outbreaks and containment, depended largely on frequency of testing and speed of reporting. I proposed a geographical pilot in the first instance to test that hypothesis, in the hope that, if successful, it would allow the Government to roll out regular mass asymptomatic testing of the whole population across all settings so as to avoid another national lockdown (MH2/424 **INQ000233930**. As stated, I considered that this was a more realistic approach to scaling and testing the new technology than trying to scale immediately to whole population testing.

483. I attended a further meeting about population testing on 5 August 2020 which was held by the Prime Minister (MH2/425 to MH2/429 **INQ000233926** **INQ000233927** **INQ000233928** **INQ000233929** **INQ000233931**. He was very enthusiastic about the idea and wished to deliver population testing nationwide by the start of October (MH2/429 and MH2/430 - **INQ000233931** INQ000102218). While I was also very supportive of the idea, I recognised that there were challenges in developing, manufacturing and ensuring a high take-up of the tests and the cost of the same. I also did not consider the start of October was feasible, but committed to coming back with a plan to rollout tests across the country (MH2/431 - INQ000129445).

484. On 12 August 2020, I attended a further meeting with the Prime Minister, Dido Harding and others about mass testing (MH2/432 to MH2/434 **INQ000233932** **INQ000233933** **INQ000233934**. As things stood, subject to the outcome of the validation results, we aimed to scale to the level required for mass population testing by Christmas. The Prime Minister stressed the importance of removing any obstacles that might slow down the work being carried out by Dido Harding to implement this and to try to bring that date forward.

485. On 19 August 2020, I attended an update meeting on mass testing with the Prime Minister, Dido Harding, the CMO, the CSA and others about mass testing (MH2/435 to MH2/438 **INQ000233942** **INQ000233943** **INQ00023394** **INQ000233945**). I then attended a further update meeting held by the Prime Minister about it on 27 August 2020 (MH2/439 to MH2/441 **INQ000233975** **INQ000233956** **INQ000233957**. The update was that all of the most promising technologies were being worked on in parallel, together with the manufacturing, workforce and data architecture required for wider roll-out. The Prime Minister emphasised the great urgency of this work and asked the team to redouble their efforts.

*Banning Staff Movement between Care Homes*

486. From early June 2020, it became apparent that a primary contributor to Covid-19 getting into care homes was staff movement, rather than residents who had been discharged from hospitals. Care providers had constant and significant vacancy levels, which meant that agency staff particularly were working in more than one care setting to meet that need, so there was a substantial number of staff moving between care settings (MH2/442 **INQ000233915**. While we had introduced guidance that recommended staff work in only one care home, and while the number of staff working in more than one care home fell by around 90% over the summer of 2020, on 3 July 2020 I chaired a meeting with the Minister for Care and Departmental leaders where we discussed how to reduce staff movement to zero and options for legislating against such movement (MH2/443 - **INQ000233875**. I chaired a further meeting with the Minister of Care and Departmental leaders on 28 July 2020 where we discussed it (MH2/444 **INQ000233921**). I asked the Minister for care to take the lead on it.

487. On 15 September 2020, I attended a COVID-O where the Minister for Care presented the Department's Covid-19 Winter Plan for Adult Social Care (MH2/445 and MH2/446 - **INQ000233991** **INQ000233992**. A key tenet of the plan was the various measures it proposed to assist with reducing staff movement so as to prevent and control the spread of infection in care settings. I pressed for going beyond the measures which had been proposed in that paper, including prohibiting in law care staff from working in more than one social care setting (MH2/447 to MH2/452 **INQ000233987** **INQ000233988** **INQ000233989** **INQ000233990** **INQ000233993** **INQ000233994** The Committee decided that the Department should take legal powers to ban staff movement between care homes in order to reduce transmission (MH2/453 and MH2/454 - INQ000090180; INQ000090012).

488. On 23 September 2020 and 15 October 2020, I received advice on the legal options to restrict the movement of staff between care homes. It proposed that Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 be amended to include a requirement that care homes not use staff who attend more than one care setting (MH2/455 to MH2/460 **INQ000234022** **INQ000234023** INQ000058362; **INQ000234102** **INQ000234101** **INQ000234100**. At that point, I wanted the regulations to be implemented by the end of October 2020. However, On 19 October 2020, I was advised that there would need to be a consultation on the proposed regulations (MH2/461 to MH2/463 **INQ000234146** **INQ000234145** **INQ000234148** The consultation ran during

November 2020.

489. On 3 December 2020, the Minister of State for Care was provided with a further submission on the scope of the proposed regulation to prohibit staff movement, accounting for the consultation responses, which I also reviewed (MH2/464 and MH2/465 **INQ000234205** **INQ000234206**). We were content with the recommendations in the submission (MH2/466 **INQ000234211**). I expressed the need to press ahead with this as soon as possible, and we sought urgent cross Government agreement.

490. On 22 December 2020, I attended a Covid-O where we discussed the proposed regulations on restricting staff movement. My view was that, to protect the most vulnerable living in care homes, and despite the much lower death rate in care homes since we had introduced the guidance against working in more than one care setting, we should deliver on the policy of zero staff movement between care homes, particularly in the face of the more transmissible Alpha variant of Covid-19 which had emerged in December 2020. I pressed the need to ensure that funding was put in place to support the policy, specifically to pay care staff for foregone hours as a result of being limited to one setting. The Committee agreed subject to the Department and Treasury agreeing a more detailed proposal to ensure funding support for staff was provided (MH2/467 - INQ000091133).

491. Over the ensuring fortnight, it became clear that HMT was reticent to fund a scheme to support staff affected by the proposed regulation, and the implementation of the plan was delayed again. By early January, in the face of this opposition and in light of the vaccine rollout and the decision to bring in the second lockdown, we decided not to pursue the regulation restricting staff movement at that time (MH2/468 to MH2/474 - **INQ000234269** **INQ000234270** **INQ000234271** INQ000059411 **INQ000234277** **INQ000234273** **INQ000234276**).

492. One extremely important lesson is that in the face of infection disease, staff movement between care settings should be restricted. This is not to blame staff, because the problem of asymptomatic transmission meant they could not have known they had the virus. I would argue this should happen, by law, in every flu season, as well as in any pandemic.

*Formation of NIHP and disbanding of PHE*

493. On 18 August 2020, I announced the formation of a new organisation, initially called the National Institute for Health Protection ("NIHP") (MH2/475 - INQ000086612). There were two reasons for the change. First, the operational aspects of the response to the pandemic had ended up in several separate organisations with messy accountability arrangements, including in PHE, NHS Test and Trace and the Joint Biosecurity Centre, and the NIHP would bring them together under joint leadership and clear accountability. This was important during the pandemic, and so prompted the decision to announce the change in summer 2020.

494. Second, one of the major flaws in pandemic preparedness was the lack of a single institution responsible for communicable diseases. The NIHP would focus on controlling communicable diseases; protecting people from the external threats to the country's health. The organisational design of PHE was flawed. As often happens when an organisation has both regular, ongoing responsibilities (for example with respect to tackling obesity), and responsibility to prepare for and respond to low frequency, high impact events, PHE's leadership had inevitably focussed on the more immediate work of protecting against non-communicable diseases. Instead, we need for the future a single organisation focussed on preparation for, and fighting pandemics.

495. Even the work to tackle non-communicable public health issues suffered from the existing organisational design, because policy levers to improve non-communicable public health are largely cross-Government – for policies like tackling air pollution and obesity. As an arms length body PHE had failed to achieve as much impact on these policies as I had hoped. These policy areas would therefore in the future be the preserve of the Department and led by the CMO, with an improved ability to influence across Whitehall.

496. The Department produced the initial proposal on my behalf on 9 July 2020 with input from the CMO and Dido Harding (MH2/476 to MH2/478 **INQ000233878** **INQ000233879** **INQ000233880**.

497. On 21 July 2020, I met with Dido Harding, the Permanent Secretary and the Prime Minister to discuss our proposal (MH2/479 to MH2/482 **INQ000233892** **INQ000233893**

INQ000233894 INQ000233895. In terms of implementation, we needed to get the immediate benefits of uniting leadership over operational response, while minimising any potential of change to disrupt delivery, which I acknowledge. In light of this, we put forward a number of options for delivery, including immediately creating a single overall Chief Executive (initially Baroness Harding) and leadership team for NIHP, which would incorporate PHE, so that they could lead the organisational design and change over the winter with a view to full technical and legal integration by April 2021. The Prime Minister agreed to the proposal and that approach. With hindsight, I am confident that the unification of operational tasks and strengthened leadership improved operational performance, and the potential risks were largely successfully mitigated.

498. The Department subsequently put in place a more detailed timetable and implementation plan to deliver on it (MH2/483 to MH2/486 INQ000233903 INQ000233905 INQ000233904 INQ000233925.

*Return to school*

499. The preparations for reopening the education system in September 2020 had been in process since June 2020. The Government's clear ambition was for all learners to safely return to education in September, but it acknowledged that contingencies had to be put in place in the event that that was not possible. The issue was discussed at various COVID-S and COVID-Os which I attended between June-July 2020, including:

    a. COVID-S on 19 June 2020 (MH2/487 to MH2/489 - INQ000088283; INQ000088284; INQ000088241);
    b. COVID-O on 26 June 2020 (MH2/490 to MH2/493 - INQ000088746; INQ000088786; INQ000088747; INQ000088752);
    c. COVID-O on 15 July 2020 (MH2/494 and MH2/495 - INQ000088829; INQ000088830);
    d. COVID-O on 22 July 2020 (MH2/496 to MH2/499 - INQ000088791; INQ000088774; INQ000088768; INQ000088771); and
    e. COVID-O on 30 July 2020 (MH2/391 - INQ000088797).

500. Notwithstanding the rising incidence of cases by the start of August, the Government remained resolute in its ambition to get schools back in September in order to tackle the injustices arising from children missing their education.

501. I attended a COVID-S on 6 August 2020 where the Secretary of State for Education presented an updated paper on the plans for the return to school in September (MH2/500 - INQ000088256). We considered and discussed three scenarios and the contingencies plans for each: (i) the incidence of Covid-19 remained relatively flat; (ii) the incidence generally remained steady but with higher incidence in specific local areas; (iii) the incidence of Covid-19 increased nationally (MH2/501 - INQ000088294). In response to those scenarios, the Prime Minister, in summary, determined that closing schools and restricting education should be a last resort and would only come after imposing (or delaying the lifting of) social and economic restrictions elsewhere (MH2/502 - INQ000088257). I thought this was a reasonable judgement for the Prime Minister to make.

502. On 27 August 2020, I was briefed for, and attended, a COVID-O where we discussed the readiness for the reopening of schools from September 2020 (MH2/503 to MH2/506 **INQ000233954** **INQ000233955** **INQ000233962** INQ000089968). The Department had been working with the Department of Education ("DfE"), including with the JBC, on how schools should react in the event of localised restrictions, including trying to find a route to ensure that teachers were prioritised for access to testing if they have symptoms. We agreed that DfE would run an exercise to test communication flows, systems and the process for responding to a local outbreak. The Prime Minister again reiterated that the schools would be the last thing that would close when considering measures to control outbreaks. DfE circulated that day its guidance for managing local outbreaks and implementing restrictions, which complemented the Contain Framework, with a view to publication on 28 August 2020 (MH2/507 to MH2/509 **INQ000233959** **INQ000233961** **INQ000233960**.

*Building to Tiers*

503. On 20 August 2020, I chaired a Gold meeting (MH2/510 and MH2/511 **INQ000233946** **INQ000233947**. It was noted that incidence levels continued to rise, especially in some parts of Northern England. I sought agreement from the COVID-O to make 'targeted interventions' in those areas, as recommended by the Gold Committee, which would apply to Oldham, Pendle and Blackburn, but would exclude some wards within those locations where local epidemiology data showed lower case levels and where measures could be brought in line with the rest of the country (MH2/512 **INQ000233948**. I approved submissions in respect of these interventions on 25 August 2020 and the local lockdown

regulations giving them effect came into force the following day (MH2/513 to MH2/515 - **INQ000233949** **INQ000233950** **INQ000233951**

504. On 26 August 2020, having returned from holiday the week before, the Prime Minister messaged a WhatsApp group which included me, the CMO, Professor Van-Tam, Sir Patrick Vallance and the Prime Minister's Chief Adviser in respect of an article in the Financial Times which said that mortality rates for Covid-19 had fallen to 0.04% (MH2/516 - INQ000102231). He queried how we could "possibly justify the continuing paralysis" on that basis and theorised that Covid "may be starting to run out of potential victims". Despite the authority of the source, the figures were, however, incredibly misleading.

505. First, measured mortality rates are dependent on testing rates, so the more tests produced, death rates apparently fall. Second, death rate is significantly higher for older people. The CMO and Sir Patrick Vallance responded putting the data into context and highlighting how dangerous the virus remained for old people. Notwithstanding, the Prime Minister remained fixated on the "negligible" risk to people under the age of thirty five and that restrictions could not be justified. In my view, it represented a fundamental challenge to the pandemic response to date and a clear shift in his attitude, when compared to his understandable and correct concern prior to going away about the second wave.

506. On 27 August 2020, I chaired a Gold meeting where we decided to ease some of the tougher restrictions then in place in a number of locations in the North from 2 September due to improving incidence levels in those areas (MH2/517 and MH2/518 **INQ000233958** **INQ000233963** It was evident that the local lockdowns and restrictions were an effective means of controlling transmission. That decision was ratified by a COVID-O later that day (MH2/519 - INQ000090168).

507. On 29 August 2020, the Prime Minister, CSA, the Cabinet Secretary and I discussed by WhatsApp the rise of cases in Spain and France and the possibility of those countries returning to national lockdowns (MH2/520 - INQ000102235). The Prime Minister was concerned that the UK would inevitably be faced with the same situation unless Test and Trace and local lockdowns proved effective. I spoke to Ed Llewellyn, the Ambassador to France, to try to get more information on why those countries had seen such an increase in cases. I was told that international comparison showed that our lockdowns were much tougher, we had much greater testing capacity and that our return to normal social activity

had been among the most cautious in the world. In light of this, I told the Prime Minister that we should use well-enforced local lockdowns, increase testing and ensure positive cases isolate and keep reiterating the social distancing and hygiene message.

508. On 31 August 2020, the ONS data showed a marked increase in cases (MH2/521 - INQ000094467). Despite this, the Cabinet Office produced a paper on social distancing which proposed a significant relaxation of rules to allow eight people to convene 'in all circumstances' (MH2/522 - INQ000094465). I did not consider this proposal was appropriate (MH2/523 - **INQ000233973**) I was of the view that the local lockdown system, while working, needed to be strengthened and simplified. The difficulty was that in each area where restrictions were imposed we had to negotiate a tailored set of rules with local councils and health officials, which led to significant confusion. David Halpern suggested a tiered system with clearly defined rules at each level. An area can move up or down a tier depending on the local situation. If the public know what tier they are in, they will know what rules apply. I conveyed the proposal to Dido Harding, the CMO, the Permanent Secretary and my team (MH2/524 and MH2/525 - **INQ000233974** **INQ000233977**. While the details needed to be ironed out, there was broad agreement that this was worth considering. I wrote a note to outline the idea, which I emailed to the Cabinet Secretary later that day in order for it to be discussed with the Prime Minister the following day (MH2/526 and MH2/527 - **INQ000233971** **INQ000233972**) The aim of tiers was to bring clarity, while still allowing low incidence areas to avoid as much intervention as possible.

## 1 SEPTEMBER 2020 – 23 DECEMBER 2020: THE SECOND WAVE AND THE VACCINE ROLLOUT

509. On 1 September 2020, I attended a Covid Strategy meeting with the Prime Minister, the CMO, the CSA and various others to discuss a range of issues in light of the rising case rates (MH2/528 and MH2/529 - **INQ000233969** **INQ000233970**. These included the proposed change to the social contact rules so that eight people would be permitted to meet in any setting (which was to replace the existing ban on gatherings of more than 30 and the guidance on allowing 2 households to meet indoors). It also included a proposal for a localised risk-based tier system (MH2/530 to MH2/534 - **INQ000233964** **INQ000233965** **INQ000233966** **INQ000233967** **INQ000233968**

510. In respect of the proposed eight people limit, while acknowledging that it had the benefit of simplicity and would be enforceable in law, the CMO, CSA and I were

concerned that it represented a loosening of measures because it would, in theory, allow eight people from different households to meet indoors. As it was, we agreed that that the current policy on social contact should be maintained for the time being alongside a simplified communications campaign. In respect of the localised risk-based tiering approach, we agreed that it should be developed and taken forward by the Department and the Covid-19 Taskforce (MH2/535 - **INQ000233976**

511. I attended a Cabinet meeting on 1 September 2020 at the FCO (MH2/536 - INQ000088930). We noted that the increase in cases in other European countries, France and Spain particularly, was a warning to the UK of what was likely to come. Notwithstanding, the Prime Minister made clear his view that a national lockdown should not be reimposed and schools would not be instructed to close again, given the damage done to the economy and children's education. He said that that course of action would be avoided by a successful test and trace system and strong local lockdowns. The CMO advised that opening schools would put pressure on 'R', particularly in the winter months, and so the Government had to respond with a range of measures. Alongside the work on a vaccine, the Cabinet discussed that the first line of defence would be ensuring people complied with social distancing rules, the second line was the test and trace system (including the Moonshot programme) and the third line was the local lockdown system.

512. On 7 September 2020, I held a meeting with the CMO, Baroness Harding and various others to discuss the most recent JBC data (MH2/537 and MH2/538 - **INQ000233980** **INQ000233981**. I was concerned that the data continued to show a significant increase in cases, which was consistent with the evolution of the case rates seen in France, Spain and Belgium, and implied that R was above 1 and measures not tight enough to suppress the virus. We discussed a number of recommended measures in response to the data which had been proposed by the Covid-19 Taskforce (MH2/539 **INQ000233982**. The measures included:

    a. Renewed communications about the importance of 'hands, face, space';
    b. Pausing a planned campaign on return to offices and delaying the roadmap steps envisaged by 1 October 2020 (e.g. allowing mass events in stadia);
    c. Changing the social contact rules to only legally permit six people to meet in all settings (stricter than eight people as previously proposed);

d. Making it a legal requirement for businesses to collect test and trace data alongside the launch of the contact tracing app planned for 24 September 2020;
e. Stronger enforcement generally, including to ensure businesses were complying with Covid-19 secure guidance and at borders to ensure people were self-isolating as required when they entered the country; and
f. Standardising 'tiers' for local intervention (as above), including implementing operating-hour restrictions in the most-severely impacted areas.

513. The CMO said it was clear the action needed to be taken, but that there needed to be a consistent, six-month view, rather than a short-term view. He said that a 'handbrake' should be introduced immediately. He advised that it was unclear what the impacts of the proposed measures would be, but that it might be sufficient for now, alongside signalling that further action would be taken if required. He said it would be critical to cut through to the public the direction other countries had gone, as behaviour change would be a key element to the response. I agreed with the recommended measures, but was worried it was not enough.

514. On 8 September 2020, I was briefed for, and attended, a COVID-S to discuss the sharp rise in cases (MH2/540 to MH2/542 **INQ000233983** **INQ000233984** INQ000088262). The Covid-19 Taskforce had produced a paper for the Committee which noted that, if the trend in transmission was allowed to continue, we could expect to follow France and Spain into a second wave (MH2/543 - INQ000088260). It recommended a package of measures in line with those set out above. The Committee agreed that there was need for a decisive package to respond to the increased cases. We discussed, amongst other matters what the numerical limit on the ban on the number of people who could meet should be, whether six or eight. The CSA advised that it was not possible to quantify the impact of either limit, but plainly the lower the number, the lower the transmission risk. The CMO advised similarly. I argued for six. A limit of six was consistent with the current regulatory landscape but would create problems for many families. A limit of eight would be easier for families but would increase transmission risk. The Prime Minister concluded in favour of six (MH2/544 - INQ000088263). The Committee otherwise agreed to the packages of measures recommended (MH2/545 - INQ000088304). The Prime Minister announced the package the next day (MH2/546 - INQ000086845). I announced it in Parliament on 10 September 2020 (MH2/547 and MH2/548 **INQ000233985** **INQ000233986**

515. On 13 September 2020, I was sent a submission to sign the Heath Protection (Coronavirus, Restrictions) (England) (Amendment) (No.4) Regulations 2020 to bring the 'rule of six' into force by 14 September 2020. I was travelling at the time that the Regulations had to be physically signed, so I approved them and the Home Secretary signed them in my stead (MH2/549 and MH2/550 - INQ000109724; INQ000058297).

516. On 15 September 2020, I chaired an emergency Gold to discuss the worsening situation in the North East (MH2/551 **INQ000233996** The Committee recommended that Northumberland, North Tyneside, South Tyneside, Gateshead, Newcastle, Sunderland and Durham be made subject to regulations to close certain night time venues, and restrict inter-household mixing, and permit table service only in hospitality, in addition to the bespoke regulations already in place in Bolton, to try to curb the rise in transmission (MH2/552 **INQ000233995**. This package of measures was as far as I could go while maintaining the support of the Committee, and in particular the Treasury. I was worried they were not strong enough.

517. I attended a COVID-O later that day where the Gold recommendations were approved (MH2/553 - INQ000090165). On 17 September 2020, I signed The Health Protection (Coronavirus, Restrictions) (North East of England) (Amendment) Regulations 2020 which gave effect to those measures (MH2/554 to MH2/556 **INQ000233998** **INQ000233999** **INQ000234000**.

518. On the same day, I chaired a further Gold where it was collectively agreed that, due to the rise in transmission rates in the North West (Lancashire, Merseyside, Warrington, Halton, but not Blackpool and Greater Manchester), West Yorkshire and the Midlands, those areas would also be subject to regulations to permit table service only in hospitality, close certain night time venues, and restrict inter-household mixing, which mirrored the North East regulations (MH2/557 **INQ000234006**. I presented the Gold recommendations to a COVID-O later that day. I said that the virus was "running riot" in parts of Northern England. I also said that despite the increase in incidence rates in Leeds being comparable to Lancashire, the local MPs did not want to see local action taken, but instead had opted for a suite of local measures. The Committee approved the Gold recommendations (MH2/558 - INQ000090181). On 21 September 2020, I signed the Health Protection (Coronavirus, Restrictions) (North East and North West of England) Regulations 2020 giving effect to these recommendations from 18 September 2020 (MH2/559 and MH2/560 **INQ000234028** **INQ000234029**

519. In light of the continued rise in cases, SAGE proposed on 17 September 2020 a two-week circuit-breaker in addition to a sustained package of NPIs (MH2/561 to MH2/564 - INQ000234003 INQ000234004 INQ000234005 INQ000234010 SPI-M modelling indicated that a two-week period of restrictions similar to those in force in late May could delay the second wave by approximately four weeks. My view was that this so-called "circuit breaker" would not work. The theory was that if everyone in the country could avoid social contact completely for two weeks, then the virus would not be able to spread. But in practice, zero social contact is not possible. A two-week lockdown would reduce cases, but then the resumption of existing rules would lead to continued rising cases, and I was concerned that this rapid change to the rules would lose support for the action necessary. The CMO's advice to me was that we needed policy in place until the spring. I favoured firmer local intervention in the form of the tier approach with a robust top tier. After all, a "circuit-breaker" was just another name for a short national lockdown. The theory of preventing all transmission for a fortnight is neat, but in practice, would only delay the problem. Instead we needed to get R below 1 and hold it there.

520. My team and I had by this point generated a more detailed tier framework to present to COVID-O (MH2/565 and MH2/566 INQ000234001 INQ000234002. On 18 September 2020, the Cabinet Secretary told me that the circuit-breaker proposal was gaining traction with the Prime Minister (MH2/567 - INQ000129483). However, later that day, the Cabinet Secretary informed me that, rather than going the circuit-breaker route, the Prime Minister wanted to, *"double down on present strategy for now – tougher local lockdown/enforcement, warnings messages about what happens if people don't follow the rules (i.e., signal return to national measures)."* I was not directly involved in this discussion with the Prime Minister. I did not think the existing strategy was adequate.

521. On 18 September 2020, I attended a COVID-O to discuss the tier proposal (MH2/568 and MH2/569 INQ000234007 INQ000234008 I presented the paper which my team and I had produced on the tier system (MH2/570 INQ000234009. The paper acknowledged that the model of targeted, localised action to control outbreaks set out in the Contain Framework adopted June-July 2020 had created a complex patchwork of bespoke regulations and guidance which could be perceived as inconsistent, not readily understood by the public and often hard to enforce. The tiered approach was designed to be simpler, provide greater clarity to the public, greater certainty and consistency of decision-making and, thereby, increase compliance. It was aimed at having maximum impact on the virus, and minimum adverse impact on the economy. We proposed a three-tier system, with interventions increasing in severity going up the three tiers. In outline:

a. Tier 1 represented the baseline, the minimum level of restrictions applicable to all of England;
b. Tier 2 was triggered in geographical areas or nationally when there has been a rise in transmission, which cannot be contained through local responses;
c. Tier 3 is triggered in geographical areas or nationally when Tier 2 measures have not contained the spread of the virus or where there has been significant rise in transmission. Tier 3 measures needed to be strong enough to ensure R was below 1.

522. We proposed that decisions on moving between tiers would be made by COVID-O on recommendation from the Gold Committee. It was intended that the tiers framework would operate throughout Winter and into Spring. I invited the Committee to agree the tier framework, for it to be set out in legislation to enable enforcement and to come into force on 1 October 2020. I was anxious that it be put into effect as soon as possible given the increase in cases, and bearing in mind that the Prime Minister had agreed to it in principle on 1 September 2020. The Committee agreed with the tier framework, but directed the Department to work with No.10 and the Covid-19 Taskforce to agree the timetable for announcing and implementing it (MH2/571 **INQ000234011**.

523. I now know that on 20 September 2020 the Prime Minister held a meeting at which the need for stronger measures was discussed. I was not present, but a number of discredited anti-lockdown proponents were, including Professor Sunetra Gupta and Professor Carl Heneghan. I have no idea why I was not invited, and when I became aware of this meeting I was alarmed and frustrated, as the views of these people had already been widely debunked. They did not represent credible scientific thinking. For example, Professor Gupta had in May declared that Covid-19 was “on its way out in this country” and had “been brought down by natural processes”. On the contrary, it was very clear by then that without stronger action to control the virus we would end up with a second wave and a second national lockdown, and that the longer we left it, the more economic damage, pressure on the NHS and death there would be. I was astonished that No10 could organise such a meeting without inviting the Health Secretary.

524. On 21 September 2020, I attended a further COVID-O where the tier framework was again discussed and endorsed by the Committee, but again, was not cleared to be announced. (MH2/572 - INQ000090177).

525. Later that day, I attended a COVID-S (MH2/573 to MH2/577 - **INQ000234012** **INQ000234017** **INQ000234014** **INQ000234015** **INQ000234013**. The Covid-19 Taskforce had produced a 'Winter Strategy' paper setting out a further package of measures in response to the continuing rise in cases (MH2/578 **INQ000234016**. It was designed to change people's behaviour in response to social distancing, while keeping children in school and minimising economic harm. It comprised:

a. A clear message to the public that winter would be difficult, underpinned by transparency regarding the current data, and a warning that the Government would take further steps if people do not change behaviour, including a circuit-breaker if infections continued to grow;
b. A return to guidance asking office workers to work from home where they could, excluding key public services;
c. A codification of local interventions into tiers, as agreed at the COVID-O on 18 September 2020 and endorsed earlier in the day;
d. The extension to all businesses of legal obligations regarding COVID-Secure guidelines, with a proposal to fine or close premises where breaches occurred;
e. Requiring, in law, that all hospitality be table-service only;
f. Restricting the operating hours of hospitality, so that the sector be closed 10pm-5am, including takeaway, although delivery could continue;
g. An extension of the requirements for wearing face coverings, to include customers and staff in indoor hospitality (apart from when customers were eating and drinking), staff in retail settings and those in taxis and private vehicles.
h. Making sure all universities did everything they could to communicate with students about safe behaviours and instructing them to stay in their university towns;
i. Limiting the exemptions to the rule of six, including by removing indoor adult team sport and wedding receptions, stating clearly in the guidance that societies such as choirs should not go ahead and reducing the number of people at life-cycle events and weddings to 15; and
j. A cancellation of the planned return of business events and socially distanced crowds in stadia from 1 October and a pause on pilot events.

526. I supported the measures proposed, as they represented progress, but I feared they were not enough, and argued for the urgent implementation of the Tiers system with a rigorous top tier. The choice was between acting now to suppress the virus, or waiting

and having to imposed more intrusive restrictions at a later date for longer and at greater societal and economic cost (MH2/579 - INQ000088271). I preferred the former. The Committee agreed to the measures (MH2/580 **INQ000234027**.

527. I attended a further COVID-O later that day to discuss the implementation of the measures (MH2/581 to MH2/583 **INQ000234024** **INQ000234025** **INQ000234026**

528. On 22 September 2020, I attended a COBR meeting to discuss the response to the current Covid-19 situation (MH2/584 to MH2/590 **INQ000234018** **INQ000234030** **INQ000234032** **INQ000234031** **INQ000234033** **INQ000234034** **INQ000234035** At the meeting, the Committee was invited to agree (i) swift UK-wide action in response to the increase in transmission in line with the measures set out above, (ii) a strong UK-wide message on the need for behavioural change, increased compliance and stronger enforcement, and (iii) to publish a joint statement from the four nations setting out its ongoing cooperation in response to the pandemic. All four nations endorsed the measures proposed (with some differences in implementation) and agreed to publish a joint statement demonstrating their shared commitment to tackling the disease and its consequences (MH2/591 to MH2/593 - INQ000083849 **INQ000234036** **INQ000234037**

529. On 23 September 2020, Lord Bethell signed on my behalf the Health Protection (Coronavirus, Restrictions) (No.2) (England) (Amendment) (No.5) Regulations 2020 to give effect to the social distancing measures which had been agreed at the COVID-O and COVID-S on 21 September 2020 (MH2/594 to MH2/603 **INQ000234044** **INQ000234045** **INQ000234046** **INQ000234047** **INQ000234048** **INQ000234049** **INQ000234050** **INQ000234051** **INQ000058358** **INQ000234053**). I also signed The Health Protection (Coronavirus, Wearing of Face Coverings in a Relevant Place) (England) Regulations 2020 to give effect to the decision to require face coverings in indoor hospitality settings (MH2/604 to MH2/609 **INQ000234039** **INQ000234038** **INQ000234040** **INQ000234041** **INQ000234042** **INQ000234043**

530. On 24 September 2020, I sent the PM a revised note on the tier framework to account for various steers he had given, the substance of which I broadly agreed with (MH2/610 and MH2/611 **INQ000234054** **INQ000234055**. I messaged the PM later that day saying that "we need to get tiering sorted and tougher local action in place pronto", following a review of case data at a Gold meeting which showed a sharp rise of cases in the North of England (MH2/612 - INQ000102271). I messaged the Prime Minister on 27 September to chase (MH2/613 - INQ000129495). I was concerned that the Tier 3 would not be

strong enough to suppress the virus, but I was not permitted to include further restrictions in Tier 3, and I could not get the Tiers proposal cleared by No10, despite repeated formal meetings to sign it off. This was deeply frustrating, as the package of measures proposed by the Covid-19 Taskforce was clearly inadequate without the top Tier to keep R below 1 in areas of significant spread.

531. On 28 September 2020, I attended a meeting with the Chief Whip to discuss the next steps on the tier framework (MH2/614 **INQ000234056**. Despite my efforts to announce the tier framework immediately and to bring it into force on 1 October 2020, it was further delayed. The Department was tasked at this meeting with producing a note covering a timetable for a potential announcement on 8 October 2020, a draft the statutory instrument changes and which tier each local authority would be in. Despite the fact the Prime Minister had agreed to the tier framework back on 1 September 2020, and it had been subsequently endorsed at COVID-O on 18 September 2020, COVID-S on 21 September 2020 and a COBR on 22 September 2020, I was informed that the Prime Minister had "not taken any final decisions on this policy – so until he has, none of the above is an agreed approach."

532. On 30 September 2020, I chaired a Gold meeting to discuss the rise in incidence in case in Merseyside (MH2/615 **INQ000234057**. Local Directors of Public Heath had recommended that further restrictions be introduced in regulations including restricting household mixing in all settings, delivery only for hospitality services and no spectators at organised sport and avoiding all but essential travel in guidance. I was inclined to agree with those recommendations and to align Merseyside with the regulations imposed in other areas of Northern England on 18 September 2020 as much as possible. The Committee recommended that Merseyside should be made subject to the same package of measures. I signed regulations giving effect to that recommendation on 2 October 2020 (MH2/616 to MH2/618 - **INQ000234058** **INQ000234059** **INQ000234060**

533. On 1 October 2020, the Department provided me with a further paper on the tiering policy, which we discussed at a meeting that day (MH2/619 **INQ000234061**. On 2 October 2020, they provided me a further paper on the policy incorporating the steers I had given at the meeting (MH2/620 and MH2/621 - **INQ000234062** **INQ000234063**. I cleared it to be submitted for consideration by the Covid-19 Taskforce at No.10 (MH2/622 - **INQ000234064**. On 4 October 2020, No.10 fed back views on the policy which differed from mine in some areas, but I agreed to them in order to get the policy through (MH2/623

INQ000234065). The edited paper was then circulated for the COVID-O the next day (MH2/624 and MH2/625 INQ000234066 INQ000234067

534. On 5 October 2020, I attended the Covid-O to discuss the tier framework again (MH2/626 - INQ000234068. I presented our paper (MH2/627 - INQ000234069. I explained that final agreement on the substance of the tiers was now needed. I again explained that there was currently an array of different interventions in place across various local areas, which had caused inconsistencies and confusion. The measures currently in place had all been designed in partnerships with local leaders and authorities, but this had resulted in a situation where a local leader would call for action and then later criticise the Government where the measures were not precisely consistent with their proposals. The tier framework mitigated this. Local authorities had broadly shown support for the tier system. It had the benefit that we could simply communicate to the public the need to know their tier or 'alert level'. Overall, the Committee supported the framework, including the substance of tier 1 (Local Alert Level – Medium) and tier 2 (Local Alert Level – High). It also agreed the legislative timetable, but stated that it would be subject to No 10 confirmation. The Committee tasked the Department with continuing to work on the triggers for moving between tiers, to work with MHCLG (in coordination with the Treasury and No.10) on engaging with local authorities and mayors on the proposal. It decided that tier 3 (Local Alert Level – Very High) should remain a bespoke intervention for each area to be agreed by me, the Chancellor and the Prime Minister (MH2/628 - INQ000234070. For ease, I will refer to the three levels as tier 1, tier 2 and tier 3 going forward in this statement. Failing to have tier 3 agreed was extremely frustrating, as tier 3 would be needed to suppress the virus, and having each tier 3 area locally agreed would undermine one of the central attractions of the tier system – to reduce confusion. My experience of engagement with local leaders was that they very rarely were prepared to support measures strong enough to suppress the virus, so this proposal was likely to lead to significant implementation challenges.

535. On 6 October 2020, I was contacted by the Prime Minister's office to convey his wish to review the approach being taking on areas of high incidence, including the interplay with NHS capacity, and the measures being considered for these areas (i.e. tier 3) (MH2/629 INQ000234071. The Prime Minister asked for the announcement on tiers to be paused whilst this was worked through. Reflecting on the worsening data, I asked at both a meeting with DHSC leaders that day (MH2/630 INQ000234072 and a pre-Gold briefing with the CMO, Dido Harding and other DHSC ministers and officials about introducing a national lockdown. The CMO advised that the rate of change and level

were different in different parts of the country which pointed to continuing with a regional approach. I said that, while I was happy for a short delay to announcing tiers if that meant being able to finalise local support and finance, I wanted it announced and implemented as soon as possible. Given the difficulties in getting this policy put in place, and the lack of agreement on the measures needed in tier 3, I feared this approach may never work, and so I also asked the team to consider national lockdown measures. I wanted to use the tiers system to avoid a local lockdown, but I knew that being blocked from introducing the necessary localised measures unfortunately made a national lockdown more likely. (MH2/631 **INQ000234073**). The repeated delays to the necessary action were exceptionally frustrating.

536. On 9 October 2020, Clara Swinson provided me with a note on tier 3, which had been agreed with the Permanent Secretary and the CMO (MH2/632 and MH2/633 - **INQ000234076** **INQ000234077**. It highlighted that the package was a step forward in that it had additional restrictions as a default package, with the opportunity to agree further measures with local leaders. However, it also highlighted that the package of measures was weaker than that discussed at a Gold meeting on 7 October 2020 and which local areas may have been expecting (MH2/634 **INQ000234074**). It outlined that the public health view was that these measures were necessary but not sufficient if the intent was to suppress the virus in the most affected areas. I agreed with that advice. The policy had been weakened to the point it would not work.

537. On 11 October 2020, I was briefed for, and attended, a COVID-O to finalise the roll out of tiers and which areas would fall into which tier (MH2/635 to MH2/639 **INQ000234081** **INQ000234083** **INQ000234082** **INQ000234079** **INQ000234080** In line with Clara Swinson's note, I received advice from JBC prior to the meeting that the tier 3 measures had been watered down in their development and that the current proposed measures were not as stringent as had been discussed by the Gold committee.

538. Together with the fact that the epidemiological picture had got worse, I was advised that the tier 3 measures would not be sufficient to suppress transmission and to reduce pressure on the NHS (MH2/640 to MH2/642 **INQ000234084** **INQ000234085** **INQ000234086** Both the CSA and the CMO similarly advised at the Covid-O that the tier 3 baseline measures were unlikely to bring R below 1 and it was only if local leaders imposed the full set of the measure in tier 3 that there was a reasonable chance of doing so. I regarded this as vanishingly unlikely. Nonetheless, the Committee agreed to the proposals as drafted and the geography of the application of the tiers (MH2/643 - INQ000090163). It

was, however, acknowledged that further engagement with, and cooperation by, local leaders in tier 3 was required if the measures were to be effective (MH2/644 - **INQ000234089**. That message was echoed in a Cabinet call later that day (MH2/645 and MH2/646 **INQ000234087** **INQ000234088** and a COBR meeting the following day (MH2/647 to MH2/650 **INQ000234090** **INQ000234092** **INQ000234091** INQ000083851). I stated at Covid-O that I was very concerned that we were not going far enough.

539. On 12 October 2020, the Prime Minister announced the tier framework (MH2/651 - INQ000075749). At the press conference the CMO explained that, on their own, the tiers we had announced would not work to control the virus. I was in despair that we had announced a policy that we knew would not work. However, I judged it was the best we were going to get at that point so I signed The Health Protection (Coronavirus, Local Covid-19 Alert Level) (Medium) (England) Regulations 2020, the Health Protection (Coronavirus, Local Covid-19 Alert Level) (High) (England) Regulations 2020 and The Health Protection (Coronavirus, Local Covid-19 Alert Level) (Very High) (England) Regulations 2020 giving effect to the tier framework on 14 October 2020 (MH2/652 and MH2/653 **INQ000234093** INQ000058529). On the 13 October 2020, it passed a vote in the Commons.

*Implementing the Tier framework*

540. Following the introduction of the tier framework, the Gold committee continued to work through the JBC data and to identify areas which needed to move tiers or otherwise required action on a public health basis. Where areas had been identified as potentially needing to move into tier 3, the Government continued to negotiate with the relevant local authorities on what additional restrictions were needed to address the high or rising Covid-19 rates. Restrictions were put in place through regulations once negotiations had concluded. The fractious and difficult local negotiations were exactly what I had designed the tiers system to avoid.

541. On 14 October 2020, I chaired a Gold meeting where we discussed funding support packages for areas moving to tier 3, the need to consolidate areas moving into tier 3 into a single statutory instrument for efficient scheduling of Parliamentary time and which areas should move or remain in which tier in order to curb transmission (MH2/654 and MH2/655 **INQ000234094** **INQ000234095** The Committee agreed that Merseyside and Halton (which had moved to tier 3 on 12 October 2020) should remain in tier 3 and that, given exponential growth in incidence rates, that local leaders be engaged to move

Greater Manchester, Lancashire, West and South Yorkshire, the North-East and Nottingham City to tier 3. The Committee also agreed that London and various other areas should move to tier 2 and local leaders in Coventry should be engaged to move to tier 2 (MH2/656 **INQ000234099**

542. I attended a COVID-O later that day (MH2/657 to MH2/659 - **INQ000234096** **INQ000234097** **INQ000090262**. I presented the update from the Gold meeting. For those areas recommended to move into tier 3, I said that they needed more than the basic package of measures in tier 3 with as much local support as possible. I acknowledged that the recommendations were subject to local engagement and had economic consequences. However, I pressed that the lesson from the previous nine months was to take action sooner rather than later. The Committee agreed with all the recommendations from Gold and that I would announce the areas moving into tier 2 that week, and that regulations would be made that would come into effect on 17 October 2020 (MH2/660 - INQ000090160).

543. I also spoke with the Prime Minister that day about the 4-week circuit breaker which had been announced in Northern Ireland. The restrictions included closure of hospitality (except delivery), closure of close contact businesses, no mass events, 25 person limit on weddings and funerals (with no receptions or wakes), working from home unless unable to do so, distance learning for universities, no indoor sport and no spectators at outdoor sport, no unnecessary travel, no mixing of households (except bubbling) and closure of schools for two weeks. Save for the closure of schools, the Prime Minister suggested that we should impose these restriction in the worst affected areas of England. I agreed and told him that we needed to "drive this through – no half measures – or the NHS will be overwhelmed" (MH2/661 - INQ000129527). I hoped that this might finally give us an effective tier 3.

544. On 16 October 2020, following the conclusion of discussions with Lancashire Local Authority, I signed the Heath Protection (Coronavirus, Local Covid-19 Alert Level (Very High)) (England) (Amendment) Regulations 2020 into tier 3 (MH2/662 to MH2/664 - INQ000109868; INQ000109870; **INQ000234103** In addition to the baseline tier 3 measures, Lancashire had requested closures of various establishments where large gathering had been observed. My view was that the package was still unlikely to be enough.

545. On the 19 October 2020, I attended a COVID-O to discuss local tier levels, specifically in Greater Manchester (MH2/665 and MH2/666 **INQ000234104** **INQ000087616**. The Covid-19 Taskforce had produced a paper on how to proceed if an agreement was not reached by 20 October 2020 with local leaders from Greater Manchester, who had still not agreed to move to tier 3, and on what measures to introduce (MH2/667 - **INQ000234105**. In line with that paper, the Prime Minister said that a letter would be sent to Greater Manchester leaders that day offering a further package of support in order to mutually agree measures under tier 3. If not agreed by midday the following day, measures would be imposed which accorded with those in place in Lancashire at the time, given the need to flatten the curve and prevent hospitalisations (MH2/668 - INQ000090127). Despite the further offer, no agreement could be reached, so the Government decided to impose tier 3 measures in Greater Manchester. This whole discussion between the Government and Greater Manchester was unfortunately extremely acrimonious.

546. On 21 October 2020, I chaired a Gold where, on the basis of the epidemiological data, it was recommended that Warrington move into tier 3 and that discussions continue with Nottingham City and Nottinghamshire and West Yorkshire above moving into tier 3. It was also recommended that discussions start with North East 7 (Newcastle, South Tyneside, Sunderland, Gateshead, North Tyneside, Northumberland and County Durham), Tees Valley and West Midlands about moving into tier 3. It was also recommended, with local support, that Stoke-on Trent, Coventry and Slough all move to tier 2 and that discussions with local leaders about moving to tier 2 should continue in North East Lincolnshire, Staffordshire, Charnwood, Hertsmere, Luton, Thurrock, Leicester, Oxfordshire and Bristol (MH2/669 **INQ000234112**. It was increasingly clear the whole of England was heading towards tier 3.

547. I attended a COVID-O later the day to provide the Gold update and to discuss a Covid-19 Taskforce paper on local authority enforcement powers to enforce Covid-19 secure rules (MH2/670 to MH2/674 **INQ000234107** **INQ000234108** **INQ000234109** **INQ000234110** **INQ000234111**. In respect of enforcement powers for local authorities, the Committee agreed with the proposals that they should have stronger powers. As to the data, the Committee noted the significant increase in cases and that the country could now be separated into three broad bands: the North of England which had the highest positivity rates; London and the Midlands were cases were increasing; and the South East and South West where cases were still low. I pressed the need for the Gold recommendations

to proceed at pace. The Committee agreed to the recommendations (MH2/675 - INQ000090162).

548. On 23 October 2020, I was briefed for, and attended, a meeting with the Prime Minister, Chancellor of the Duchy of Lancaster, the CSA and Simon Stevens to discuss NHS Winter Preparations (MH2/676 to MH2/681 **INQ000234118** **INQ000234113** **INQ000234114** **INQ000234115** **INQ000234116** **INQ000234117**. Simon Stevens updated us that Covid-19 inpatient demand was rising and was significantly impacting on non-Covid-19 services in areas such as the North West, North East and Yorkshire and that trusts in Liverpool and Lancashire had already exceeded first peak levels. The CSA noted that though cases were rising less quickly, they would exceed the first peak unless R was brought below 1. We agreed that there was a need to closely monitor both NHS capacity and the impact of the existing restrictions.

549. On 27 October 2020, I attended a Covid-O to discuss local tier levels, particularly Nottingham (MH2/682 to MH2/684 **INQ000234119** **INQ000234120** **INQ000234121** The Covid-19 Taskforce sought agreement for a package of measures, which had been co-developed with local leaders, to bring Nottingham and surrounding areas into tier 3. Given the epidemiology and that over 300 hospital beds in the area were occupied due to Covid-19 (similar to the peak in April 2020 and trending upwards), the local leaders had agreed to a more extensive set of measures than any other area. The Committee agreed the move to tier 3 and the package of measures. It was acknowledged that it was taking too long between making decisions about which areas needed to go into tier 3 and implementing those decisions, because of the length of time it was taking to negotiate measures beyond the tier 3 baseline with local leaders (MH2/685 and MH2/686 - INQ000090164; INQ000090294). It was clear to me that the measures in tier 3 were not sufficient to curb transmission and that another national lockdown would be inevitable.

550. Seeing that the tiers system had failed, and knowing by now that others were effectively running campaigns against a second national lockdown, I decided to bring external pressure to bear. At my weekly meeting of health leaders, I asked them vocally to make the case for a second national lockdown (MH2/687 **INQ000234140**. I spoke to the BMA, RCN, Royal Colleges, NHS Confederation and other trusted institutions, and encouraged them to campaign publicly to save lives. These health bodies responded with enthusiasm and unanimity. This was a highly unusual tactic which I had never deployed before, but I thought justified given my failure to win the argument internally despite what I regarded as overwhelming evidence of the need to lock down to save lives

and stop the NHS being overwhelmed. As a result, over the ensuing days, multiple, loud, clear calls were made that dominated the media and made it much easier for me to win the argument internally.

551. On 28 October 2020, I undertook a statutory review of the tier regulations, which was required every 14 days in respect of each local authority allocated to tier 3 and every 28 days for restrictions in all three tiers (MH2/688 – INQ000109906). In the face of the rapid and widespread rise in transmission, it was obvious that the clearly the restrictions remained necessary and proportionate.

552. I also chaired a Gold meeting that day (MH2/689 to MH2/695 **INQ000234122** **INQ000234123** **INQ000234124** **INQ000234126** **INQ000234125** **INQ000234127** **INQ000234128** The data showed that cases continued to rise rapidly across the country as did hospital admissions and deaths. Warrington had moved into tier 3. Gold recommended that West Yorkshire, North East 5 (Darlington, Middlesbrough, Hartlepool, Stockton on Tees, Redcar and Cleveland), West Midlands, Leicester and Leicestershire also move into tier 3, alongside further areas moving into tier 2. By this point, 59% of the English population were living under tier 2 (38% or 20 million) and tier 3 (21% and 11.2 million).

553. On 29 October 2020, I attended a COVID-O to discuss tier levels and provide the Gold update (MH2/696 to MH2/698 **INQ000234129** **INQ000234131** **INQ000234130** It was noted that the epidemiological data was going in the wrong direction across the board. I said that local leaders had to be pushed to agree measures well beyond the tier 3 baseline such that they would cause a decline in case rate and not just flatten it, and that further negotiations had to be carried out at a quicker pace. It was suggested that the areas should be moved into tier 3 no more than 48 hours after a direction from the COVID-O that they do so and that local leaders should be informed that that was the negotiating window. The Committee agreed to the Gold recommendations on which areas should be escalated up the tiers (MH2/699 - INQ000090176).

554. By now I had come to the view that the tiers system, as introduced, had failed. By requiring consent of local leaders it had not reduced public confusion, but more importantly, the measures were just not strong enough to keep R below 1, even in the top tier. I had argued for strong local measures to prevent a national lockdown, but having been blocked from pursuing those measures, it was clear national measures would be needed.

*Imposing the Second National Lockdown*

555. On 30 October 2020, I attended a COVID-O chaired by the Prime Minister to discuss the growing incidence rates across the country and the increasing pressure on the NHS. No.10 had produced a paper for the meeting which detailed a proposal for a national intervention to apply for four weeks, in order to (i) protect the NHS, (ii) get R decisively below 1, to curtail the exponential growth in hospitalisations, and (iii) act now to allow better choices for Christmas (MH2/700 and MH2/701 **INQ000234132** **INQ000234133** The intervention proposed was:

> *"a. Keeping schools and universities open.*
> *b. Encouraging people to continue to go to work where they cannot work from home and where their workplace is not closed (as set out below). This would keep industries such as construction and manufacturing open. Elite sport would be permitted to continue.*
> *c. Restrictions on hospitality, leisure and personal care. Hospitality would be limited to takeaway and delivery. Indoor and outdoor leisure, entertainment and the personal care sectors would be closed.*
> *d. 'Stay at home' legislation. No indoor or outdoor household mixing would be permitted (apart from exemptions like support bubbles) but unlimited outdoor personal exercise would be allowed. People would be told that they should leave the house if required for work purposes.*
> *e. Closure of non-essential retail. Given that we will be telling people to generally stay at home, we would close non-essential retail.*
> *f. Guidance against non-essential travel in private or public transport. Exemptions from this rule, for 'essential' travel, would include, but not be limited to, work, hospital appointments and essential shopping."*

556. I argued strongly for the measures as an absolute minimum. Following discussion, the Committee agreed the proposed intervention, save in respect of non-essential retail which required further investigation as there was an absence of evidence of transmission in that space (MH2/702 - INQ000090156). The Prime Minister concluded that the number of deaths predicted would be intolerable if action was not taken. He said it was not possible to see any other serious option and it was not possible to let exponential growth continue, given the immediate risks of rising hospitalisation and mortality and the consequent impact on the NHS. The Prime Minister announced the lockdown the

following day and that it would take effect from 5 November 2020 for four weeks (MH2/703 - INQ000086830).

557. On 31 October 2020, in line with the agreement above, I was sent a sighting submission with a proposed timeline for regulations to be made on 3 November 2020 that would introduce a second national lockdown on 5 November 2020 (MH2/704 to MH2/706 **INQ000234134** **INQ000234135** **INQ000234136** On 1 November 2020, I was sent further sighting submissions on the substance of the policy for the proposed national lockdown (MH2/707 to MH2/712 - INQ000058813; INQ000058814; INQ000110002; **INQ000234137** **INQ000234138** **INQ000234139** On 3 November 2020, I was sent the final signing submission (MH2/713 to MH2/719 - INQ000110008; **INQ000110007** INQ000110014; INQ000110013; INQ000110011; INQ000110010; INQ000110009). That day, I made the Health Protection (Coronavirus, Restrictions) (England) (No.4) Regulations 2020 which gave effect to the second national lockdown.

558. I was enormously relieved to finally have measures in place that could control the spread of the virus. Had these measures been available in tier 3 a month earlier, it is possible these national measures may have been avoided, but it was better to act than not.

*Easing of the Second National Lockdown and the Revision of the Tier Framework*

559. On 3 November 2020, I held a meeting with senior Department officials to begin preparing an exit strategy out of the lockdown (MH2/720 **INQ000234141**. The CMO noted that the data would show in the next few weeks how effective the November lockdown would be.

560. On 11 November 2020, I chaired a Gold meeting where we discussed the introduction of a revised tiers system from 2 December 2020, when the national lockdown was due to expire (Exhibits MH2/721 to MH2/723 **INQ000234143** **INQ000234144** **INQ000234142** We discussed the various amendments to the tier framework which the Covid-19 Taskforce had proposed in order to enhance effectiveness, including the addition of a further tier which would mirror the national restrictions imposed during the second lockdown. The lower tiers then containing a strengthened package of measures. I preferred to keep a thee tier system (consistent with what had been implemented in October) with the third tier being much tougher and broadly the same as the measures applied in the national

lockdown, which necessitated adjustment to the second tier (Exhibit MH2/724 - **INQ000234147**

561. On 12 November 2020, the Department provided me with a further update on the policy content of a revised tier framework (Exhibits MH2/725 and MH2/726 **INQ000234152** **INQ000234153**. In line with the steer I had given, their proposal consisted of three Tiers, rather than four; and proposed some changes to each of the tiers, including putting the "working from home" guidance into legislation in all tiers.

562. On 15 November 2020, I provided a further steer on the policy content for tiers 2 and 3. For tier 2, I preferred to include the 'rule of six', with no household mixing indoors; a complete ban on mass events; and, a requirement that hospitality venues only serve alcohol with a substantial meal. For tier 3, I preferred to prohibit any form of household mixing to mirror the current national lockdown rule, but to allow outdoor sport to continue. I was clear that religious venues should remain open in all circumstances and that there be no changes to support bubbles (Exhibit MH2/727 **INQ000234154**

563. On 17 November 2020, I held a meeting with senior figures in the Department about the plans for exiting lockdown on 2 December 2020 and Christmas (Exhibit MH2/728 - **INQ000234159**. The CMO advised that the more restrictions were relaxed over Christmas, the more that they would have to be tightened before and after. He advised that the main trades-offs for Christmas were the size of the bubbles allowed, and the length of time people would be able to spend with their bubble. He was of the view that relaxing restrictions over Christmas was very likely lead to an increase in cases, with the question being to what extent. I accepted that there was a case for restrictions to be looser for a period than during the national lockdown, and supported the attempt to reach a UK wide approach.

564. I was not heavily involved in the Christmas regulations. I thought the whole policy problematic, and thought it would be very hard to achieve UK-wide agreement. I knew that Chancellor of the Duchy of Lancaster was similarly sceptical, so I left it to him to negotiate an agreed position with the devolved authorities as tasked by the Prime Minister. I focussed instead on the rapidly growing need for stronger measures.

565. I attended a COVID-O later that day to discuss the strategy for the 2 December 2020 end of the national lockdown (Exhibits MH2/729 and MH2/730 **INQ000234155** **INQ000234157**. The Covid-19 Taskforce had produced a paper on the strategy aimed at

suppressing the virus, keeping R below 1 and avoiding any prolonged exponential rise in cases which threatened NHS capacity, while allowing a degree of contact with family and friends over Christmas which approximated normality (Exhibit MH2/731 - **INQ000234156**. I was not heavily involved in its production. It proposed strengthening the existing tier framework, based on analysis of the impact of the previous system, including standardising tier 3 so it was imposed on areas and not negotiated, and it proposed social contact easing between 22-28 December 2023 to allow for 'Christmas bubbles'. The Committee broadly agreed the proposals, including exiting lockdown on 2 December, subject to possibly shortening the period of easing over Christmas and limiting bubbles.

566. The exit from the November lockdown confirmed why a "circuit breaker" would not have worked. Temporary measures to keep R below 1 do not work if when they end R goes above 1 again. This was confirmed by the implementation of so-called circuit breakers in both Wales and Northern Ireland, after which case rates shot up again. The lesson of this period is that what is needed is a consistent set of actions to suppress the virus until a vaccine can make us safe. If this can be done with test and trace – as we tried – then that is all that's needed. But if the virus is too transmissible to be kept down with test and trace alone, social distancing measures will be needed.

567. On 18 November 2020, I chaired a Gold exit strategy meeting to implement the revised principles for tiers as agreed at the Covid-O and to consider the allocations of areas to tiers (Exhibit MH2/732 **INQ000234160**

568. On 19 November 2020, I was provided advice by my team on the policy content of the proposed changes to the tier framework as well as the latest Covid-19 Taskforce position (MH2/733 to MH2/735 **INQ000234161** **INQ000234162** **INQ000234163** They sought my steer on specific policy issues, including in respect of changes to support bubbles and each tier, ahead of the COVID-O, scheduled for 21 November 2020, which I provided (MH2/736 **INQ000234164**

569. On 21 November 2020, I attended a Covid-O to discuss the revised tier framework and the plan for Christmas (MH2/737 and MH2/738 **INQ000234165** **INQ000234167** The Covid-19 Taskforce produced a paper setting out the proposals and seeking final agreement on the restrictions for each tier, the escalation and de-escalation process between tiers and the headline policy for Christmas (MH2/739 **INQ000234166**. It revised the Christmas social easing time period to 23-27 December 2020 and limited bubbles to three households. The Committee acknowledged that the most important aspect of the revised

tier framework was that tier 3 restrictions had to be sufficient or else the only alternative would be another national lockdown. The Committee broadly agreed the proposals (MH2/740 and MH2/741 INQ000090954 INQ000054189).

570. On 22 November 2020, I attended a Cabinet meeting to discuss the current Covid-19 position (MH2/742 to MH2/746 INQ000234173 INQ000234169 INQ000234169 INQ000234171 INQ000234172. I noted that the number of cases was levelling off and the trend was moving in the right direction, which demonstrated that the lockdown was working. I took the view that it was right to go back into a strengthened localised tier system when the lockdown ended. I noted that the revised tier framework and measures had been carefully calibrated based on the Government's understanding of the impact of non pharmaceutical interventions deployed before. Taken together with mass testing, it ought to be enough to get rates falling. I also said that I was very hopeful about the potential vaccines (discussed below), which were cause for optimism. The Cabinet approved the return to the revised tier framework as set out in the paper (MH2/747 - INQ000089062).

571. On 23 November 2020, the PM set out the Covid-19 Winter Plan in Parliament as agreed at the Cabinet meeting the day before (MH2/748 - INQ000054192).

572. On 24 November 2020, I sought a briefing on proposals for Christmas on which CDL had led, ahead of a COBR meeting the same day (MH2/749 and MH2/750 INQ000234174 INQ000234175. The Department provided a note setting out the revised proposal for easing social contact rules, which would permit each household across the UK to form one exclusive "Christmas bubble" with up to two other households, enable people to see, and travel to, their Christmas bubble between 23-27 December 2020 and enable people to travel between tiers and between nations. The note outlined that, in line with SAGE guidance, the Government should aim for the lowest possible prevalence in the build up to Christmas to reduce the risk associated with the easing over Christmas. Although the note highlighted that the proposal would increase transmission risk, it considered that not introducing a change could lead to more people breaking the existing rules, and doing so in an unplanned and perhaps more significant way (MH2/751 and MH2/752 - INQ000234176 INQ000234177 We agreed the Christmas proposals at the COBR meeting that day (MH2/753 to MH2/756 - INQ000234180 INQ000234181 INQ000234178 INQ000234179.

573. The same day, the DHSC team provided me with a policy update on reinstating the revised tier framework (MH2/757 and MH2/758 INQ000234182 INQ000234183). It

highlighted a number of outstanding policy issues, including ongoing policy discussions around dealing with Christmas and that DfE and DCMS were seeking exemptions to the 'rule of six'. On 26 November 2020, I agreed with DfE and DCMS that extra-curricular activities provided by an education provider should be part of the 'education' exemption and that there should not be switching of bubbles (MH2/759 **INQ000234190**. I was provided further advice incorporating those steers (MH2/760 and MH2/761 - **INQ000234191** **INQ000234192**. I agreed to the proposals the following day.

574. Further to a Gold meeting on 24 November 2020, I attended a Covid-O on 25 November 2020 chaired by the Prime Minister to discuss the allocation of tiers (MH2/762 to MH2/766 **INQ000234184** **INQ000234188** **INQ000234186** **INQ00023418** **INQ000234185**. I presented the Gold recommendations for allocation. The paper noted that there were two important factors: (i) the festive season would see a change in behaviour that would increase transmission, and (ii) it would be easy to relax restrictions, but difficult, and damaging to public confidence, to rapidly reimpose them, so we needed to avoided making decisions that would mean we had to re-imposed tougher measures before Christmas. I pressed that the most important goal of the decisions was to try to avoid a further national lockdown. As set out in the Winter Plan, decisions about allocations were primarily based on five key epidemiological indicators:

a. Case detections rates in all age groups;
b. Case detection rates in the over 60s;
c. The rates at which cases are rising and falling;
d. Positivity rate (positive cases as a percentage of tests taken); and
e. Pressure on the NHS, including the current and projected occupancy.

575. There were many obvious candidates for tier 3, which included the North East, Lancashire, Greater Manchester and Kent, but also some marginal cases, such as London, where many boroughs qualified for tier 2, but some for tier 3. The Prime Minister acknowledged the potential case rate risk if it was put into tier 2 and the pressure on the NHS. However, he considered that tier 2 restrictions were sufficient to maintain the current course of the virus and said that the wider economic position had to be borne in mind. He concluded that London should be set in Tier 2. The Committee otherwise agreed with the Gold recommendations (MH2/767 - INQ000090969).

576. On 26 November 2020, I issued a written ministerial statement confirming the decision to exit the national lockdown and revert to a localised tiered approach for managing the

virus from 2 December 2020 (MH2/768 - INQ000185082). I also made an oral statement to Parliament (MH2/769 **INQ000234189**

577. On 30 November 2020, I signed the Health Protection (Coronavirus, Restrictions) (All Tiers) (England) Regulations 2020 giving effect to those decisions, which came into force on 2 December 2020 and replaced the Fourth Restrictions Regulations with the revised tiers framework (MH2/770 to MH2/773 **INQ000234194** **INQ000234196** **INQ000234195** **INQ00023419**.

578. In practice, we did not know it then, but the Alpha variant (discussed below) was by then established in Kent and easing the lockdown measures was a mistake. We should have kept the second lockdown in place until the vaccine arrived, and avoided the confusion around Christmas 2020, and the consequential significant rise in the number of cases. The calibration of the new tier 3 to suppress the virus would have worked for the original variant but did not work for the new, more transmissible, Alpha variant.

*Introduction of Tier 4 and Christmas*

579. On 1 December 2020, I was sent advice by the CMO on reducing the self-isolation period for contacts with positive cases from 14 days to 10 days, as agreed by the four UK CMOs (MH2/774 and MH2/775 **INQ000234201** **INQ000234200** I agreed with the recommendation for the reduction to be introduced as soon as possible, with an aligned approach across the four nations (MH2/776 -**INQ000234204**. On 9 December 2020, I was sent a submission detailing the plan for the implementation of this policy and seeking a steer on amending the process for a household ending a support bubble and forming a new one from the previous agreed 14 days to 10 days, for consistency (MH2/777 and MH2/778 -**INQ000234208** **INQ000234209**. I was content with the proposals (MH2/779 - **INQ000234210** On 11 December 2020, I signed the Health Protection (Coronavirus, Restrictions) (Self-Isolation and Linked Households) (England) Regulations 2020 to bring these changes into force as of 14 December 2020 (MH2/780 **INQ000234212**).

580. On 13 December 2020, I chaired a meeting to review the epidemiological data in London, South East and East of England and to specifically consider moving London, Essex, Southend on Sea into tier 3 in view of the trajectory of cases there (MH2/781 and MH2/782 -**INQ000234214** **INQ000234215**. London was by that stage seeing exponential increases in cases across all boroughs. The Permanent Secretary and the CMO both advised that what we had learned was that it was better to move sooner rather than later.

The CMO also advised that with Christmas easements rates would just continue to rise so it was better to move earlier and harder. Johnathan Van-Tam agreed with their assessment, as did I (MH2/783 **INQ000234216**. I chaired a Gold later that day to discuss the data and recommendations (MH2/784 to MH2/787 **INQ000234217** **INQ00023421** **INQ000234218** **INQ00023422**. The Committee decided that the areas should move into tier 3.

581. On 14 December 2020, I attended an emergency COVID-O to discuss the Gold recommendations and the response to the epidemiological data (MH2/788 to MH2/791 - **INQ000234221** **INQ000234224** **INQ000234223** **INQ000234222** The situation was very serious in London, Essex, parts of Hertfordshire and Bedfordshire and Kent. I noted that there were two possible explanations: (i) that the public were not following the regulations and/or (ii) a new rapidly spreading variant of the virus had emerged in Kent. I conveyed the Gold recommendations that in the first instance London, Essex and parts of Hertfordshire be placed into tier 3. We discussed concerns about whether the measures under tier 3 were sufficient in the current context to control the virus, particularly in face of a potential more rapidly spreading potential variant. Following discussion, the Committee and Prime Minister agreed to the recommendations (MH2/792 and MH2/793 - INQ000091065 **INQ000234227**.

582. I signed the Health Protection (Coronavirus, Restrictions) (All Tiers) (England) (Amendment) Regulations 2020 that day to give effect to those decisions, which came into force on 16 December 2020 (MH2/794 to MH2/796 **INQ000234225** **INQ000234226** **INQ000234228**.

583. Following the Covid-O, the DHSC team provided me with advice on how to further strengthen the tier framework, and in particular to address concerns that tier 3 measures were not effectively curbing transmission in some parts of England, particularly in Kent where case numbers had continued to increase (MH2/797 and MH2/798 -**INQ000234229** **INQ000234230**. They proposed a two-pronged approach: (i) a renewed communications strategy to drive compliance, and (ii) adding a tier 4 should with more robust measures as well as a reduction in exemptions to social contact measures.

584. On 16 December 2020, following a Gold (MH2/799 **INQ000234231**), I attended a Covid-O to discuss tier review (MH2/800 to **MH2/804** -**INQ000234232** **INQ000059305** **INQ00023423** **INQ000234235** **INQ000234236** ). I explained that the context of

the tier review was that there had been around 25,000 new cases that day, which was one of the highest ever case rates since the first peak. However, as of that day, 137,000 people had been vaccinated (the rollout of which I discuss below). There was no proposal to change the rules around Christmas. In light of the case rate, I explained that there would be serious consequences if the areas recommended to move to tier 3 (largely in the commuter belt around London) did not do so. The Committee and Prime Minister approved all the recommendations for escalations from tier 2 to tier 3 (MH2/806 - INQ000091076).

585. On 17 December 2020, I was sent a signing submission the Health Protection (Coronavirus, Restrictions) (All Tiers) (England) (Amendment) (No.2) Regulations 2020 to give effect to the decisions made at the Covid-O (MH2/807 to MH2/811 - INQ000110193; INQ000110201; INQ000110197; INQ000110199; INQ000110194). The Minister of Care signed the amending regulations on my behalf which came into force on 19 December 2020.

586. On 18 December 2020, I attended a COVID-O to discuss the response to new variant which had emerged in Kent which was responsible for a substantial increase in transmissions (MH2/812 to MH2/816 - **INQ000234241** **INQ000234242** **INQ000234244** **INQ000234245** **INQ000234243**. I said that, notwithstanding the new variant, there was already a significant risk of the NHS in Kent, Essex and East London being overwhelmed. Given the sobering statistics, I said that the Government needed to act fast, or it would regret it. Neither November's lockdown nor tier 3 measures had stopped the spread of the new variant. I said a 'stay at home' message should be deployed in affected areas and would be critical. With the vaccine coming, I said it ought only to impact the first two months of the year. Many attendees at the meeting suggested that the relaxation of rules around Christmas should be cancelled. The Prime Minister decided to reflect on it overnight (MH2/817 - INQ000091087).

587. The following day, I attended another Covid-O to discuss the response options (MH2/818 to MH2/820 **INQ000234246** **INQ000234247** **INQ00023424**). Further to my team's proposal on 14 December 2020, which I had conveyed strong support for (MH2/821 - **INQ000234240**, the Committee was invited to consider a paper proposing that tier 4 be introduced. It suggested that the measures in tier 4 be based on the November lockdown restrictions and include a 'stay at home' message in law and the closure of non-essential retail and entertainment. It also proposed a reduction in the Christmas social contact easing. The Committee agreed to put the areas with high prevalence of the new variant

into tier 4 and that in tier 4 Christmas social contact easing should be cancelled entirely and in other tiers the time period for easing would be reduced to Christmas Day alone (MH2/822 - INQ000091091). This was agreed, and it was agreed at Cabinet call later that day that London, the South East and East of England would be placed in tier 4 (MH2/823 to MH2/825 - **INQ000234249** **INQ000234250** INQ000089042). The Prime Minister announced the measures later that evening (MH2/826 - INQ000086623).

588. On 20 December 2020, I signed the Health Protection (Coronavirus, Restrictions) (All Tiers and Obligations of Undertakings) (England) (Amendment) Regulations 2020 to give effect to those decisions and which came into force that day (MH2/827 to MH2/832 - INQ000110212; INQ000110223; INQ000110220; INQ000110219; INQ000110214; INQ000059348).

589. On 23 December 2020, I attended a COVID-O to carry out another tier review (MH2/833 to MH2/836 **INQ000234255** **INQ000234256** **INQ000234257** **INQ000234258** further to a Gold meeting the previous day (MH2/837 **INQ000234259**). Notwithstanding the fact that it was the day before Christmas eve, I made it clear that further areas needed to be moved to tier 4. Gold recommended, inter alia, that Cambridgeshire, Norfolk and the rest of Essex be moved to tier 4 and that the new tiers be given effect by 27 December 2020. The Committee agreed to move all the areas recommended by Gold, including marginal areas, into higher tiers (MH2/838 - INQ000091116).

590. On 24 December 2020, I signed the Health Protection (Coronavirus, Restrictions) (All Tiers) (England) (Amendment) (No.3) Regulations 2020 giving effect to the Covid-O decision the previous day (MH2/839 to MH2/843 **INQ000234260** **INQ000234261** **INQ000234262** **INQ000234263** **INQ000234264**

591. Overall, with hindsight, it was a mistake to end the November lockdown, and a mistake to have special rules for Christmas. Looking at the whole experience of the autumn 2020 with hindsight strongly supports the doctrine I set out above. My view now, on reflection, is that the second lockdown should have been brought in much earlier, and maintained, with a lower case rate, until the vaccine made people safe. Had we brought in the November measures in September, either nationally or in a stronger tier 3, that would have caused less damage to both health and the economy. The consequence of those who blocked efforts to put in place strong enough measures was that by early January we needed a strong national lockdown, including school closures, which lasted a further

six months. We could have avoided the full second lockdown had sufficient action earlier not been blocked.

*Vaccine rollout August - December 2020*

592. During all of this work on trying to suppress the virus, urgent vaccine development and deployment work had continued.

593. On 4 September 2020, further to advice I had received from the Department's Covid-19 Vaccines Team at the end of August 2020 (MH2/844 and MH2/845 - **INQ000233952** **INQ000233953**, I agreed that we should focus our planning on two of the leading vaccine candidates, Oxford/AstraZeneca and Pfizer/BioNTech (MH2/846 - **INQ000233978**. I chaired a meeting that day with DCMO Jonathan van Tam and various senior Departmental, NHS, and Vaccine Taskforce officials to discuss deployment.

594. I began weekly (later daily) meetings on vaccine deployment which I chaired. While the timing was uncertain, the best case was a vaccine being approved at the start of December. In terms of bringing clarity to the timelines, I was told that as soon as the submission was made to MHRA for approval we should have a clear indication of when a vaccine would be approved. We decided to establish a Vaccine Deployment Delivery Board, which I would chair, and which would run rollout once the submission had been made to the MHRA. I pressed the team to plan for a best case scenario perspective and challenged the speed at which we could be vaccinating at scale (MH2/847 - **INQ000233979**

595. On 22 September 2020, I was briefed for and attended a COVID-O to discuss vaccine deployment (MH2/848 and MH2/849 **INQ000234019** **INQ000234021**. I and the Secretary of State for BEIS presented a paper on the progress of the work of the Vaccine Taskforce – who were responsible for purchasing – and I set out the plans for deployment (MH2/850 **INQ000234020**. I explained to the Committee that the Vaccine Taskforce would oversee the procurement and manufacturing of the vaccines through to regulatory approval by the MHRA, when responsibility would transfer over to the Department to handle deployment under the new Vaccine Deployment Delivery Board. Deployment would primarily be through the NHS with support from the military. I confirmed that the Treasury had expedited the financial approval process for the early expenditure required to put in place the logistical operations. I noted that the Oxford/AstraZeneca and BioNTech Pfizer were the two leading vaccine candidates for early deployment and, in the best case

scenario, these would first be available from December 2020, subject to successful completion of Phase 3 efficacy trails and regulatory approval for use (MH2/851 - INQ000090166).

596. On 9 October 2020, I approved a submission for the Human Medicines (Coronavirus and Influenza) (Amendment) Regulations 2020 to be laid before Parliament (MH2/852 and MH2/853 **INQ000234075** **INQ000234078**. The Regulations were made on 15 October 2020 and came into force on 17 October 2020. They amended Regulation 174 of the Human Medicines Regulations 2012, so as to enable conditions to be attached to the temporary authorisation of a Covid-19 vaccine by the MHRA, which render the authorisation as close as possible to that of a marketing authorisation under non-emergency routes. Until the end of the transition period of the UK's withdrawal from the EU (31 December 2020), the UK would ordinarily have had to wait for the European Medicines Agency ("EMA") to approve a vaccine before looking to distribute it. However, the regulations allowed for the MHRA to issue a temporary authorisation. I had agreed back on 28 July 2020 to use regulation 174 to authorise a Covid-19 vaccine (MH2/854 to MH2/856 **INQ000233916** **INQ000233917** **INQ000233918** This supported delivery at pace of a mass vaccination programme.

597. On 11 November 2020, I chaired the first of what became a daily series of meetings on the progress of vaccine deployment, which were attended by DHSC, DCMO, BEIS and NHSE officials (MH2/857 **INQ000234158**. Emily Lawson, as Head of the NHS Covid-19 Vaccine Programme, and from December 2020 Maddy McTiernan, Director General of the Vaccine Taskforce, reported to me at these meetings. I exhibit, for example, the readout of the daily vaccine meeting on 7 December 2020 (MH2/858 **INQ000234207**. We would then update the Prime Minister at weekly meetings as to progress. After he was appointed minister responsible for Covid-19 vaccine deployment at my suggestion on 28 November 2020, Nadhim Zahawi chaired the daily vaccine meeting if I was absent. He reported to me as a joint minister between the Department and BEIS (MH2/859 - **INQ000234193**.

598. On 13 November 2020, I attended a COVID-O to discuss vaccine development and deployment (MH2/860 to MH2/862 - **INQ000234149** **INQ000234150** **INQ00023415**. I presented a paper on the interim JCVI recommendation on the priority groups for vaccination (MH2/863 - INQ000090908). I was determined that, before a vaccine was approved, we had to agree which groups should receive the vaccine in which order, and the reasoning had to be clearly communicated prior to the rollout. In anticipation of the

need for an orderly and objectively justified prioritisation, I had in the summer asked the JCVI to recommend a clinically based prioritisation, which they had published as interim advice on 25 September 2020. The interim advice, which I agreed with, set out that care home residents and should staff receive vaccines first, followed by people aged over 80 and health and social workers, before rolling out to the rest of the population in order of age and risk. The Committee agreed the recommendation in principle and for it to be put before the Prime Minister for a final decision, subject to further consideration by the DCMO and JCVI on prioritisation for the CEV cohort (MH2/864 - INQ000091132). This was important because I anticipated that many groups (teachers, police, even students) would demand the vaccine first, so I wanted an objective, clinically valid prioritisation from an authoritative source to ensure we were not blown off course by presentational or political pressure.

599. On 30 November 2020, the JCVI sent its final advice to the Department on the prioritisation for vaccination deployment of the Pfizer/BioNtech vaccine, which was broadly as above, but inserting the CEV cohort and adults age 18-65 at risk at appropriate level in the priority order. I was sent a submission that day seeking my agreement to rollout the vaccine in accordance with that prioritisation, which I provided (MH2/865 and MH2/866 - **INQ000234198** **INQ000234199**) I arranged for a meeting with the Prime Minister the following day to update him on this, where he approved the publication of the JCVI's prioritisation list (MH2/867 **INQ000234202**)

600. On 2 December 2020, the Pfizer-BioNTech vaccine gained regulatory approval from the MHRA under regulation 174 of the Human Medicines Regulations 2012, as amended. On the same day, the JCVI published its prioritisation list. I updated Parliament later that day (MH2/868 **INQ000234203**). On 8 December 2020, the University Hospital Coventry and Warwickshire NHS Trust administered the first Pfizer-BioNTech vaccine, which continued to be rolled out thereafter. This was the first clinically authorised vaccine against Covid-19 in the world. I was incredibly proud of the whole team who had delivered it.

601. The vaccine rollout was an example of a superbly delivered programme, from which many lessons can be drawn. The main lessons I would point to are:

    a. Clear mission, with strategic and tactical goals, widely agreed and bought into;
    b. Clear lines of accountability with protection from political interference;
    c. High quality leadership personnel, with clear routes to resolving disputes;

d. Open permissive can-do culture, within an agreed framework;
e. Aggressive use of best available data and digital infrastructure; and
f. Adequate resourcing with funding decisions taken off the critical path.

602. The high quality structure in pace to deliver the vaccine made it possible to react quickly to circumstances, or new ideas. Above I have drawn out one such example as it is instructive, but there are many others.

603. On 12 December 2020 I attended a call with the Permanent Secretary and others in the Department concerning the new variant. In that meeting I made clear that if the new variant was a cause of the then growing case rate, the Tiers system would not be calibrated for it. I set out that my instinct would be to go hard and early in any response to it (MH2/869 **INQ000234203**).

604. In late December 2020, we decided to extend the vaccine dose interval to ensure that more people would be protected as soon as possible by getting the first dose, which offered 90% protection, than having to wait for two doses to be available at a closer interval, given the constrained supply. It is instructive to describe how this decision, which saved thousands of lives, came about. Special Advisers often get a bad press, but in this case, one of my brilliant team of Special Advisers was instrumental. When aligned with the mission Special Advisers are often good at challenging or breaking down groupthink. Damon Poole brought my attention to the idea which was set out in a tweet from an American epidemiologist, Professor Keith Klugman, on 17 December 2020 which said:

> *"First doses of Pfizer/Moderna vaccines are 90%+ effective after 14 days. Most high risk lives will be saved by giving all these limited early supplies of vaccine as first doses - second doses can be given later if first dose effectiveness wanes or when supply improves"* (MH2/870 **INQ000234239**

605. On 21 December 2020, I sought urgent advice on using a single dose of the Pfizer / BioNTech vaccine, and raised the idea of a longer dose interval with the CMO, who discussed it with the DCMO (MH2/871 to MH2/873 **INQ000234251** **INQ00023425** INQ000129637). The DCMO gave preliminary advice later that day that there was strong enough data on the protection provided by one dose to justify taking that approach and delaying the second dose interval (MH2/874 and MH2/875 **INQ000234253** **INQ000234254** I judged that, so long as the policy had clinical approval from the CMO and DCMO, the public would accept the change. Following further investigation and discussion, the CMO

and DCMO confirmed at a meeting I attended with the Prime Minister on 29 December 2020 that, from a clinical perspective, they were comfortable with the extension of the period between doses (MH2/876 - **INQ000234268**. On 30 December 2020, we announced the policy change (MH2/877 - INQ000075739). We handled various communications challenges, and the public very largely accepted the decision. Later research estimated that over 10,000 lives were saved by this decision alone.

## 24 DECEMBER 2020 – 17 FEBRUARY 2021: LOCKDOWN AND VACCINATION ROLLOUT

606. Throughout the period with which this section is concerned the vaccine rollout continued at considerable pace. The speed with which the vaccine was administered is a testament to the hard work of everyone involved.

607. Following Christmas, the Government turned to consider the question of whether and how schools could or should reopen. My view, considering the spread of the Kent variant and our experience over the autumn, was that another full national lockdown was inevitable and that schools should remain closed after the Christmas break. The Secretary of State for Education, Gavin Williamson, was clear in his view that they should open to avoid damage to children's education. On 28 December 2020 I attended a meeting chaired by the Prime Minister to discuss the various options. The DfE circulated slides in advance of the meeting (MH2/878 and MH2/879 **INQ000234265** **INQ000234266** with a recommendation that early years and primary school children return on 4 January 2021 as planned with a staged return for older children. No decision was made at the meeting, with the Prime Minister asking for the DfE to urgently provide a note on the delivery of a plan for Covid-19 testing in every school (MH2/880 - **INQ000234267**

608. On 30 December 2020 I met with my counterparts in the Devolved Administrations and agreed a 4 January 2021 start date for the roll out of the Oxford/AstraZeneca vaccine, which had just been approved by the MHRA. An announcement was made by the Joint Committee on Vaccination and Immunisation later that day with advice on prioritisation of the first doses given by the four CMOs for the United Kingdom (MH2/881 to MH2/882 - INQ000059401; INQ000059403). A Written Ministerial Statement was also prepared to announce the approval (MH2/883 - INQ000059406).

609. Further on 30 December 2020 I was sent a signing submission attaching The Health Protection (Coronavirus, Restrictions) (All Tiers) (England) (Amendment) (No. 4) Regulations 2020 (MH2/884 to MH2/889 - INQ000110272; INQ000110273;

INQ000110275; INQ000110278; INQ000110279; INQ000110281). I reviewed the submission and documents, including those related to my legal duties, and signed the Regulations at 17:45 (MH2/890 - INQ000059409).

610. On 1 January 2021 I chaired a meeting of Local Action Committee ("LAC") Gold at which the decision was taken to delay the opening of schools in London until 18 January 2021 (MH2/891 **INQ000234272**. This decision was taken in recognition of the growing number of cases of Covid-19 in the area. I wanted all schools to stay closed but I knew the Prime Minister would not sign off that decision, so took the more limited decision to keep schools closed in London. I chaired other, similar LAC meetings throughout January and February 2021, although by then they were less important as the whole of England (for example, MH2/892 - **INQ000234285**

611. On 3 January 2021 I spoke to the Prime Minister over the telephone about the worrying, rising numbers of cases. Based on these new data, I made it very clear that unless the country was placed into another lockdown, the NHS would be overwhelmed. Following extensive consideration over the next day, at 20:00 on 4 January 2021 the Prime Minister announced that England would be going into a national lockdown and that the public must stay at home, leaving only for those limited reasons permitted by law. Over the following fortnight I was extremely worried that even these measures might not be enough to control the spread and get R below 1. I worried that there was nothing more we could do in those circumstances, and that the NHS was already near breaking point. Thankfully, this full package of measures did control the spread and get R below 1, and so after 4 January we did not need to introduce any further restrictions. This was obviously a huge relief. We implemented a gradual step down from national lockdown, as the vaccination programme protected a greater and greater proportion of the population. I discuss the timing and approach to that unlocking below.

612. On 5 January 2021 I attended a meeting chaired by the Prime Minister concerning vaccine deployment. I set out that there was an achievable, but challenging, target of offering a vaccine to the JCVI cohorts 1-4 by mid-February 2021 (MH2/893 - **INQ000234275**. Supply of vaccine was the rate-limiting factor, and the NHS rollout was currently able to deliver all the vaccine that we expected to receive. I also attended a meeting with the Prime Minister to discuss NHS capacity at which I outlined that the NHS in London, the South East and the East of England were already approaching the limit of their capacity to treat Covid-19 and non-Covid-19 patients (MH2/894 – INQ000059480).

Various actions were agreed in order to support the NHS in those areas and to try and avoid it being overwhelmed.

613. Further on 5 January 2021 at 16:30, having considered my legal duties, I made The Health Protection (Coronavirus, Restrictions) (No. 3) and (All Tiers) (England) (Amendment) Regulations 2021, which came into force the next day (MH2/895 to MH2/902 – INQ000110290; INQ000110301; INQ000110300; INQ000110299; INQ000110298; INQ000110297; INQ000110296; INQ000059475).

614. On 6 January 2021 I tabled a written statement in Parliament concerning the contingent liabilities arising from the contract between the Government and AstraZeneca/Oxford in respect of the vaccine (MH2/903 **INQ000234274**. The point was made in the statement that:

> *"It has been and is the Government's strategy to manage COVID-19 until an effective vaccine/s can be deployed at scale. Willingness to accept appropriate indemnities has helped to secure access to vaccines with the expected benefits to public health and the economy alike much sooner than may have been the case otherwise.*
>
> *Given the exceptional circumstances we are in, and the terms of which developers are willing to supply a COVID-19 vaccine, we have had to take a broader approach to indemnification than we usually would…*
>
> *Even though the COVID-19 vaccines have been developed at pace, at no point and at no stage of development has safety been bypassed…"*

615. On 7 January 2021 I attended a further meeting with the Prime Minister and others about the vaccine rollout. The meeting focussed on how the vaccine rollout would be delivered across the country and building trust in it (MH2/904 **INQ000234278**. I managed the vaccine rollout on a day-to-day basis, including through a daily call with all of the key responsible officials. We updated the Prime Minister, generally weekly, and he gave his steers, which were essentially to try to go faster. We occasionally asked the Prime Minister to make calls to key international players, like the Chief Executives of the major vaccine manufacturers, which were helpful.

616. On 8 January 2021 I was provided with an information only submission concerning the interim readout from RECOVERY AND REMAP CAP trials concerning convalescent plasma (MH2/905 – INQ000059533).

617. On the same day I was provided two other submissions, one concerning asymptomatic testing during lockdown and another on new areas going live as part of the community testing programme, both of which sought my approval (MH2/906 and MH2/907 - **INQ000234281** **INQ000234280**). My approval was communicated by my Private Office the next day, along with a request from me as to an explanation as to what would be done with the data collected as part of the asymptomatic testing (MH2/908 - **INQ000234279**

618. On 18 January 2021 I chaired a meeting concerning a potential new Covid-19 variant in Liverpool, noting that the Department must do everything possible in response to new variants (MH2/909 **INQ000234282**, which were a significant concern given that we did not yet know whether the vaccine would be effective against emerging variants. Now that we had two vaccines that worked against Covid-19, the major remaining concern was of a variant that was resistant to the vaccine, as this would have sent us back to the start and risked disaster.

619. Whilst the Government was accelerating the rollout of the vaccine towards the end of January 2021, the EU sought to frustrate this by seeking to impose an export control that would have hampered the UK's ability to take delivery of doses the Government had already purchased. EU leaders were frustrated that we had put in place legally binding contracts to secure early vaccine doses for the whole UK population, and sought to use all possible legal powers to divert vaccines into the EU. This row took up a huge amount of time and effort over the forthcoming months, and involved a wide range of Government actors to defend our position. Thankfully, the EU eventually backed down. The lesson from this whole ugly episode is the vital importance of exclusive contracts for delivery, and as much onshore manufacture of vaccine as possible. Thankfully, we had been attuned to this from the start, and I had insisted the contracts we put in place protected UK supply as much as possible. Nevertheless, it was uncomfortable that the EU attempted to act in this manner.

620. On the night of 27 January 2021 I did a night shift at Basildon Hospital alongside NHS staff. It was an extraordinarily sobering experience. I have described before the incredibly impactful experience of seeing a patient with Covid-19 consent to being intubated in the

knowledge that his chances of waking up were 50/50. This drove home to me once more the horror of the pandemic.

621. On 29 January 2021, ahead of a meeting with the Prime Minister on the same day, I had a meeting with Departmental officials to discuss the exit strategy from lockdown, as by that point the restrictions, combined with the vaccination programme, was starting to drive case numbers down (MH2/910 **INQ000234284**. At the COVID-S meeting chaired by the Prime Minister a draft document on the 'Strategy and Pace of De-escalation' was discussed (MH2/911 **INQ000234283**). I argued that we needed to exit lockdown at a pace that was as fast as reasonably possible, subject to there being no reversals. We should always keep R below 1, increasingly relying on the vaccine to suppress the virus. I also argued England should move at one pace and we should not revert to the tiers system. Both these points were agreed. It was rewarding to see that the number of cases was falling faster among vaccinated cohorts, demonstrating that the vaccine was working in practice.

622. Further on 2 February 2021 a letter was sent to the Prime Minister on behalf of myself and the Chancellor of the Duchy of Lancaster in response to a request from him about options for making the NIHP (which subsequently was formally named the UK Health Security Agency "UKHSA") a substantially more UK-wide body. Our response noted that:

> *"We should therefore remain clear within Government that we are prepared to legislate in the future to secure UK-wide approaches to significant health protection issues. We should plan a fundamental review of UK health protection legislation, including the Public Health Act (1984), to look afresh at how health protection powers and responsibilities are delivered across the UK.*
>
> *This should build on our learning from COVID-19 (Annex A), but must also take account of both the high volume of 'business-as-usual' health protection activity, with many thousands of smaller-scale incidents managed at a local level each year, and of the wide range of potential future threats. Given the heightened phase of the COVID-19 response we are currently in, we propose that we plan for this review to begin in Autumn this year."*

623. The Prime Minister indicated his support for the approach outlined in our letter on 8 February 2021 (MH2/912 **INQ000234287**

624. On 3 February 2021 the Department announced that more than 10 million people in the UK had received one dose of a vaccine against Covid-19, with those doses being delivered between 8 December 2020 and 2 February 2021. 9 out of 10 people aged 75 and over in England had had their first dose. As I said at the time, and by which I resolutely stand now:

> *"This terrific achievement is testament to the monumental effort of NHS workers, volunteers and the armed forces who have been working tirelessly in every corner of the UK to deliver the largest vaccination programme in our history. Every jab makes us all a bit safer – I want to thank everyone for playing their part.*
>
> *Vaccines are the way out of this pandemic. The unprecedented national effort we have seen right across the United Kingdom means the majority of our most vulnerable people are now inoculated against this awful disease.*
>
> *The UK government has worked rapidly to secure and deliver doses to all of the UK, demonstrating the strength of our union and what we can achieve together."*

625. On 9 February 2021 I gave an oral statement to the House of Commons concerning the work that I had been leading on with the Department, the Home Office and the Department for Transport on strengthening our health protection at the border (MH2/913 **INQ000234288**. I set out the three elements of the strengthened end-to-end system for international arrivals, which was due to come into force on 15 February 2021 (MH2/914 **INQ000234286** hotel quarantine for UK and Irish citizens who had visited a red list country in the last 10 days and home quarantine for all passengers from any other country; strengthened testing with a three-test regime for all arrivals; and strong enforcement. I won the argument for the stronger border policy because of the reasonable fear of a variant that might undermine the success of the vaccine programme. Finally, we had a border health protection policy worthy of its name. Building the system to put this policy into practice was an enormous effort. We brought in a leading Civil Servant Shona Dunn, and General Sir Gordon Messenger to lead the project, and they delivered the hotel quarantine on time incredibly quickly. One huge learning from the pandemic is of the vital importance of border protection measures. We must use the geographical advantage of being an archipelago to protect people. Work is needed now

to be able to implement comprehensive, UK-wide or GB-wide health measures at the border at pace for next time.

626. I signed The Health Protection (Coronavirus, International Travel) (England) (Amendment) (No. 7) Regulations 2021 on 12 February 2021 in advance of the 15 February 2021 start date (MH2/915 to MH2/921 - **INQ000234290** **INQ000234291** **INQ000234292** **INQ000234292** **INQ000234295** **INQ000234296** **INQ000234293** These regulations had been developed following discussion at COVID-O meetings throughout this period (MH2/922 to MH2/926 – INQ000091827; INQ000091660; INQ000091715; INQ000091717; INQ000091708).

## 15 FEBRUARY 2021 – 26 JUNE 2021: EMERGING TOWARD 'THE NEW NORMAL'

*The Roadmap*

627. On the morning of 15 February 2021 I attended a COVID-O meeting chaired by the Prime Minister to discuss the proposed approach to regular testing in school environments as a pivotal part of the first step in the roadmap out of the third lockdown, which was in the process of being discussed and finalised (MH2/927 to MH2/930 - INQ000091747; INQ000092358; INQ000092359; **INQ000234289**

628. Almost immediately after this meeting I chaired a meeting with Departmental officials to discuss the details of the roadmap (MH2/931 **INQ000234299**, following a submission I had received on the Departmental position on the various elements of the roadmap the day before (MH2/932 and MH2/933 **INQ000234297** **INQ000234298**. I was clear in this meeting that any reopening should be *"…driven by the data, not dates."*, which in my view had not been the case during the reopening in Summer 2020 and, as set out earlier in this statement, led to us re-opening too far, resulting in exponential spread of Covid-19 and the second wave. Five steps were proposed in the Roadmap (starting with returning children to education settings as a priority) assessed against four 'tests':

a. The vaccine deployment programme continuing successfully;
b. Evidence showing that vaccines were sufficiently effective in reducing hospitalisations and deaths in those vaccinated;
c. Infection rates not risking a surge in hospitalisations which would put unsustainable pressure on the NHS; and

d. The assessment of the risks not being fundamentally changed by new Variants of Concern.

629. On 18 February, I then met with the Prime Minister, the Chancellor of the Duchy of Lancaster, the CMO, Baroness Dido Harding and Steve Barclay to discuss the schools testing plan, as well as plans to regularly test employees who returned to work as part of the roadmap: (MH2/934 **INQ000234306**). The Prime Minister agreed with our proposals, and also requested proposals on how the certification of vaccines and testing could be used to assist with opening risky sectors and venues, which he considered needed to be addressed in the roadmap.

630. Later on 18 February, I held a further meeting with senior officials in the Department to discuss the thinking that had developed on how we would approach some of the finer details of the roadmap out of the third lockdown (MH2/935 **INQ000234300**). We were anticipating that any easing of social restrictions prior to the Easter weekend would only apply to outdoor interactions, which we had been advised by the CMO carried a lower risk of transmission. We discussed how the five tests for easing restrictions might be met in the coming months, noting that some restrictions (particularly international travel) may need to kept in place, subject to the current data on variants of concern and vaccines.

631. As I explained in this meeting, it was imperative that the roadmap was guided by the scientific advice on whether or not the vaccines were effective against variants of concern. Not only was this consistent with the stipulation that we would follow 'data not dates', but it was central to our agreed strategy: the vaccines were our route out of lockdown because they lowered Covid-19 deaths significantly. If they were not effective against variants of concern, the justification for easing restrictions disappeared entirely. I was particularly concerned about the widespread expectation that international travel would be resumed as part of the roadmap: this would inevitably expose the country to a number of new variants. Unless the scientific advice was that the vaccines were effective against developing variants, the risk of reopening too quickly was unacceptably high levels of Covid-19 hospitalisations and deaths. I said publicly around this point that I expected us to have a "great British summer" but that we could not expect international travel to have returned to normal.

632. Alongside vaccines, testing was another critical plank of the easing of restrictions. Although it was hoped that the vaccines would significantly reduce C19 rates, it remained pivotal that we identified positive cases and restricted their spread, and that we had the

best possible information on variants of concern, which were detected through PCR tests with genomic analysis. Our testing capacity had continued to increase, and we were able to offer regular testing to the entire symptomatic population.

633. Finalised proposals on the roadmap out of lockdown were discussed at a COVID-S meeting on 21 February 2021: (MH2/936 - INQ000088274). A key assumption underpinning the roadmap was that it would proceed cautiously but irreversibly. We were not aiming for the eradication of Covid-19, which we were advised would be impossible – as the Scottish Government had discovered when they announced a plan for eradication against scientific advice. Instead the goal was to reduce the impact of Covid-19 as much as reasonably possible, consistent with the levels of seasonal influenza recorded in the UK. Each of the five steps of the roadmap were preliminarily scheduled to be five weeks apart to allow sufficient time to review the impact of the previous step; however, the dates were not fixed and Government agreed that the progression to a subsequent step must be determined by the latest data regarding the impact of the latest easing of restrictions on Covid-19 rates, and on any emerging variants of concern.

634. The roadmap proposals were agreed by all at the COVID-S meeting on 21 February, and then also noted without dissent at Cabinet the following day. The same day, the Prime Minister gave a press conference announcing the roadmap, which was also published in a comprehensive document explaining how the Government intended to progress through the roadmap and provide support to various sectors (MH2/937 - INQ000185087). There was a reasonable debate about the inclusion of provisional dates. I could see the argument of those who said dates were not helpful, but in practical terms an indication of timings was necessary.

*The Vaccine Rollout and the Facilitation of the Roadmap*

635. Following the first vaccination on 8 December 2020, the vaccination programme had moved at an astonishing pace, with 15 million first doses and half a million second doses having been given to adults in England as of 22 February 2021 when the roadmap was agreed.

636. In October 2020, the Serum Institute of India ("SII") had approached the Department to offer 10million doses of the Oxford AstraZeneca vaccine, which they had manufactured in India. The SII were grateful for the UK's approach of allowing them to manufacture the vaccine at cost. This would have been subject to the approval of the

MHRA and receiving confirmation that India would permit the exports of the vaccines after they had been purchased. I asked the Department to take this offer forward, but unfortunately, the Vaccine Taskforce did not proceed with this proposal at the time, stating that the MHRA's approval would not arrive in time for the vaccines to be used.

637. However, the SII continued to offer vaccines. They maintained their argument that without the exceptionally generous Oxford / AstraZeneca agreement to allow manufacture of the vaccine at cost around the world, they would not have been able to make vaccine for India and many African countries at all. In February 2021, this offer was brought to the Prime Minister's attention, and he asked why it had not been taken up.

638. Upon investigation, it became clear that the members of the Vaccine Taskforce had in fact blocked the Department's proposal because they did not approve of purchasing vaccines from India, on the mistaken assumption that the UK was 'taking' vaccines from a lower income country that needed the vaccines (MH2/938 to MH2/940 - INQ000095800; INQ000129723; INQ000129725). This was not accurate: the SII was a significant manufacturer of vaccines, producing 50 million doses per month which were shipped worldwide. In receiving 10 million vaccines from the SII, the UK was purchasing vaccines that had been intended for worldwide sale, not for deployment within India. In fact this was reflected in the contract with AstraZeneca, which explicitly required AstraZeneca to warrant that any supply from SII would not prevent SII satisfying the supply of vaccines to India and other low to middle income countries.

639. The AstraZeneca / Oxford contract is one of the most generous contracts ever written. Unlike most of the other vaccine manufacturers, AstraZeneca did not charge for the intellectual property, and during the pandemic, allowed for the vaccine's manufacture at cost. Personally, I was frustrated that we as a country did not make more of this generosity. Debates around this time about "donating" small number of vaccine doses entirely missed the point that AstraZeneca was donating the ability of most of the world to manufacture the vaccine. Later debates pushed by the White House promoting banning charging for IP for vaccines for the developing world missed the point that the UK had done this from the start through this remarkable contract. Accepting a small number of doses, essentially in thanks for and recognition of this enormous generosity, was entirely reasonable. AstraZeneca should be showered with praise for their role in helping protect more people around the world than anyone else.

640. It was disappointing that this proposal had not been proceeded with in October 2020, and that the objection had not been explained truthfully so that it could be aired and resolved. Had the proposal been accepted at that stage, we would have received 10 million doses at a much earlier date, which would have propelled the vaccine rollout significantly which could, in turn, have saved more lives.

641. Having straightened all this out, at a meeting on 19 February 2021 (MH2/941 - **INQ000234302**) the Prime Minister approved the SII proposal, on the basis that the 10 million doses fell within the 100 million doses that the UK had contracted from AstraZeneca. On 21 February we were able to announce that all adults would be offered a Covid-19 vaccination by the end of July.

642. At the same time, we were continuing to work hard towards our commitments under the WHO's COVAX programme, and on 24 February 600,000 doses of the Oxford AZ vaccine arrived in Ghana, which was the first batch of COVAX vaccines to be delivered outside of India under the programme, marking the start of the first wave of billions of vaccine deliveries to COVAX recipient countries. The UK was a significant contributor to the programme directly, and contributed tens of million of vaccines to the programme, on top of the supply of billions of doses of vaccine at cost due to the AstraZeneca contract.

643. Throughout 2021, many of the large pharmaceutical companies were accused of 'pandemic profiteering', by selling vaccines for profits when much of the developing world did not have access to vaccines. In my view, Oxford University and AstraZeneca did not receive enough credit for their role in ensuring worldwide access to the vaccine by delivering the Oxford / AstraZeneca vaccine at cost during the pandemic, enabling orders to go further and therefore protecting a larger proportion of the world's population.

644. By 25 February, we had administered 18 million doses of the vaccine across the UK, and it was anticipated that the JCVI's priority cohorts 1-9 would be vaccinated by mid-April. We had requested advice from the JCVI as to how the remaining population should be prioritised for vaccination to prevent as many deaths and hospitalisations as possible. The interim advice received by the JCVI as of 25 February was that the most effective approach was to offer vaccines in age bands, as age was one of the biggest contributing factors to the development of severe Covid-19 (MH2/942 - INQ000091751).

645. I asked the JCVI to consider that the data showed an increased risk of hospitalisations among men, BAME communities, those with a BMI of 30 or more (who were therefore

classified as obese or morbidly obese) and those who were considered to have socio-economic deprivation. The JCVI considered these facts, and nonetheless found that based on an objective analysis their prioritisation was right, and for those groups it recommended encouraging uptake insofar as possible (MH2/943 to MH2/945 - **INQ000234304** **INQ000234303** **INQ000234305**

646. We agreed to adopt the interim recommendations of the JCVI which I announced at the daily press conference that day, on the basis that we needed to be guided by scientific advice as to how we could save as many lives as possible.

647. The JCVI's advice was confirmed as final on 12 April 2021: (MH2/946 and MH2/947 - **INQ000234314** **INQ000234313**

648. On 8 April, PHE announced that it estimated that the vaccination programme had prevented 10,400 deaths in the UK (MH2/948 **INQ000234312**). Subsequently, oy 27 April (when 1 in 4 UK adults had been vaccinated), the number of deaths involving Covid-19 had fallen by an astonishing 97% since the peak of the second wave; the vaccine's development and rapid roll out had fundamentally improved the consequences of contracting Covid-19 for the vast majority of the population, and was a true British success story.

649. Due to the success of the vaccine rollout we were able to move to Step 2 of the roadmap as of 12 April 2021, which enabled the re-opening of all non-essential retail and outdoor venues. A Cabinet Office review was prepared for COVID-O prior to the decision and we agreed that the country was ready for the move to Step 2, noting that nearly half of the adult population had received their first dose (over 30 million doses) (MH2/949 to MH2/953 - INQ000091824; INQ000091825; INQ000092027; INQ000091855; INQ000091856). The scientific advice that we were receiving at that time suggested that the vaccine provided 60% protection against contracting Covid-19, 80% protection against being hospitalised as a result of contracting Covid-19, and up to 85% protection against death due to Covid-19. It was therefore highly likely that Covid-19 rates would go up (among the unvaccinated but also, to some degree, the vaccinated) but that we would not see an accompanying sharp rise in hospitalisations and deaths.

650. Cognisant of the likely time-limited protection of the vaccine, and the need to ensure that protection was adequate in the winter months, we had also been preparing plans for a vaccine booster programme, beginning in the Autumn. On 20 April I attended a meeting

with the Prime Minister and the CMO to discuss these plans, including how and when they would best be delivered, as well as the nature of the vaccine to be delivered in a booster programme (MH2/954 **INQ000234315**). This resulted in agreement in principle to begin booster jabs in September 2021, and I put in place a series of further meetings to plan the booster rollout.

651. Following the easing of restrictions on 12 April 2021, we had been keeping a close eye on Covid-19 data to assess the impact of the easing and whether it was likely to be possible to move toward Step 3. As of 28 April, 33 million UK adults had received their first dose and 13 million had received their second dose of the vaccine, which meant that a significant proportion of the most vulnerable adults had the enhanced protection that the second dose offered.

652. In COVID-O discussions as to whether or not the UK was prepared for Step 3 of the roadmap, we noted that the next step would inevitably pose challenges to social distancing given the higher limit on gatherings, and as venues and public transport got busier. This would inevitably result in increased transmission, and an increased demand on the test and trace programme. By this stage, the country's PCR testing capacity was 635,000 tests per day, and in addition to the now very widely available LFT tests had expanded to a level which meant that we could offer asymptomatic testing as a preventative and mitigating measure for the increased risk associated with Step 3 of the roadmap. Furthermore, the overall prevalence of Covid-19 across the UK was less than 0.1%, which we considered to justify proceeding with the move to Step 3 as planned (MH2/955 to MH2/963 – INQ000091902; INQ000091903; INQ000091881; INQ000091924; INQ000092458; INQ000092126; INQ000091901; INQ000092063; INQ000092474).

653. Although the overall prevalence of Covid-19 was less than 0.1%, there remained areas of concern where cases were being reported at enduring transmission levels which were out of keeping with the national average. We were advised that these were high risk areas because they were, broadly speaking, populated by groups who were particularly susceptible to the risks of Covid-19, and among whom vaccine uptake was particularly low. This was a difficult problem to solve: we could not force anyone to have the vaccine, but it was a big concern that individuals in these areas could be badly affected by Covid-19, particularly if a virulent variant of concern emerged. We agreed that further work would be undertaken to try and encourage vaccine uptake in these areas, which would

need to be led by a proper understanding of why vaccine uptake was low, and any concerns that were held.

654. Since March, much consideration had been given to the resumption of international travel which, for the reasons set out above, posed particular risks. In tandem, further consideration had been given to the role that vaccine and/or testing certification could play in the UK's reopening and in relation to international travel. As part of Step 3, it was announced that international travel would resume on 17 May, and that the NHS App would facilitate an NHS Covid Pass for the purpose of demonstrating vaccination status for travelling. I discuss decision making in relation to international travel in further detail below.

655. On 10 May, the day that the Prime Minister announced that the country would move to Step 3 of the roadmap on 17 May, deaths and hospitalisations due to Covid-19 were at the lowest levels since July 2020 thanks to the impact and rapid roll out of the vaccine.

656. As was to be expected with the easing of restrictions, Covid-19 cases began to rise in mid to late May 2021. However, the relationship from cases to hospitalisations and deaths, which had remained constant throughout 2020, was now much weaker, thanks to the vaccine. As is now widely known, it is possible to catch Covid-19 after a vaccine, but the disease is usually much milder. It became clear that a large number (between half and three quarters) of new cases were of the Delta variant, a new variant of concern which was first identified in India in October 2020. Not only was the Delta variant of concern because it was associated with rapid transmission, the scientific advice that we had received was that the Delta variant was to some degree resistant to one dose of the vaccine. However, thankfully, protection against Delta increased significantly following the second dose of the vaccine.

657. The delivery of the vaccination programme therefore remained a pressing priority (MH2/964 - **INQ000234317**. We also agreed to conduct surge testing and surge vaccination in eligible cohorts within areas that had the highest rates, particularly the North West of England (MH2/965 - **INQ000234316**). We resisted calls to allow a wider group access to the vaccine in these areas, having seen how local lockdowns had caused problems of fairness, but we did put extra resources in to help ensure as high a proportion of those eligible got the vaccine as fast as possible. We put in place significant resources to ensure vaccine adoption was as high as possible across all communities.

658. By the end of May 2021, cases of the Delta variant were growing exponentially, which resulted in Government's consideration of whether it was acceptable to progress to Step 4 of the roadmap: we could not risk cases spiralling out of control as they had done after the first lockdown.

659. SPI-M concluded that the Delta variant had a 40-60% growth advantage over the Alpha variant (MH2/966 - **INQ000234319**, and on 4 June 2021 I was provided with a risk assessment (MH2/967 - **INQ00023432**) which explained that early evidence indicated an increased risk of hospitalisation from the Delta variant, and that around 20% of the Delta cases were people who had received only one dose of the vaccination (as compared to those who had received two doses, who made up 3% of the cases).

660. A delay to the roadmap was far from desirable given the prolonged impact of the restrictions on society, particularly on a number of groups with specific vulnerabilities and known disadvantages, including: disabled people, BAME groups, and those on a lower income, of whom women and young people made up a greater percentage. We considered the decision very carefully and noted these impacts. We were presented with evidence that a relatively short delay of 4 weeks would save many thousands of lives, because the delay would enable us to deliver more vaccines: all adults would have been offered their first dose by 19 July, and all over 40s would have had their second dose, which was an important protective factor against severe Covid-19 infections and hospitalisations. Not only had we committed to making sustainable and irreversible changes to restrictions, the entire roadmap plan was founded on the protection of the vaccine and therefore had to reflect the rollout and the data on vaccine efficacy against variants of concern. This delay was discussed at a Quad meeting on 13 June, and then at the COVID-O meeting on 14 June (MH2/968 to MH2/972 - **INQ00023432** **INQ000234322** **INQ000234323** **INQ000234325** INQ000092509).

661. Given that Step 4 of the roadmap lifted the legal restrictions on gatherings both indoors and outdoors, this was an important stage for significant gatherings, such as weddings, civil partnerships, wakes, or other commemorative events. We were conscious that many postponed events had been arranged as of 19 June onwards, in reliance on the indicative date set out in late February. These events were, by their nature, high risk for Covid-19 transmission. The information provided to us by the sector indicated that the economic impact of a delay to Step 4 would impact 60,000 businesses, and that approximately 50,000 weddings were planned between 19 June and 19 July. We therefore gave consideration to whether some of the Step 3 restrictions could be eased in respect of

these events, to prevent further impacts on these already significantly affected businesses, and also on families who had already experienced delays and disappointment: (MH2/973 **INQ000234324**.

662. Recognising that such events presented a high risk of transmission, and that their normal resumption would effectively amount to a move to Step 4 only for these events, we agreed that there would be no legal restriction on the number of people at such gatherings, provided that they were taking place at a Covid-19 secure venue, which meant that: numbers were in any event restricted by the venue's socially distanced capacity, face coverings were mandatory, and certain activities were still restricted, including singing, dancing, and movement around the venue was restricted necessitating table service.

663. By 18 June, vaccine bookings were open to all adults. As of 18 July, a day before the easing of the final remaining Covid-19 restrictions, every adult had been offered a first dose of their Covid-19 vaccine, 87.9% of adults had received their first dose, and 68.5% had received their second dose (MH2/974 - **INQ000234326**. We had achieved a phenomenal amount as a country in the seven months since the first patient received a Covid-19 vaccine on 8 December 2020 and since the MHRA approved the Oxford AstraZeneca vaccine on 30 December 2020.

664. Step 4 of the roadmap proceeded on 19 July 2021 as intended. Prior to that date, it was agreed that mandatory testing certification was not suitable nor workable for great swathes of daily life, but that it had a potential role to play in high-risk venues, such as concerts. It was agreed that testing certification based on home testing would take place on a trial basis for 60 days from its introduction, and that it would broadly be appliable to: indoor and unstructured settings with capacity of over 500; any event with capacity of over 20,000; and unstructured or blended outdoor events with capacity of over 4,000 (MH2/975 – INQ000092240).

*The Impact of the Roadmap and the Vaccine Rollout on Care Homes*

665. As part of the cautious easing of restrictions under the roadmap, it was decided that care home residents would be able to receive a regular indoor visit from one named individual as of 8 March, in addition to the existing pod, screen, or outdoor visits (MH2/976 to MH2/978 **INQ000234301** INQ000091741; INQ000091745). A resident's named visitor was required to take a Covid-19 test before entering the care home, and

had to follow certain rules and protocols to ensure that the visits did not pose a threat to the safety of the residents.

666. In line with the roadmap, that one named visitor increased to two named visitors under Step 2, and then to five named visitors when the country moved to Step 3 before restrictions were lifted entirely as of Step 4.

667. A great deal of thought was given to whether to proceed with the initial relaxation and to allow visitors to return to care homes: we knew that care home residents were extremely vulnerable and did not want to do anything that would result in care home outbreaks like those seen in 2020. However, the need to protect residents had to be balanced against their mental health and wellbeing, and the importance of connections with loved ones; giving residents the ability to hold the hand of a loved one was, in our conclusion, a necessity that could not be withheld and was in accordance with the easings for the general public. We also recognised that what we had learned on community transmission and the importance of limiting staff movement would, we hoped, prevent a great deal of transmission.

668. During the easing of restrictions it had been identified that there had been a low uptake of vaccines by social care workers, with the percentages of workers and residents who had received the vaccine reported as being below the targets which had been set by SAGE to keep the R number below 1 and prevent spread in care homes. This was a matter of extreme concern given the vulnerable people that those carers worked with, and the proven impact of the vaccine on both transmissibility and the severity of Covid-19 cases. The data on the Delta variant only exacerbated those concerns.

669. The Prime Minister and I had therefore discussed making flu and Covid-19 vaccinations a condition of work for all care home workers. Although the concept was a restriction on individual choice, there were parallel requirements in respect of other viruses and diseases, and the decision was necessary to protect the most vulnerable in society. I was in no doubt that it was the right thing to do. On 17 March, at a Ministerial meeting of COVID-O, it was agreed that the Government should proceed to take steps to make vaccination a condition of deployment, while also working on non-legislative solutions in the interim, including the assessment and mitigation of any particular impacts on disproportionately impacted groups: (MH2/979 to MH2/981 - INQ000091817; INQ000092064 **INQ000234310**

670. In response to a submission on this issue, received on 25 March 2021 (MH2/982 - **INQ000234311**), I agreed that the Department should run a consultation on mandatory vaccinations for care home workers, which opened on 14 April. Following receipt and consideration of the consultation responses, it was announced on 16 June 2021 that the Covid-19 vaccination would become mandatory for care workers, with a grace period of four months to enable workers to obtain a vaccination if they had not already done so.

671. Around the same time, and considering that the same public health concerns were applicable to healthcare staff who worked with vulnerable patients as well as visiting care home patients, the Department announced that it would run a second, similar consultation in relation to the mandatory vaccination of all other healthcare staff. This was dropped, without good reason. However, this science-based policy has been a very significant success. The concerns raised, especially about staff leaving these caring professions, did not materialise. One important lesson is that mandatory vaccinations for Covid-19 and flu should be extended to all health and social care staff to save lives.

*Decision Making in Relation to International Travel*

672. The Department regularly provided the Prime Minister with data relating to borders and any emerging variants of concern. Before, and during the outset of, the roadmap I urged the Prime Minister to take a cautious approach to international travel, particularly to countries known to have variants of concern. For the reasons I have already explained in this statement, those variants presented the biggest threat to our easing of restrictions and went to the core of the principles underpinning the roadmap. At this stage, the UK's 'red list' of countries was determined by a methodology devised by the Joint Biosecurity Centre (MH2/983 **INQ000234318** which considered, in particular, the significant risk posed by any variants of concern in those countries. To my mind, this unknown went to the core of all of our strategies, which were underpinned by the vaccination roll out.

673. I urged this cautious approach on the Prime Minister when he was making decisions on red list designations; for example, in late February and early March 2021 when consideration was given to placing France on the red list due to its high number of cases from the South African variant (5% of its Covid-19 cases), which was ultimately decided against given the economic impact of doing so: (MH2/984 to MH2/986 - INQ000129736; **INQ000234309** **INQ000234307** These were obviously challenging and finely balanced calls for the Prime Minister to make, but my perspective was that we should always take steps to maximise the protection of public health until the situation was less precarious.

674. As the roadmap progressed and the number of vaccinated adults in the UK rose (causing hospitalisations and deaths to fall, as stated above), there was an ever increasing amount of media interest in when international travel would be resumed, with the roadmap having stated that a review of travel would take place at Step 2, with a view to international travel resuming at Step 3 (on 17 May).

675. In late March, we agreed that the UK should adopt a 'tiered' system to international travel, moving from red (high risk) and amber (lower risk) countries to a more nuanced range of red, amber plus, amber, and green countries, reflecting the risk posed by the relevant countries and therefore informing international travel. As was the case previously, those returning from red list countries would be required to enter a Managed Quarantine Service on their return. An amber plus designation would serve as a warning that a county may be escalated from amber to red, thereby requiring MQS on their return. (MH2/987 to MH2/1002 - INQ000091831; INQ000091832; INQ000091833; INQ000091834; INQ000091835; INQ000091836; INQ000091837; INQ000091838; INQ000091839; INQ000091840; INQ000091841; INQ000091849; INQ000091851; INQ000092425; INQ000092426; INQ000091853). As the Inquiry is aware, international travel was resumed on 17 May as part of Step 3 of the roadmap.

676. The NHS app was strengthened so those wishing to show their vaccination status abroad or to travel could do so. This was a very significant success, and the data integration internationally was unprecedented, which meant the NHS app could be used in many countries that had vaccine passports.

677. In the UK we considered vaccine or testing passports repeatedly. However, other than for international travel they were never introduced. On balance I think this was the right decision. For vaccine passports to work effectively, the clinical advice was that they needed to be applied in a very wide variety of settings, including pubs, restaurants, places of work as well as large events. They are therefore likely to be extremely divisive as a social distancing tool. While some object in principle, I supported this practical reservation. Nevertheless, an international study of their effectiveness would be valuable, as in considering future social distancing measures to suppress a future virus, we should not only consider the tools we did use, but also the ones we did not, so as to be able to suppress a future virus at the least cost in future, according to the doctrine I have set out.

678. On 25 June 2021 I resigned from the position of Secretary of State for Health and Social Care, as I had broken the Covid-19 guidelines. Although I had not broken the law, I believe that it was right to take responsibility and be held accountable. I regret this mistake and apologise unreservedly again here.

## CONCLUSION

679. Throughout the pandemic, I worked round the clock and with dedication to build a pandemic response, often from scratch, that protected the British public, and allowed the country to take steps toward resuming normal life. It was the greatest challenge of my life, and a privilege to lead such a talented and dedicated team across the health sector. I am wholeheartedly committed to, and focused on, providing this Inquiry with my experience of responding to the pandemic, and doing all I can to ensure that the country learns the right lessons before the next pandemic arrives.

680. I have tried to set out in this statement, and to the best of my ability, the facts about what happened, and my recollections about what went well and what went badly. The absolutely central lesson is that if a lockdown is needed, it should be brought in faster, broader, and more firmly than feels comfortable. The facts show that delaying a lockdown leads to a worse lockdown – with worse health and economic outcomes. Fine judgement is needed to ensure any lockdown does as little damage as possible, subject to getting R below 1. Preparations should be in place for the myriad operational requirements that must be capable of being expanded rapidly. A vaccine must be ready to be rolled out as fast as possible. We must learn these lessons for the future, to protect lives in the next pandemic, and ensure there is a plan for the next Health Secretary, when that awful event occurs.

**Statement of Truth**

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

**Signed:** **Personal Data**

**Dated**: 3 August 2023