Monday, 19 June 2023

(11.00 am)

LADY HALLETT: Yes, Mr Keith.

MR KEITH: Good morning, my Lady.

As sometimes happens, I know the next witness, and so he will be examined by Ms Blackwell.

MS BLACKWELL: Thank you. May I call David William Donald Cameron, please.

Mr Cameron, will you please take the oath.

MR DAVID CAMERON (sworn)

Questions from COUNSEL TO THE INQUIRY

MS BLACKWELL: May I begin, Mr Cameron, by thanking you for the assistance you have so far given to this Inquiry and for coming to give evidence today.

May I also ask you to keep your voice up and speak into the microphone so that the stenographer can hear you for the transcript.

Is your full name David William Donald Cameron?

A. Yes.

Q. You were leader of the Conservative Party and the Leader of the Opposition from 2005 until 2010, when you became Prime Minister of the United Kingdom, leading a coalition government with the Liberal Democrats, with Nick Clegg as your Deputy Prime Minister and George Osborne as your Chancellor.

A. Yes.

Q. To put that in context, you became Prime Minister in the wake of the 2008 global financial crisis, and you remained Prime Minister in 2015, when the Conservatives won the general election and you formed a Conservative government. In 2016, you stood down following the European Union exit referendum result.

Now, your evidence this morning is going to fall under four topics. First, the architecture in place to deal with large-scale emergencies in 2010 and changes implemented during your time in office; two, the state of pandemic preparedness before and during your tenure; three, your concerns around the World Health Organisation; and, four, the impact of austerity on the health and social care service and underlying health inequalities.

First of all, can we please have on the screen your witness statement, which is at INQ000177808.

Can you confirm, please, Mr Cameron, that this is your witness statement and it's made true to the best of your knowledge and belief?

A. Yes, it is. Yes, I can.

Q. Thank you. For the record, it is in fact signed at page 19, but that signature has been redacted, my Lady, so we don't need to go to that.

Thank you, we can take that down, please.

So dealing first of all, please, Mr Cameron, with the architecture in place to deal with large scale emergencies in 2010 and changes implemented during your time in office.

When you became Prime Minister in 2010, you tell us in your witness statement that, in your opinion, the existing architecture to deal with large-scale emergencies such as pandemics derived in large part from the Civil Contingencies Act of 2004, and since 2008 had included the national risk assessment and the National Risk Register assessment. So by "architecture", you mean framework including legislation?

A. Yes.

Q. Yes.

But before come being into power, your sense whilst in opposition was that whilst the National Risk Register was a welcome innovation, the overall architecture for dealing with civil contingencies such as pandemics and the national security machine more widely could benefit, in your view, from improvement.

In what ways did you think it should be improved?

A. Well, I commissioned Pauline Neville-Jones, who had been head of the Joint Intelligence Committee, to write a report on national security and foreign policy in

opposition, and one of the recommendations she made was to have a sort of full-on national security council, to have a national security adviser, to have a national security secretariat, and the point was: to, first of all, make sure that the whole government looked at these risks; second, to make sure there was sort of real ministerial oversight, because the National Security Council would be chaired by the Prime Minister; third, to make sure that it was more strategic, thinking right across the board about all the risks, and also making sure it was truly international. So you were looking at risks of terrorism and climate change and space weather and all sorts of things, but also things like pandemics.

Why I particularly thought this was important was, while I think the Civil Contingencies Act and the previous government had done a good job in this regard, I knew that Prime Ministers are always in danger of being pulled into the short term rather than the long-term, and having a National Security Council that you chair and a National Security Advisor, and having as part of that looking at the danger of things like pandemics and -- and -- it would make sure you did focus on those long-term things as well.

So that was the point of the reform, and I think it worked. I really -- I liked the way the National

Security Council and the adviser worked and the time the Prime Minister spent on that stuff, because it had a good structure.

Q. You implemented those recommendations as soon as you came into office?

A. That's right. I mean, it was -- we were in the middle of the Afghan conflict, and I thought, for instance, we would handle that conflict better if we had a whole government approach and if the National Security Council could address the challenges, and you'd have round the table all the relevant people, whether it was the defence secretary, the aid secretary, the energy secretary, the Home Secretary and the Prime Minister.

Why I think it's so important is while, of course, Prime Ministers are very powerful, because they're Prime Ministers, they don't have a department in the same way that other ministers do, and having the National Security Adviser and the National Security Secretariat working for you and bringing together the whole of government to address these challenges, I thought got politicians involved at the highest level and the right level to make sure this was being looked at properly.

Q. So a National Security Council, as you've described, supported by a National Security Secretariat and

a National Security Adviser?

A. That's right, and the National Security Adviser had deputies, one of whom was mostly concerned with intelligence and terrorism and security, and the other more with foreign policy, but specifically part of the job of the National Security Adviser, together with the National Risk Register and the National Security Secretariat, was to look at all the potential risks, and, you know, it's important that we did make a pandemic, a health pandemic, a Tier 1 risk.

So it was about looking across the risks and saying: which ones are the most likely? Which ones do we need to prepare for the most? And, as I say, this pressure always to look at the most pressing risk, the terrorism risk, or the most dangerous risk or the most immediate risk, you need to balance that with making sure you're looking at all the risks, including ones that might not occur next month or next year but might occur at some stage, and that's why I think this reform was important.

I'm not saying these things weren't looked at before, of course they were, but this embedded in the system Prime Ministerial leadership and political oversight and a whole-government approach.

Q. Thank you.

Now, the risk of a future pandemic was, as you've

already made reference to, prioritised as a Tier 1 risk and remained as such, did it not, throughout your time in office, one of the highest risks that the United Kingdom faced. Although you tell us at paragraph 12 in your report that it was a pandemic that was prioritised as a Tier 1 risk, in fact it was more discrete than that, it was an influenza pandemic, wasn't it?

A. That's right. I mean, I think -- I mean, this is maybe getting ahead of myself, but, you know, when I look at all of this and read all the papers and thought so much about, you know, what subsequently happened, and the horrors of the Covid pandemic and, you know, let me say the massive sympathy I feel for all those who have lost loved ones and for the suffering people have felt and the importance of this Inquiry's work to get to the bottom of, you know, the decisions that were made, decisions that could have been made, and the preparations for the future, you know, this is the thing I keep coming back to, which is the pandemic was a Tier 1 risk, pandemics were looked at, but there was this -- the former Chief Medical Officer Sally Davies has said it was a groupthink -- it -- much more time was spent on pandemic flu and the dangers of pandemic flu rather than on pandemic -- potential pandemics of other

more respiratory diseases, like Covid turned out to be.

Q. Yes.

A. You know, I think this is -- this is so important, because so many consequences follow from that, and I've been sort of wrestling with why -- you know, I think the architecture was good, National Security Council, National Security Adviser, the risk register and also this new security risk assessment, which was perhaps a bit more dynamic. But that's what I keep coming back to, is so much time was spent on a pandemic influenza, and that was seen as the greatest danger, and we've had flus, we've had very bad years for flus, so it is a big danger, but why wasn't more time -- more questions asked about what turned out to be the pandemic that we faced?

And it's very hard to answer why that's the case, and I'm sure this Public Inquiry is going to spend a lot of time on that.

Q. Yes. Because during your time in office, there were several outbreaks of other coronaviruses across the world, weren't there?

A. Yes.

Q. This Inquiry has heard about multiple outbreaks of SARS and MERS, both of which were coronaviruses. I'd like to put on screen, please, the following document: INQ000149116, which is a note of a meeting of experts,

including Professor Mark Woolhouse at the University of Edinburgh and also Dame Sally Davies.

Could we go to page 2, please, because under the heading "Clear and present danger" -- if we can highlight the third paragraph -- we can see it, in fact:

"Coronaviridae, including the severe respiratory infections SARS CoV and MERS Cov. We note that although there are not currently any vaccines available against human coronaviruses there are vaccines for animal coronaviruses ..."

Now, this was a note from a meeting in March of 2015, when you were still in office, a meeting chaired by the former Chief Medical Officer, Dame Sally Davies, to whom you've just made reference.

Do you remember, Mr Cameron, if this assessment of coronaviruses as posing a clear and present danger was brought to your attention by the Chief Medical Officer in March of 2015?

A. I'm afraid I don't recall a specific conversation. But -- and it's difficult, this, because you're trying to remember, you know, conversations you had or didn't have seven years ago. And of course before this Inquiry I've read all of this documentation, and obviously in the documentation there is, and the government did look at, SARS and MERS, and particularly there is Operation

Alice in 2016 --

Q. Yes, we'll come to that.

A. -- which I'm sure we'll come to, but in terms of the specific conversation, I don't remember that. I would certainly say that my relationship with the Chief Medical Officer was very strong, and we met quite regularly, and because of the experience with Ebola, which I'm sure we'll also come on to --

Q. Yes.

A. -- I think this was a government and a Prime Minister that was very concerned about potential pandemics and about dangerous pathogens and about things like antimicrobial resistance and all the rest of it. So we weren't backward in thinking about it, but it still comes back to this issue, why so much time was spent on a flu pandemic and not so much on these others.

Although having said that, you know, the MERS exercise in 2016, that was looking at a respiratory condition.

Q. Yes, we'll come to that in a moment.

A. Yes, sorry.

Q. Not at all.

You've mentioned Ebola there, Mr Cameron, and indeed you were alive to the dangers that that disease or a similar disease with high transmissibility and high

mortality rates posed, and in the --

A. Sorry to interrupt. I think the point about Ebola, though, it's less transmissible but it's highly lethal, and I think that -- so we had been looking at pandemic flu, we had a plan for pandemic flu, we obviously wrote about, in the National Risk Registers, SARS and MERS, Ebola comes along, which is not that transmissible but highly deadly, and so you're -- you know, I think the question I keep coming back to is: why weren't more questions asked about something that was highly transmissible, indeed with massive levels of asymptomatic transmission --

Q. Yes.

A. -- which was lethal but at a lower level than either MERS or Ebola?

And I don't have an answer to that question, but that's clearly where the gap was.

Q. Well, so concerned were you about the Ebola crisis that you created a new body, didn't you, a threats body, the NSC(THRC), which is a rather clunky initialism for the National Security Council Threats, Hazards, Resilience and Contingencies committee.

A. Yes, I thought that pre-dated Ebola, but I may be --

Q. Well, forgive me, I think in your witness statement you tell us that it was formulated partly as a result of the

Ebola crisis, and in addition to which you also formed a horizon scanning committee, both of which were run by Oliver Letwin. And Oliver Letwin was, as you say in your witness statement, in many ways your resilience minister.

Why did you think it was necessary to establish the threats committee and the horizon scanning department?

A. I thought the Threats, Hazards, Resilience and Contingencies committee, I think it was set up before Ebola, but I have to check that. The reason for that was, as I said a bit earlier, clearly the National Security Council spent a lot of time on terrorism, on security, on Afghanistan, on Libya and Syria, and things like that. And so I thought it was important to make sure that the National Security Secretariat and the politicians in the government spent time on hazards, threats, things like pandemics, and other such things that were less immediate and current, but otherwise you spent all your time on the other things.

So that's why THRC was set up. Oliver was an extremely capable minister, and had worked in government before and was in the Cabinet Office and sat on National Security Council. So I knew he'd do a great job at chairing that and running that. Then, as you say, after Ebola, he suggested, and I think the letter

to me is in the bundle somewhere --

Q. Yes, we're going to come to that.

In fact, can we put that on screen now, please, INQ000017451.

Now, this is in fact the contingencies forward look, because the threats committee, as you explain in your statement, had a six-month forward look, didn't it, which was a much shorter term to -- when compared to the National Risk Register, which was five years, and the National Security Risk Assessment, which had a 20-year timeline.

This is one of the updates which, as the man in charge of the threats committee, he would give to you.

Can we look at page 22, please, and paragraph 6.2, and we will come on to the letter in a moment.

At paragraph 6.2, we can see here "An outbreak of a novel strain of an infectious disease causing serious illness (excluding pandemics)" is raised within this forward look. He tells you here that:

"The risk of an emerging infection becoming prominent is always present, particularly at the interface between animals and humans (ie zoonotic infections). Globally, there are currently three main areas of concern: the ongoing cases of MERS-CoV in the Middle East and Eastern Africa; the large number of

avian and human cases of influenza ... particularly in Egypt; and the epidemic of Ebola Virus Disease (EVD) in West Africa."

We can take that down, please, and can we go to the letter which you've made mention of, Mr Cameron, which is at INQ000146550.

This was a letter sent to you by Oliver Letwin the following year. We can see that it's dated 22 March of 2016, and we can read through this together. It's titled "Horizon scanning for international health risks":

"Diseases like Ebola and Zika can constitute major risks to our national security.

"I have therefore asked the Civil Contingencies Secretariat to develop a new scanning system for international health risks."

So this is the horizon scanning group.

A. Yes.

Q. "The results of this work have now been agreed with all relevant departments and have been endorsed by the Chief Medical Officer.

"I am confident that the new system will enable ministers to:

"- spot major emerging diseases across the world.

"- understand the direct risks to the UK, British

Nationals and broader UK interests in the affected countries; and

"- receive expert advice on clear and flexible UK responses and mitigation arrangements:

"A monthly report will be issued to the Health Secretary, the International Development Secretary and me. This will outline: key international health risks, departmental assessments of the impacts, and actions to mitigate the risks. I have asked the Chief Medical Officer to approve each monthly report before it is presented. Attached is an illustrative example of the report for your reference ....

"To avoid this becoming just 'business as usual', I suggest that, rather than sending these reports each month to the NSC(THRC), I shall write whenever officials have flagged a health risk of particular concern."

Then he goes on to talk about the implementation in April.

Were you concerned, Mr Cameron, that rather than -- using this as an example -- these bodies which you set up extending pandemic preparedness to a whole-government procedure, that what this was doing was encouraging working in a silo, so that fewer people rather than larger departments were going to be involved?

A. Oh, no. No, not at all. I think this was a really

excellent idea of Oliver's, and I think it came out of Ebola, because -- we'll come on to the World Health Organisation I'm sure -- you know, I don't think there really was very timely information coming out of the WHO about Ebola, and this was Oliver saying, "Let's have our own horizon scanning to look across the globe for emerging problems". And the next one that comes along, of course, is the Zika virus, and this -- the horizon scanning unit spots that quite early and then there are conversations in government.

So, no, I think this was saying: we can make the national security architecture work even better if we scan the horizons and look for novel pathogens and problems coming down the tracks. And I think that was a thoroughly good thing.

I don't know what happened to this organisation after I left, whether it continued, but I think this was a really good idea and I think it -- I don't think it was in a silo at all.

Q. All right. Well, I'd like to ask you some questions about placing Mr Letwin charge. You deal with this in paragraph 21 of your statement, in which you say:

"In terms of oversight of our resilience planning, I found that civil servants were very good at enumerating risks, setting them out and getting them in

the right order. However, to get follow on action, I tended to use very strong Ministers in the Cabinet Office."

And you say that in addition to Oliver Letwin you also had Francis Maude, who were "both very senior and experienced Ministers, driving change and action on those fronts".

It may be suggested by others to this Inquiry that, rather than having a minister in charge of resilience, there should be an independent assessor, so somebody independent of government responsible for resilience who might be an expert and be able to dedicate himself or herself full-time to the role, and effectively be beyond the civil service.

What's your view of that, Mr Cameron?

A. I don't think they're alternatives, I think they should be complements. As I said, I had the National Security Adviser with his deputies, but the idea of having someone equivalent to that, who is in charge of resilience and threats and hazards at the civil service level, I think is an excellent idea, and I think the government themselves have suggested that. I personally would keep that in the National Security Council architecture. But then you do need a minister to take responsibility. For two reasons: one, otherwise there's

a danger that the ministers round the Cabinet table just think: well, threats and hazards and resilience, that's taken care of by someone else elsewhere else, so a civil servant. And so they won't spend time on it.

The second is the reason I give in my statement -- which is not in any way to denigrate the incredible work that civil servants do, but I think ministers often come at these problems on a committee asking the question: right, here's the information, what are we going to do? What are the actions we're going to take? What is the outcome of this meeting? What are we actually going to do that's different? And I found that -- maybe we'll come to COBR -- chairing COBR as often as I did, that is what I think the Prime Minister and other politicians bring, is: yes, here's all the information, here is what we need to communicate it to all the right people, to make sure everyone is across it, but what's the action, what are we going to do?

I think it would be a mistake to park resilience at the official level and not have senior politicians, including the Prime Minister, at the National Security Council discussing it.

Q. Thank you.

A. For instance, when we did the National Security Risk Assessment, that assessment came to the National

Security Council. I can't remember the date of the meeting, but I absolutely remember sitting around the table debating with the Secretary of State for home affairs and foreign affairs and defence and all the rest of it, which risks should be where. You know, "Have we got this right?"

That -- by its very act, you're getting people who don't think every day about pandemic preparedness and the importance of pandemics and other things that can happen to focus on those things as well as the terrorism and the foreign affairs and ... yeah.

Q. You've explained why you chose Oliver Letwin and the qualities that he had to be placed in the shoes of, effectively, the resilience minister. And you would of course expect him as resilience minister to deal with the threat which had been already assessed as a Tier 1 threat, that is pandemics.

A. Yeah.

Q. So I'd just like to look, please, at Mr Letwin's witness statement. It's at INQ000177810.

Can we go, please, to page 2, and highlight the first part of paragraph 6 down to and including the words "much less well prepared", halfway down. Can we zoom in, please, and highlight that. Thank you.

He says:

"During this period, 2011-2016, I was not directly involved in planning for the government's response to pandemic influenza in the UK. In retrospect, it may seem surprising that my resilience-reviews did not cover this issue, given the fact that pandemic influenza was ranked high (both in terms of impact and in terms of likelihood in the national risk register). The reason was that I was informed by Cabinet Office officials (when I initiated the resilience-review process in 2012) that an unusually large amount of attention had already been focused on this particular threat because of its position in the national risk register, that (as a result) the UK was particularly well prepared to deal with pandemic influenza, that the Department of Health was preparing to carry out a major exercise to test our national capabilities in the face of pandemic influenza, and that my time would therefore be better spent examining other whole-system risks for which line departments might be much less well prepared."

Could we go, please, to the next paragraph and highlight paragraph 7, please. Reflecting on that, Mr Let goes on to say:

"I now believe, however, that it might have been helpful if I had delved into the pandemic influenza risk for myself, notwithstanding the amount of attention

being focused on this issue by the line department and the consequently high level of preparations for responding to it. This is *not* because I believe such a review would have been likely to lead to any significant improvements in our preparedness for a pandemic 'flu itself, but rather because it might have led me to question whether we were adequately prepared to deal with the risks of forms of respiratory disease *other* than pandemic influenza."

Are you surprised, Mr Cameron, that Mr Letwin, in the shoes of resilience minister, did not perform any tasks in relation to the Tier 1 risk of pandemic influenza?

A. Well, I think he explains it, really, which is that this was a risk that he was told that was already well covered because there was already a pandemic preparedness plan. But I must say I thought his statement was incredibly clear and I think he's being very frank here and saying, you know, the more people who were in there questioning what sort of pandemics we might have, the better. And I think his suggestion about having a sort of "red team" to challenge -- whatever architecture you build, it's only as good as the people within the building and the decisions they make -- and his idea of sort of having a "red team" to

challenge the thinking I think is an excellent one, because, as Sally Davies has said, there's always a danger of groupthink, and perhaps that's what was happening here, is that we were so focused -- or the system was so focused on pandemic influenza, because of the well known risks of it, that the system had got itself into a belief that that was the most likely pandemic and that was the one that needed to be prepared for, and so I think Oliver's statement is very powerful.

Q. So you don't think, as resilience minister, ignoring this risk, he let you down?

A. I don't think he was ignoring it. I don't think he was ignoring it. He was doing the work on other risks because this one already had a plan. Some of the other things he was looking at, catastrophic failure of power grids, breakdown of the internet, you know, some even quite ... space weather and slightly more wacky things, had had almost no attention, and he thought they needed to have that attention. So, no, I never felt Oliver let me down.

Q. All right.

I want to move on to the second area of questioning now, the state of preparedness immediately before and during your tenure.

So within a couple of months of you taking up

residence in Downing Street, Dame Deirdre Hine produced her report on the government's response to the 2009 swine flu pandemic, which included 28 recommendations.

Just to remind ourselves about swine flu, it hit the world in 2009, it was an influenza virus, a respiratory disease, causing just under half a million global cases, and 18 and a half thousand deaths worldwide, with a fatality rate of between 0.01 and 0.2%, and causing, sadly, 457 deaths in the United Kingdom.

You were aware of this report, were you not, Mr Cameron?

A. Yes. I can't --

Q. Yes?

A. I can't remember the exact circumstances of when I was told about it, but yes, and obviously I've read it subsequently.

Q. Thank you.

Can we put it up, please, on screen, INQ000035085. We can go, please, to page 96, paragraph 5.38. Thank you.

"The National Framework was designed to prepare the UK for a variety of pandemic scenarios up to and including a reasonable worst case in which the clinical attack rate reached 50% and the case fatality rate reached 2.5%. In late April, the limited information

coming from Mexico gave cause for considerable concern, but as the pandemic progressed it gradually became clear that a scenario approaching that scale was unlikely. A number of contributors to this Review have noted that it was difficult to switch from the plan we had -- predicated on a worse pandemic than that which emerged -- to a more proportionate response."

Can we now go, please, to page 63, and highlight paragraph 3.65, dealing with the worst case. Thank you. Top of the page:

"The worst case in the planning framework is for 750,000 additional deaths. Given pressures on resources, ministers will need to consider whether they wish to make any additional investment required to cope with the full worst-case scenario. I have no recommendation to make on what the correct figure might be for the worst-case scenario, although in Chapter 4 I have recommended that the Government Chief Scientific Adviser convene a working group to review the calculation of planning scenarios. However, I do believe that it would be unsatisfactory if the National Framework implied that government and local responders were prepared to cope with many more thousands of deaths than they were in fact equipped to handle."

Are you aware, Mr Cameron -- we can take that down,

please -- that these worst-case scenario figures, that a pandemic could affect 50% of the population, it could kill 2.5% of the population, and, assuming a population of around 65 million in 2015, that would equate to infecting 32,500 people and causing around 800 deaths, those figures remained in place and indeed formed the basis of the United Kingdom influenza pandemic preparedness strategy the following year, and remained in place until Covid hit?

A. I --

Q. They were never amended.

A. Yes. I -- if you're asking me was I -- I mean, the trouble is I can't remember exactly what I was told at the time.

Q. You've seen the report now though?

A. I've seen the report now, yes.

Q. Those figures were never altered during your time in office and, as far as the Inquiry is aware, although there were moves to update the 2011 strategy much closer to the pandemic hitting, in fact those matters were never dealt with. Do you consider that that was a mistake?

A. Well, I think it was a mistake not to look at -- you know, repeating myself slightly, not to look at -- not to look more at the range of different types of

pandemic. My reaction to reading Hine was, like many of the other reports, it doesn't mention the potential for asymptomatic transmission, and so, you know, when you think what would be different if more time had been spent on a high infectious asymptomatic pandemic, different recommendations would have been made about what was necessary to prepare for. That's what I think is ... is my focus.

Q. In terms of focusing on a pandemic other than influenza, it's right that the strategy in 2011 states as follows:

"Plans for responding to a future pandemic should therefore be flexible and adaptable for a wide range of scenarios."

A. Yes.

Q. So that was acknowledged, but nothing appears to have been done, no further papers were prepared, or exercises undertaken to say how the strategy should be adapted --

A. Well --

Q. -- no practical solutions?

A. -- there were other exercises undertaken, like Alice, which was --

Q. We'll come to that in a moment, yes.

A. So other -- I don't think it's right to say the government only looked at pandemic flu, it didn't look at other things. The risk registers and other documents

mention MERS and SARS and other types of pandemic.

Q. Yes.

A. So that wasn't a failing, I think the failing was not to ask more questions about asymptomatic transmission, highly infectious. What turned out to be the pandemic we had. And I think there are occasions where, reading these reports, you can see -- was there adequate follow-up --

Q. Yes.

A. -- to some of the work? I spotted that in one or two places.

Q. Yes.

Well, I want to come back to Ebola, please. I don't know if you heard the opening statements to this Inquiry, but Pete Weatherby King's Counsel, on behalf of the Covid-19 Bereaved Families for Justice UK, began with your words, and I'd like to display, please, INQ000146555, and this is the press release from June of 2015 when you were speaking ahead of the G7 summit in Germany on the wake-up to the threat from disease outbreak.

Can we go, please, to page 2, and we'll go straight to your words, please, at the bottom of the page, where we can see that in this press release recorded is the following:

"Speaking ahead of the G7, the Prime Minister, David Cameron, said:

"The recent Ebola outbreak was a shocking remainder of the threat we all face from a disease outbreak.

"Despite the high number of deaths and devastation to the region, we got on the right side of it this time thanks to the tireless efforts of local and international health workers.

"But the reality is that we will face an outbreak like Ebola again and that virus could be more aggressive and more difficult to contain. It is time to wake up to that threat and I will be raising this issue at the G7.

"As a world we must be far better prepared with better research, more drug development and a faster and more comprehensive approach to how we fight these things when they hit."

Indeed, your plan that you set out included a UK vaccines research and development network, with £20 million invested from the outset, and also what you described as a rapid reaction unit, ready to deploy to help countries suffering such devastating epidemics in the future.

Was your warning that Ebola was a wake-up call based on your understanding of the effect that Ebola had had and a concern as to how the global community could

improve for next time?
A. Yes. I mean, I -- you know, the reason I chose to raise that at the G7 was I had become really concerned about this whole issue and Ebola was, you know, one example of it, and it was through conversations with Dame Sally Davies and others that I became more and more interested in this. You know, I thought we had taken important steps at home, and this was, you know, genuinely trying to put on the table the UK Vaccine Network and the rapid reaction force that you mentioned, saying that these were going to be our contributions, as well as this horizon scanning unit.
Q. Yes.
A. So I thought we were putting in place good steps and it was important to say to other countries: we all need to do this.

Because with Ebola specifically, there was this sense that (a) the WHO was quite slow to announce that it was happening, also quite slow to ask for help, and the help that was given to Sierra Leone, to Guinea and to Liberia was very much ad hoc. I think I put it in my statement. It was in a meeting -- it was at a NATO summit, I was next to Obama, and he said, "Look, the world is being too slow on this, we will help with Liberia, can you help with Sierra Leone, can the French

help with Guinea?" And it was quite an ad hoc response that led to this, and we spent half a billion pounds sending troops and nurses and all the rest of it. And I think they did a magnificent job, but it was quite ad hoc. So it made me think that we needed to put -- again, the international architecture was lacking and we needed to put it in place, and that's what this press release and that announcement was about.
Q. Yes, thank you.

I'm going to turn to two exercises, UK exercises, one of which you have made mention of, Exercise Alice, which took place in February of 2016, and the hypothetical scenario of this exercise was an outbreak of the MERS coronavirus in March of 2016, having been reported to the World Health Organisation and caused about 500 deaths, most cases having occurred in the Kingdom of Saudi Arabia.

This was a tabletop exercise, as the Inquiry has already heard, involving the Department of Health, as it then was, the NHS and Public Health England. It was commissioned by the Department of Health in response to concerns raised by Dame Sally Davies about planning and resilience in response to a major outbreak of MERS in England.

The Cabinet Office is described in the report as

having observer status. So does that mean that the Cabinet Office was not actively involved but was there in order to observe?
A. I'm afraid I don't know the answer to that question. I mean, I think -- these exercises are good and it's important they take place. I think Oliver Letwin's evidence about they should happen with great regularity and at a senior level I think is absolutely right because --
Q. Yes.
A. -- as I said earlier, you want in the end to have ministers asking questions about: right, well, what will we actually do? What needs to change? What needs to be put in place? And you want their attention to be focused on this.
Q. Yes. Well, let's have a look, please, at the recommendations of Exercise Alice.

They are in document INQ000056239. Thank you.

If we can go to page 16, please.

Here we are, the page of "Summary of lessons/actions identified". I'm just going to read through a few of these.

At number 1:

"The development of MERS-CoV [special] instructional video on PPE level and use.

Number 4, to:

"Develop a MERS-CoV serology assay procedure [that's blood tests searching for antibodies] to include a plan to scale up capacity."

Number 7, to:

"Produce an options plan using extant evidence and cost benefits for quarantine versus self-isolation for a range of contact types including symptomatic, asymptomatic and high risk groups.

Just going back a little further up the page to number 5, to:

"Produce a briefing paper on the South Korea outbreak with details on the cases and response and consider the direct application to the UK including port of entry screening."

Now, you may be aware that Professor Heymann, the esteemed epidemiologist, gave evidence to the Inquiry last Thursday, and he told the Inquiry that he thought that recommendation 5 was an extremely good idea, to learn from the experiences of South Korea in terms of their response to MERS and to see how those matters could be possibly adapted to the United Kingdom in the event of a similar pandemic.

Do you agree that that was a useful and important recommendation?

A. Yes, I do. And, I mean, I think it's -- having read through, now, Alice, I -- because ministers weren't involved.
Q. Yes.
A. But, you know, there is a sentence in Alice which is "access to sufficient levels of PPE was also considered and pandemic stockpiles were suggested". That's a sentence in Alice but it doesn't make it into the recommendations. So, I mean, if you're asking were there failures -- does it look like there were failure to follow through from this --
Q. Yes.
A. -- I think the answer to that is yes.
Q. Thank you.

At the same time -- we can take that down, please -- there was another exercise being planned, Exercise Cygnus. Now, although this was not delivered by Public Health England until you had left office, in fact it took place over two days between 18 and 20 October of 2016, planning for this exercise began in 2014 but was postponed due to the Ebola response.

Were you aware at the time that Exercise Cygnus was being planned, Mr Cameron?

A. I'm afraid I just don't recall. I haven't -- in the papers, I haven't --

Q. Yes.
A. -- seen anything, sort of a note from an official saying, "There's this exercise going on". I mean, I've seen notes of me saying to Jeremy Hunt, "Let's do an exercise on Ebola", and I do remember that, but I don't remember -- that doesn't mean I didn't get a note about it, but I haven't been able to find one and I don't think you have.
Q. All right. Well, we haven't, no. But this was an exercise designed to assess the UK's preparation and response to an influenza pandemic. The Inquiry has heard about it already and no doubt will continue so to do throughout the course of these public hearings. But it involved 950 representatives from the devolved administrations, the Department of Health, 12 other government departments, NHS Wales, NHS England, Public Health England, and eight local resilience forums, and six prisons took part in the exercise. Huge, then, in terms of organisation.

I'd like to look briefly, please, at some of the recommendations from this exercise, whilst acknowledging again that you had left office by the time this report was produced.

A. Yes.
Q. Could we go, please, to page 30. Now, we can see that

here we have the "Table of Lessons Identified". I'm going to move through these quite swiftly, because the common theme of the recommendations that I'm going to highlight is capability and capacity in health and social care.

So we can see at KL 4:

"An effective response to pandemic influenza requires the capability and capacity to surge resources into key areas, which in some areas is currently lacking."

LI 5, please, further down the page:

"Further work is required to inform consideration of the issues related to the possible use of population based triage during a reasonable worst case influenza pandemic."

LI 16, please. Thank you.

"Expectations of the MoD's capacity to assist during a worst case scenario influenza pandemic should be considered as part of a cross government review of pandemic planning."

LI 17, please:

"The process and timelines for providing and best presenting data on which responders will make strategic decisions during an influenza pandemic should be clarified."

If we can have LI 18, please:

"A methodology for assessing social care capacity and surge capacity during a pandemic should be developed. This work should be conducted with Directors of Adult Social Services and with colleagues in the Devolved Administrations."

And finally LI 20:

"[Department of Health], NHS England, CCS and the Voluntary Sector and relevant authorities in the Devolved Administrations should work together to propose a method for mapping the capacity of and providing strategic national direction to voluntary resources during a pandemic. Given the experience of Exercise Cygnus, it is recommended that this work draw on expertise of non-health departments and organisations at national and local level."

Standing back for a moment, Mr Cameron, and considering that these recommendations were made in October of 2016, would you have expected the government to have implemented the lessons learned from Exercise Cygnus by January of 2020?

A. Well, you would ... I don't really want to comment on my successors, but, I mean, you would hope so. I mean, I've thought a lot about this, because, you know, having been back through all the paperwork and everything,

I haven't found any moment when I was asked or the Treasury was asked to approve sort of surge capacity for PPE supplies or anything like that. I think that's because there wasn't enough attention on the sort of pandemic that we ultimately experienced. But I hadn't -- I hadn't -- I don't recall any recommendations like that. But these, as you say, are quite clear, and I think that the Treasury, while -- I'm sure we're going to come on to -- money was tight and we made difficult decisions about public spending, when we did need to spend money on important priorities, when we had to spend money on Ebola, we did and we would.

Q. All right. Well, before we come to deal with austerity and the effects of that on health and public health, I'd just like to draw together the lessons that we have just seen identified in these exercises.

So in Exercise Alice, we saw recommendations of a need to plan for scaling up testing capacity, for isolation and self-isolation options, for asymptomatic transmission and issues with the provision of PPE.

Do you know whether those matters were addressed during your time in office?

A. What I know is that there were -- there was capacity for isolation when we had the Ebola outbreak in Africa, and obviously there were some cases in the UK, but,

you know, I would say that the problem with Alice was that it was a MERS outbreak with a very high degree of mortality, 35% mortality, but a very low case load. And so, again, that wasn't anywhere close to the sort of pandemic we then actually experienced.

Q. By the time you left office, do you accept, Mr Cameron, that there had not been any planning specifically of the effects of a pandemic? By that I mean this: there had been no planning, for instance, by the Department of Education, about the impact of school closures, had there?

A. Well, the -- I don't know the answer to that. Somewhere in the bundle there's mention of school closures, I think -- is it with respect to Cygnet? But --

Q. Certainly that it should be looked at, yes. It was raised as a recommendation.

A. The point is, during my time in office, there were investigations into SARS and MERS and other types of pandemic, including Ebola.

Q. Yes.

A. But there wasn't one into a highly transmissible coronavirus-style pandemic like we had, and so these questions weren't asked.

Q. But even in relation to an influenza pandemic, which had, as we have already established, been a Tier 1 risk

during your whole time in office, here we have Exercise Cygnus, reporting just after you've left office, saying that there should be plans and research into the effect of school closures in the event of a pandemic. That hadn't been done. It was being raised as a recommendation in Cygnus on your departure from office because that planning hadn't been done, had it?

A. Well, it had been -- it was raised -- as far as I can see, that's the first time it was raised.

Q. Yes.

A. After I'd left office.

Q. Yes, which means that that type of planning was absent during your time in office.

A. But I don't -- I haven't seen a report while I was in office saying that sort of planning should be done, because the pandemic preparedness plan, which had been worked up by the previous government and then amended and improved and enhanced during my time in office, there were lots of recommendations made and all sorts of things about stockpiles of Tamiflu and all the rest of it, but it didn't go into things like school closures.

Q. No. Had there been any planning of the economic, political and social consequences of the imposition of restrictions in the event of a pandemic?

A. Well, the answer to that is, first of all, our whole

economic strategy was about safeguarding and strengthening the economy and the nation's finances so that we could cope with whatever crisis hit us next. And I think that's incredibly important because there is no resilience without economic resilience, without financial resilience, without fiscal resilience. And so that was absolutely line one of our plan of dealing with any unexpected crises.

Also I think I'm right in saying that in the National Risk Registers in 2014 and subsequently, there was quite a lot of examination of how to respond to different catastrophic economic problems that these sorts of pandemics would bring about. There was national business resilience planning going through area by area looking at what you might have to do.

But I think all of those -- I mean, a plan, you know, is only as good as the financial and economic capacity of a country to deliver it, and that was the most important thing of all.

Q. You've told the Inquiry that as soon as you came into office in 2010 and you made significant improvements to the architecture of planning and resilience, that one of your major intentions was that that would lead to a whole-system --

A. Yeah.

Q. -- level of preparedness. Do you accept that you failed in that desire? By the time you left government in 2016 there wasn't wholesale preparation and resilience, was there?

A. I don't accept that, because we set up a much superior architecture for looking at risks, for judging risks, and planning for risks, and that's what the National Risk Register, the National Security Secretariat, the National Security Council did, and I think there was more attention, including more attention of senior politicians, onto those sorts of risks than there had been previously. But, as I've said, the problem was that when pandemics were looked at, there was too much emphasis on pandemic flu, and when other pandemics were looked at, including Ebola, including MERS, they tended to be high fatality but low infection, and, you know, the regret -- and you see it in Oliver Letwin's evidence, you see it in George Osborne's evidence -- is more questions weren't asked about the sort of pandemic that we faced. But I think many other countries were in the same boat, of not knowing what was coming. But I would argue we did more than many to try and scan the horizon, to try and plan. We did act on Ebola, we did carry out these exercises, we did try to change some of the international dynamic about these things, and we

planned and prepared in accordance with that.

Q. The evidence of Mr Mann and Professor Alexander that was received by the Inquiry last Thursday included them posing this question: who is in charge of keeping the country safe?

What is your answer to that question?

A. Well, the Prime Minister is always in charge of keeping the country safe, and under my reforms the Prime Minister was much more actively involved because he was chairing the National Security Council, the National Security Adviser was appointed by him, reported to him, and in my case I'd set up a specific subcommittee on threats, hazards and resilience that looked exactly at this area with a highly capable minister in. I'm sure there are further improvements we can make, and the government has announced some which seem to me sensible, with the proviso that I made.

But at the pinnacle of it must be the Prime Minister, because, from all my experience of chairing COBRs, whether it was during terrorist problems or Fukushima nuclear disasters or Ebola or anything else, the system works extremely well, but the system works better when the Prime Minister is in the chair asking questions, driving changes and making sure decisions are made.

So my answer is: it's the Prime Minister.

Q. Thank you.

We've dealt with your concerns around the World Health Organisation and how you sought to deal with those, so I'm now going to move on to the final area of questioning, the impact of austerity on the health and social care service and underlying health inequalities.

I'd like to display, please, paragraph 26 of George Osborne's witness statement, which we have at INQ000187308. Paragraph 26, please.

"Reducing the deficit and placing debt as a percentage of GDP on a downward path was also essential to rebuild fiscal space to provide scope to respond to future economic shocks. A responsible approach to repairing the UK's public finances following the financial crisis was essential. I have no doubt that taking those steps to repair the UK's public finances in the years following the financial crisis of 2008/09 had a material and positive effect on the UK's ability to respond to the Covid-19 pandemic. The most urgent task facing the UK economy, as stated in Budget 2010 ... was therefore to implement an accelerated plan to reduce the deficit. Indeed, there was cross-party consensus on the need to reduce the deficit following the financial crisis."

You have also made reference, Mr Cameron, to the need for this to happen and, in your view, for the positive effect that that had on the state of the country's finances going into the Covid-19 pandemic.

I make it clear -- we can take that down, please -- that the purpose of the following questions that I have for you is not to explore whether that policy was right or wrong. That is no part of this Inquiry, to descend into those political areas. But what we are interested in are the impacts and consequences of that policy in three areas, please: health, inequality and societal resistance.

The Health and Social Care Act of 2012 changed the landscape of public health, did it not, because it transferred to local authorities public health features, and the involvement of directors of public health?

So from that time, from 2012, those areas of public health were no longer funded through the Department of Health, in the way that they had been before.

Mr Osborne says, at paragraph 71 of his witness statement -- we don't need to put this up -- that the Department of Health's budget from 2011 to 2012 until 2014 to 2015 was to increase in real terms in each financial year, and that that growth occurred in

circumstances where all other departmental budgets, other than overseas aid, were cut by an average of 19% over the same period.

He also goes on to say that in 2010 the budget for public health was ringfenced, but of course, as we've just discussed, that was only relevant up to 2012, at which point in time public health was no longer funded through the Department of Health.

Do you accept, Mr Cameron, that the health budgets over the time of your government were inadequate and led to a depletion in its ability to provide an adequate service?

A. I don't accept that, neither on a sort of big picture level or on a small picture level. I mean, the big picture level, I don't think you can separate the decision and the necessity of getting the budget deficit down and having a reasonable debt to GDP ratio, so you can cope with future crises, I don't think you can separate that from the funding of the health service or indeed anything else.

I mean, if you lose control of your debt and you lose control of your deficit and you lose control of your economy, you end up cutting the health service. That's what happened in Greece, that's what happened in countries that did lose control of their finances. So

I don't think you can separate the two.

So we made the important decision to say that the health service was different, its budget would be protected, and so there were real terms increases every year and so, for instance, there were 10,000 more doctors working in the NHS at the end of the time I was Prime Minister than there were at the beginning.

Would everyone like to spend even more on the health service? Yes. I mean -- you know, making these difficult choices about spending was -- it wasn't a sort of option that was picked out of thin air. I believed, and I still believe, it was absolutely essential to get the British economy and British public finances back to health, so you can cope with a future crisis.

Q. The Inquiry has received witness statements from Jeremy Hunt, who was the Secretary of State for Health, and then Health and Social Care, from 2012 to 2018. Were you aware that during the time that you were in power, Mr Hunt laboured considerable concerns about the structural problems within NHS capacity and the workforce and funding, as he has set out in his witness statement?

A. I've read his witness statement. I -- he was a very capable health secretary. I worked with him extremely

closely. Of course he was always batting for the NHS and for all the extra resources he could get. These decisions were arrived at collectively. I agree with a lot of what's in his witness statement, you know, where he says there's more that could be done, for instance, for future workforce planning. But I will absolutely defend the record of the government in both getting control of the finances and increasing funding for the health service at the same time.

Q. Aren't these concerns, Mr Cameron, that Jeremy Hunt sets out, structural problems with the NHS and workforce and capacity, the real issues which preparedness for a public health emergency needs to address, not papers and guidelines and protocols, but action to remedy fundamental problems?

A. Well, I think what's needed to prepare for a pandemic is, first of all, you've got to have that overall economic capacity. As George Osborne puts in his statement, without our action you could have had almost a trillion of extra debt, and you would have -- as well as a coronavirus crisis and a public health crisis, you'd have a financial and economic and fiscal crisis at the same time.

But I think the answer to your question is that the best way to prepare is to have a strong economy and the

next thing you need to do is prepare for all of the relevant pandemics that you might face, and we've already discussed where, you know, the system I think didn't spend enough time on the sorts of pandemic that we did end up facing.

Q. Do you accept, Mr Cameron, that the government was repeatedly warned about growing pressures on the NHS? Firstly, from the Nuffield Trust annual statement in 2015, which detailed growing concerns that demand was outstripping capacity and "the warning lights on care quality now glow even more brightly", and finally, in 2016, in the Nuffield Trust annual statement, before you left office, which stated:

"Slowing improvement in some areas of quality, combined with longer waiting times and ongoing austerity suggests the NHS is heading for serious problems. It seems likely that a system under such immense pressure will be unable, at some point, in some services, to provide care to the standards that patients and staff alike expect."

A. Well, of course there were pressures on the NHS, as there were pressures on many public services, but at the end of my time in office I think public satisfaction with the National Health Service was still extremely high. I think the King's Fund, it might have been, was

ranking it as one of the most successful health systems in the world. We'd virtually abolished mixed sex wards, we'd got hospital infections down, we were carrying out 40% more diagnostic tests every week. There were successes in the NHS as well as pressures. But there are -- you know, there are always pressures on these services, and our job was to try and sort out the economy, which we did, so we could then have bigger increases in health spending, which then followed.

Q. In preparation for your evidence today, you were invited to consider the witness statement of Professor Kevin Fenton, who was the president of the United Kingdom Faculty of Public Health, which is a professional standards body for public health specialists and practitioners, with over 4,000 members.

You will know, then, that according to Professor Fenton, health protection teams saw successive reductions in funding and capacity over the pre-pandemic years and a lack of investment in regional emergency preparedness, response and resilience teams. The summary of his evidence as provided to the Inquiry, so far in written form, is that there was no ringfencing of funding to local government for health protection, that health protection teams had their funding reduced and their capacity reduced, and that ultimately this

resulted in a lack of capacity for pandemic preparedness.

What's your response to that, please?

A. Well, I read the Fenton report, as the other reports. I thought ... I mean, I don't want to be too critical, but throughout all of them I thought there was very little acceptance that it is possible to reform public sector organisations, sometimes to merge them and get rid of duplicating bureaucracies and overheads and get more output for the same amount of money.

I thought in Kirchelle, in Marmot, in Fenton, there was just this assumption that you only ever measure inputs rather than measuring outputs. So, for instance, I would say that the creation of Public Health England, where it was merging together a lot of other bodies, increased the focus on public health, meant money was spent more wisely, and I would argue also that the Health and Social Care Act, by putting public health into local authorities, that was the right place for it. Local authorities are responsible for housing and for education and for licensing, and so making them responsible for public health is very logical, and even -- I think most of the experts coming to your Inquiry, I don't think people are arguing to turn the clock back and put it into the health service.

So I think these were good reforms, and yes, we faced very difficult financial circumstances, but where we could we tried to encourage the spending of money more wisely and sometimes the merging of public bodies was a sensible thing, but they don't seem to give that much credence.

Q. Well, you've mentioned the evidence of Professor Sir Michael Marmot and Professor Clare Bambra, you've clearly read their report, and you will know that they gave evidence to this Inquiry on Friday. Do you accept their evidence, Mr Cameron, that health inequalities increased during your time in office?

A. Well, I accept -- I mean, I've read their reports.

Q. Yes.

A. I accept that after 2011 in lots of countries in the world life expectancy continued to improve but didn't continue to improve so quickly. Now, their conclusion is to look a lot at austerity and what have you. I'm not sure the figures back that out. We had some very difficult winters with very bad flu pandemics, I think that had an effect. We had the effect that the improvements in cardiovascular disease, the big benefits had already come through before that period and that was tailing off. Then you've got the evidence from other countries. I mean, Greece and Spain had far more

austerity, brutal cuts, and yet their life expectancy went up. So I don't think it follows, and I found -- you know, I mean, there is one sentence in Bambra and Marmot that just baldly says, you know, child poverty increased. Well, actually, the number of children living in absolute poverty went down, the number of people living in absolute poverty went down, the number of pensioners living in absolute poverty went down very considerably. So I --

Q. So you don't agree with it?

A. Well, I mean, they've got lots of important evidence and I've looked at it very carefully and will think about it very carefully, but I did find their -- I found that they had leapt to a certain set of conclusions quite quickly, not all of which was backed up by the evidence. And they don't mention the evidence that I've just mentioned, which I think is quite important.

I mean, added to the fact that I agree with Professor Bambra that social and economic conditions have a big bearing on health inequalities, and so therefore the fact that there were 2.6 million more people in work, there were over half a million fewer children in households where no one worked, these are -- there were -- obviously a big dent in pensioner poverty because of the triple lock and the increase in the

pension. These are positives as well, which -- they don't seem to get mentioned in the same way.

So I had my problems with them, but I'm sure that the Inquiry can look at all the evidence and come to its conclusions.

Q. Do you accept that cuts to public health budgets tended to be largest in the most deprived areas and that, as a result, local authorities working with the most vulnerable populations faced the biggest challenges in carrying out their public health functions?

A. No, I don't necessarily accept that. The way the local authority spending decisions were made was to try to make sure that the reductions in spending power in each local authority were broadly equivalent, and obviously when you're looking at spending power you've got to look at the grants from central government to local government, the business rate revenue and the council tax revenue. So, for instance, I mean, I checked this last night, the 2015 settlement was for a -- no council should lose more than 6% of its spending power. So that does affect different councils in different ways in terms of their grant, but it affects them in a more similar way when it comes to spending power, and it's obviously the spending power that --

Q. Yes.

A. -- (inaudible) that matters, and I think that's a better way of measuring it.

Q. All right.

Were you aware whilst in government of evidence that people from lower social economic groups and minority ethnic groups would be more likely to be affected by whole-system catastrophic shocks?

A. I think it was well known, and I knew, that when you have health pandemics of any sort you get differential effects on different parts of the population.

Q. Yes.

A. I think as coronavirus turned out, the biggest category -- that's the wrong word, the biggest impact was obviously on older people, but many of our policies were directed towards lifting people out of poverty, the -- more jobs, the first national living wage, the big increase in the minimum wage, taking 4 million people out of paying income tax. All of these things, the reform of universal credit and the reform of welfare and the whole effort of getting people out of without of welfare and into work, all of these things have an economic and social benefit, but also have a health benefit too.

Q. The Inquiry saw last Friday that pre-existing health inequalities only featured minimally in the UK pandemic

planning, in fact they were barely mentioned at all. Do you accept that this was a significant omission?

A. I think all plans can be improved and updated, and I've read the evidence about that, and I'm sure that future plans will. But if you're asking was it -- you know, did you understand, did your government understand the importance of trying to left people out of poverty and into work and into prosperity, yes, absolutely, that's what the whole plan was about.

And going back to this economic thing, because it is important, you know, over the period of my government, in the G7, after America we had the fastest growth of GDP and fastest growth of GDP per head. So this is important, because ultimately, your health system is only as strong as your economy, because one pays for the other.

Q. Do you agree that different political decisions will have to be made in the future if a strong public health system is to be nurtured to withstand another pandemic?

A. I think different decisions -- well, I think we need to improve the way we look at pandemics and the way we plan our resilience, because while, as I've said, you know, the architecture was there, the structure was better, the involvement of ministers was better, the dialogue between ministers and civil servants was good, there is

this gap that I keep coming back to, which is: how do we make sure that you're not subject to groupthink, that you don't plan for one type of pandemic, because it's very current, it's very risky, it's very dangerous? You need to have teams going in to question the assumptions. And, I mean, the biggest one was this issue about asymptomatic transmission.

I kept looking through all these documents, looking for, "What about a pandemic with wide-scale asymptomatic transmission?" And if that question had been asked, then a lot of things would follow from that.

You know, in Jeremy Hunt's evidence, the hospitals in Hong Kong had to have three months of PPE supplies. I was never asked: can we have funding for three months' PPE supplies for every hospital? But had I been asked, we would have granted it. That's not expensive. That's not a huge commitment. But that comes out of planning for the right sort of pandemic.

So, you know, all these questions about economic policy, we can have an argument about was it the right economics or the wrong, I think it was the right economic policy, but the real problem was time spent quizzing the experts on what potential pandemics were coming, and preparing for those in the right way, and the questions that would follow from that.

MS BLACKWELL: Thank you.

My Lady, that concludes my questions of Mr Cameron. I know that prior to today permission has been given to Ms Mitchell King's Counsel on behalf of Scottish Covid Bereaved Families for Justice to ask a short series of questions. May she be allowed to do that?

LADY HALLETT: Certainly. I would normally break now, but if the stenographer can carry on for Ms Mitchell's questions?

Thank you very much.

Ms Mitchell.

Questions from MS MITCHELL KC

MS MITCHELL: I'm obliged.

Mr Cameron, I'm senior counsel instructed by Aamer Anwar & Co for the Scottish Covid Bereaved.

You have made it clear both in your written evidence and your evidence here today that you understood that pandemics were a very real threat, and you might not have understood or remembered the phrase "clear and present danger", but you would agree with me that, as a Tier 1 risk, is certainly was something that was immediate, important and potentially grave in terms of risk?

A. Yes.

Q. We've also heard that, given pandemics have happened

throughout history, it was a matter of when and not if a pandemic would occur?

A. Yes.

Q. Your language, indeed, "We will face an outbreak like Ebola", made it clear that you understood effectively that a pandemic was inevitable?

A. Yes.

Q. You also referred to it I think here and also in your statement about taking a longer-term strategic view and trying to fix the roof while the sun is shining. Presumably because whilst things are good you put plans in place so that when the pandemic arrives, it will allow those to deal with it, to weather the storm safely?

A. Yes.

Q. Because presumably you appreciated that failure to properly plan would be likely to have a catastrophic effect for the United Kingdom?

A. Yes.

Q. Can I ask you to look at the following document. It's document INQ000087193, and we're looking at page 7 of that document.

While we're waiting for that document to come up on screen, this is a document from the Public Accounts Committee of the House of Commons entitled "The whole of

government response to Covid-19".

Now, I'd like to draw your attention, please -- I'll wait until it arrives on screen -- to the heading "Conclusions and recommendations".

MR KEITH: My Lady, I'm extremely sorry to have to get to my feet. My learned friend knows very well that we're constrained by the rules of Parliamentary privilege, not to be able to put Parliamentary material which includes NAO reports in a way which calls into debate the merits of whatever conclusions have been drawn by the particular Parliamentary body or anything in fact said in the chamber of the House of Commons.

So I'm just a bit concerned that we may be breaching Parliamentary privilege by going down this line of examination.

MS MITCHELL: Well, there's certainly a way, my Lady, that I can ask the questions without having to refer to those documents, so I'll be able to do that in that way.

I'm obliged to my learned friend for highlighting that before that route was gone down.

LADY HALLETT: Thank you.

MS MITCHELL: While you were in government and when you were Prime Minister, did you make any plans for the effect economically on individuals in the United Kingdom?

A. Well, I think, as I answered earlier, there are two

answers to that. One is, the biggest thing was to get the British economy and the public finances in a state where they were capable of responding to the next crisis, because, just as I answered earlier, you know, we will have another pandemic, we will have another economic crisis of some sort, whether it's a recession or a banking crisis or an insurance ... who knows what it will be. The question is: do you have the capacity, do you have the spare capacity to suddenly borrow another 10, 15, 20% of your GDP to help the country and help people through it? That's the key question. And that was very much in my mind when we drew up the plan to reduce the budget deficit and get the debt/GDP ratio under control, because that's the responsible thing to do.

The second answer is that, as I think I said, in the national risk assessments there's quite a lot of people about national business resilience planning, working out, if you had a pandemic flu, and even with the pandemic flu we were looking at, which would have had, you know, hundreds of thousands of deaths and a huge effect on the economy, what do you do to help the various sectors of the economy to recover?

So to that extent, yes, there was a plan.

Q. Well, your plan was about the country. What I was

asking you about, and if I'd ask you to focus on the question: was there a plan made for the economic impact on individuals during a pandemic?

A. Well, until you know exactly what pandemic you face and whether you're going to need to have people at home, so you have a furlough plan, or you're going to have to act in a different way, and you might need to cut VAT or change tax rates or ... you know, you need to have -- those decisions could be made very quickly, as they were, to the credit of the Chancellor, when the pandemic hit, but you need to have the capacity in the economy to do it.

Q. You clearly understood that the effect of a pandemic might mean that people were sick and weren't able to attend work and businesses might have problems?

A. Yes.

Q. Did you, while you were in government, put any plan -- make any plans, have any conversations about what a furlough might look like, about what an economic plan might look like? Were those discussions had?

A. Well, I can't remember every discussion I had, but I have seen that in the national risk assessments those sorts of things are looked at. And obviously in government, when we were looking at the threat of pandemics or the threat of terrorist attacks, or the

threat of something worse, you know, a major terrorist attack that could take out a whole city, what would you do in order to keep the economy going and help people, yes, we did have those conversations.

Q. What I'm actually specifically asking about, though, is not at the level that you're talking about; I'm talking about the individuals who would not be able to go to work. I'm talking about the businesses that needed to keep going. There were no concrete plans made for that; correct?

A. Well, I mean, you keep asking me this. I mean, I think -- I will have to go back over the national risk assessments -- I think there were plans looking at individual sectors and businesses and what would have to be done. So -- but maybe I can look that again and give you a written answer, because I ... I don't want to say there's something in them that there isn't. But I think they do address some of these questions.

Q. I'm sure the Inquiry would be greatly assisted if you can find anything in relation to the economic planning, but as of today's date you can't think of anything?

A. Well, I can, which is, if you have a strong economy and good public finances, you can flex your tax, your benefit system, your spending. You have the enormous financial capacity of the British state to act and help

people.

Q. We now know that over 227,000 people died from Covid, and we've heard evidence that the UK was not prepared for a pandemic. We've heard evidence that, after years of underfunding, cuts, inequalities, that this impacted upon the devastating scale of the death.

In retrospect, do you agree that, as Prime Minister, it would have been wise for you to plan for economic impacts of the pandemic? And I mean by that the furloughs and the business schemes. So you had a plan readymade, off-the-peg, available to implement, so that the government was not left scrabbling around and making ad hoc decisions in very fast time right at the very moment when they could have better been focusing on other matters like the pandemic?

A. Well, I just -- I'm afraid, with great respect, I'm not sure I agree with the premise of the question. I mean, the furlough scheme came in very quickly, very boldly, and made an enormous difference, and that was possible because we had the financial capacity to do it. But it proves the point that, you know, for all the plans you can have in the world, until you actually see the nature of the pandemic and how it's developing, planning in advance exactly what your economic responses are going to be is only of, I would argue, limited use.

Q. It would certainly be useful, though, to have an economic response which took into account something you knew which would happen, which is people would be sick and off work.

A. Yes, but what you don't know is: are you going to have a pandemic where people who are symptomatic stay at home, or are you going to have a pandemic where, effectively -- I mean, the committee I'm sure will decide whether right or wrong -- you have a lockdown and everybody stays at home? So these are two, you know, different types of pandemic requiring two different types of economic response.

Q. Despite what you say about planning, do you accept that when the pandemic arrived, the UK still found itself in a situation where essential medical items, such as the ventilators, stockpiles of PPE, hygiene control were not still readily available?

A. Well, clearly there were problems when the pandemic hit, and I think this does go back to identifying the different sorts of pandemic that could hit you and planning for each one. And I come back again and again to this issue about, you know, asymptomatic transmission of an easily transmitted virus, which is, yes, lethal, but much lower than MERS or lower than Ebola, and that's what we had, and, you know, more -- if more time -- if

more questions had been asked inside the system or challenging the system about that, then lots of consequences about PPE and about surge capacity and Nightingale hospitals and all the rest of it, a lot of consequences might have followed.

Q. So we were not only preparing for the wrong pandemic but the wrong questions were being asked? Can I ask --

A. So I think it was more we were -- I think it's wrong to say we were preparing for the wrong pandemic. I mean, there could easily have been -- there could still be a pandemic flu and it's good that we have been prepared for that, but as Oliver Letwin says in his evidence and George Osborne says in his, and they put it perhaps better than I have, a lot of time was spent preparing for a pandemic that didn't happen rather than the one that did happen.

Q. In retrospect, Mr Cameron, do you think that, as Prime Minister, your government's failure to plan for the economic impacts on individuals and businesses played any role in the catastrophic loss of lives when the storm of Covid-19 arrived in the UK some four years after your departure?

A. Well, I'm desperately sorry about the loss of life. So many people have lost people who are close to them, and there has been a lot of heartache, and obviously that

continues, and people also suffered in all sorts of ways through the pandemic. That's why this Inquiry is so important. I've tried to be as frank as I can and as open as I can about the things my government did that helped put in place the right architecture for looking at these threats: the horizon scanning, the units we put in place, the exercises that were undertaken. But I've also tried to be frank about, you know, the things that were missed, and the thing I struggle with is why they were missed, because -- you know, it was not asking questions about asymptomatic transmission of an easily infectious disease with a certain level of lethality that we hadn't seen before but nonetheless might appear. You know, that is, I think, where some of the difficulties flow from.

I mean, there's then a whole question of how the response is actually managed in practice, which I know the committee will come on to.

MS MITCHELL: My Lady, I have no further questions.

LADY HALLETT: Thank you very much, Ms Mitchell.

MS BLACKWELL: That concludes Mr Cameron's evidence.

LADY HALLETT: Thank you very much for your help, Mr Cameron.

(The witness withdrew)

LADY HALLETT: I'm also being encouraged to break now so

that the stenographer can rest her work fingers. I'm also being encouraged to resume at 12.45 and then sit until 1.30, and then have lunch. Is that going to cause people serious problems? If it doesn't, then I will return at 12.45.

MS BLACKWELL: Thank you, my Lady.

(12.30 pm)

(A short break)

(12.45 pm)

MS BLACKWELL: My Lady, just before we return to the evidence, may I invite you to provide permission for Mr Cameron's witness statement to be published.

LADY HALLETT: I do.

MS BLACKWELL: It was put up on screen at the beginning of his evidence. Thank you.

LADY HALLETT: Thank you very much.

MR KEITH: My Lady, Sir Christopher Wormald, please.

LADY HALLETT: Sorry to keep you waiting, Sir Christopher.

THE WITNESS: No problem.

SIR CHRISTOPHER WORMALD (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY

MR KEITH: Are you Sir Christopher Wormald?

A. I am.

Q. Thank you very much, Sir Christopher, for coming today. Whilst you give evidence, could you please remember to

keep your voice up, not merely so that we can all hear you, but also for the purposes of the transcript and the aid of the stenographers.

If I ask you a question which I have not made sufficiently clear, please do ask me to put it again. There will be a break at lunchtime, and it's possible that you may get the benefit of a break in the middle of the afternoon, depending on where we get to.

You have provided a number of statements to this Inquiry, unusually named statements: first, second, fourth, sixth and seventh. I don't think that we need to put them all up on the screen, but obviously, my Lady, could they all be published? Each one of them has been signed by you with the usual declaration --

A. Yes.

Q. -- as to the truth of their contents, and plainly you adopt them all as part of your evidence?

A. Yes.

Q. I'd like to start, please, with addressing some of the structures which underpin the approach of the Department of Health and Social Care to its pandemic-related duties.

It's convenient, perhaps, if you could just give us a very brief resumé, both of your position at the Department of Health and Social Care and of your career

in the civil service.
A. Yes, thank you.
If I may, before I start, I would like to reiterate the department's heartfelt sympathy for everyone who suffered in the Covid epidemic, both directly and indirectly, and also our thanks to the amazing staff in the health and care sector who helped us get through. I wanted to put both those things on record.
Yes, I am Permanent Secretary of the Department of Health and Social Care, which position I have held since 2016. Prior to that, I was the Permanent Secretary of the Department for Education, between 2012 and 2016, and before that I worked in a variety of roles at the Cabinet Office between 2009 -- yes, 2009 and 2012, where I should put on record that a number of the conversations you had with the last witness I was supporting the coalition, including on a number of the decisions they took around austerity and the issues that were discussed this morning, which I ought to note.
Prior to the Cabinet Office, I was Director General for Local Government and Regeneration at the Department of Communities and Local Government, as it was then called, and then a whole series of other roles in the civil service at more junior levels prior to

that.
Q. All right, thank you.
In the general scheme of things, in a department, particularly one as important as the Department of Health and Social Care, where does a permanent secretary come in the order of things?
A. Well, you have three roles as a permanent secretary. Well, I will say this, in a department like the Department of Health at this time, which is largely a strategy and policy department in this period. We've already heard some discussion about the changes in the 2012 Act. Before that it was a much more operational department --
Q. Sir Christopher, I'm so sorry to interrupt. The question really was: where is the permanent secretary in the general order of things? I'm going to ask you questions about the role of the Department of Health and Social Care, and of course we'll go into those issues.
A. Yeah. Okay. Sorry, it's important to the role that you play, but yes. You do largely three things: so you are chief executive of the organisation, which means you lead the staff of the department, you are the chief adviser on policy to the Secretary of State, and you are the accounting officer for the budgets that Parliament delegates to the department.

Q. The Inquiry has heard evidence that the Department of Health and Social Care was designated as what is known as a responder, in fact a Category 1 responder, under the Civil Contingencies Act 2004. In fact, the Secretary of State --
A. Yes.
Q. -- in the Department of Health and Social Care is the designated responder.
Can you just assist the Inquiry with the extent to which it is understood in a department what the extent of those obligations are under the Civil Contingencies Act? Is this an obligation which is placed on the Secretary of State personally, or is it an obligation that is discharged by the department as a whole?
A. Well, legally the department is an emanation of the Secretary of State, so in almost all cases the legal powers of the department are vested in the Secretary of State personally. Secretaries of state discharge those functions, normally via their department. So they are effectively indivisible. So if you asked people within the department, they would say that the department is a Category 1 responder, in the way that you describe.
Q. Every Secretary of State has any number of ministerial obligations, both by way of being in charge of

a department, both by way of discharging obligations imposed on him or her under our constitutional structures, but also a fair few number of legal obligations --
A. Yeah.
Q. -- of the type to which I have just made reference under the Civil Contingencies Act.
So what extent are secretaries of state reminded or constantly informed that they are subject to direct legal obligations as well as their normal ministerial obligations?
A. You would normally be -- have your legal responsibilities explained to you when you come into office. That would be the most important moment. And then obviously if you're an experienced Secretary of State, you will largely be aware of what your legal responsibilities are.
Q. So as a department, but then directly as the Secretary of State, the department was under a legal obligation, as a Category 1 responder, to assess the risk of emergencies occurring, plan for contingency planning, put into place emergency plans and business continuity arrangements, make information available to the public, share information and co-operate with local responders to enhance emergency response co-ordination

and efficiency measures.

So there was a fairly extensive list of specific obligations placed on the department --

A. Yes, that's correct.

Q. -- in this field of civil contingencies, by virtue of --

A. That's correct, with one addition. The other responsibility of the department was to assure itself of the readiness of other Category 1 responders. In this context, mainly NHS England and Public Health England, as our two main delivery agents. And we discharge that function by having full-time permanent civil servants who work specifically on emergency response, which is in the directorate led by Emma Reed, who I believe the Inquiry is going to hear from directly.

So how those powers play out in practice is by the allocation of resources within the department of staff whose primarily responsibility is to act as that Category 1 responder. As we've put in various of our witness statements, there are a whole series of incidents in which they respond in that way.

Q. Indeed.

A. But the assurance piece is a very important addition to the list you read out.

Q. Do those legal obligations apply to all emergencies or just health-related? For example, pandemic emergencies.

A. Well, there are -- it's easy to oversimplify, but there are things which are clearly a health lead because the heart of the emergency is a set of health issues, for example the recent monkeypox outbreak I think would be in that category, and then there are a large number of things where health is one player in an emergency that is led from somewhere else. So something like a terrorist incident, obviously there is a health service response, but it's led from elsewhere.

Now, I say it's easy to simplify because, of course, the nature of emergencies means it's not always that clear cut, so the Novichok poisonings, for example, would be an example where there was a clear security lead on the security aspects and then a huge health lead on the health consequences.

Q. My question related in fact to the legal duties under the Civil Contingencies Act. Those duties apply on a department, as --

A. Yeah.

Q. -- the Secretary of State, in relation to any emergency, do they not?

A. Yes.

Q. They're not limited to a health emergency, but in practice, for reasons I'll come on to in a moment, the Department of Health and Social Care is obviously

concerned with health emergencies?

A. Yes, that's correct.

Q. The reason it's concerned particularly with health emergencies is that, under this governmental system of risk identification, risk ownership and departmental response to emergencies, the DHSC, and before it the Department of Health, was the lead government department relating to pandemic risks?

A. That's correct, yes. Now, lead government department is -- that's an administrative designation rather than a legal designation --

Q. Yes.

A. -- but yes.

Q. Therefore, as the lead government department, your department was responsible for leading the government's work on risks which concerned you directly, and for which you had to be responsible?

A. Yes.

Q. To use a terrible word, risks which you owned?

A. Yes, that's correct.

Q. That meant that you would be involved in the system of risk assessment in relation to pandemics, dealing with other government departments of course in relation to how they respond, dealing of course with how your own department would respond in the event of a pandemic,

and, through various other parts of the government, ensuring -- and I refer there to the Cabinet Office role and the role of the Resilience and Emergencies Division in the Department for Levelling Up, Housing and Communities -- making sure that all the other parts of the government do what they're meant to do?

A. That's correct.

Q. That's part of the heavy burden of being the lead government department?

A. That's correct.

Q. Of course, in this pandemic which my Lady is inquiring into, your department was the lead government department?

A. Certainly in the planning phase and the initial response -- I mean, obviously this becomes more of an issue for your second module --

Q. It does.

A. -- obviously the onus of activity moved to a national scale in this particular crisis, as it does in many others.

Q. Yes. May we take it from your answers, therefore, Sir Christopher, that because of this legal obligation, because of the fact that your department was the lead government department, when it came to pandemic-related matters, risks, planned response, planned recovery,

anything to do with pandemics, this was, during the ten years leading up to the pandemic, of core importance to your department?

A. Yes. I mean, obviously, as you said earlier, the department has many, many responsibilities across the health and care sector, which is of course a huge sector, but this is one of the very important responsibilities that we hold.

Q. In your department there is a directorate called the EPHP directorate, I think it's the Emergency Preparedness and Health Protection Directorate?

A. Yes, it's had a variety of names and acronyms, which I'm sure you have identified, but basically, yes, there is a directorate that is responsible for emergency preparedness and oversight of health protection, as you describe, pretty much throughout.

Q. Including pandemic preparedness?

A. Yes, correct.

Q. Obviously we've seen that there were a significant number of bodies and entities and boards and so on and so forth, both within your department and also connected to your department, arm's length bodies and so on --

A. Yeah.

Q. -- which were focusing on pandemic flu preparedness?

A. Yes.

Q. So one of them, and we heard evidence of this last week, the Pandemic Influenza Preparedness Board, PIPP. Was that a DHSC-led programme or was that a cross-government programme?

A. That one is the DHSC-led programme. There was a second board, which I'm sure we'll come on to, which was cross-government.

Q. Was that PIPP board chaired in fact by Clara Swinson, to whom you've referred, who was the then Director General for Global Health, and health protection, from whom we'll be wearing perhaps later today, this afternoon?

A. Yes, from the point of her appointment, which I think was towards the end of 2016.

Q. That board first met in October 2007, you may recall?

A. Well, I don't --

Q. Take it from me, Sir Christopher.

A. I'm told by the record that -- yes.

Q. Another board was the Pandemic Influenza Preparedness board and, as we've heard in evidence, that was a board which was a cross-government board which was set up by order of the National Security Council THRC, Threats, Hazards, Resilience and Contingencies committee, chaired by the then Prime Minister Theresa May, in 2017?

A. That's correct.

Q. Was that a board on which the DHSC had a place --

A. Yes.

Q. -- and which considered directly influenza planning?

A. Yeah, I mean, it was a -- it was the part of the follow-up to the Cygnus exercise, and it was the main body charged with taking forward the learning and actions from that exercise, and it was co-chaired between the Cabinet Office and DHSC, recognising that there were recommendations that went directly into the health service and those for wider government.

Q. Within the internal management of your department, did the various individuals and employees who were contributing to these and other boards report up to, through you, a departmental board?

A. I'm not sure "report up to" is the correct terminology, so --

Q. Forgive me.

A. Well, no, I mean, this is a ... I'm not quite sure what the right word -- I'll simply --

Q. Sir Christopher, will you allow me to rephrase the question?

A. Yeah.

Q. In your department, as part of its internal management structure, is there an overarching body called the departmental --

A. Yes, there is. Now, as I said earlier, all the legal powers are in fact vested in the Secretary of State, so departmental boards -- and sorry, this is why I was struggling to find the correct words -- they are not like the boards of arm's length bodies or the boards of private companies or charities, in that they do not hold any decision-making or ficundary(sic) responsibilities. So they are, legally, purely advisory boards to the Secretary of State, who exercises all the --

Q. The legal powers?

A. -- all the legal powers. So they are important, but they are important in that advisory function, as opposed to being a decision-making body.

Q. But subject to the legal powers vested in and imposed upon the Secretary of State personally, the departmental board is the most senior board or advisory group within the whole department, is it not?

A. Yes, but it's very important to note that that does not mean it is the conduit of advice that goes to the Secretary of State in the vast majority of cases. As I think I set out in my first witness statement, the basis of departmental decision-making is the submission system to the Secretary of State. So what I don't want to give the impression of is that Secretary of State decision-making is particularly advised by the board.

Q. No.
A. It doesn't meet that often. But you are correct that it is the highest committee in the department.
Q. May I just observe that I didn't suggest that it was a body for giving advice to the Secretary of State.
A. No, I'm sorry.
Q. It is, however, a body which addresses matters of the greatest import, of the greatest importance to the department as a whole, matters which could imperil the very existence of the department. For example, the major risks to its functioning, its operation, go to that level, do they not?
A. Yes, so the department's risk register is normally a standing item of the board, and one of the board, and particularly the non-executive members of the board's role is to critique what the department is doing on all those issues as a challenge function. As I say, decision-making sits elsewhere.
Q. Like many entities and boards, the board has a risk register which it has half an eye on --
A. Yeah.
Q. -- or a full eye, which tells it which risks pose the greatest threat to the whole entity, the whole department, which risks need to be focused upon by the board, and a register is of course kept of where the

risks come in the general order of things and what is being done to mitigate those risks?
A. That's correct, and --
Q. In a general sense?
A. Yeah, and as you correctly identified earlier, what the board does is it sits on top of a structure that assesses those risk and subcommittees that do so.
Q. So the board examines matters that are of the gravest importance to the department, and one such matter it examined by way of a risk deep dive was the issue of major infection diseases, which it did in September 2016?
A. Yes.
Q. Could we have, please, INQ000022738. "Departmental Board: Risk Deep Dive" dated, we can see, 28 September 2016, and then page 2, please, paragraph 1:

"In keeping with the departmental risk guidance, each quarter a risk from the Departmental High Level Risk Register is to be selected for a more in depth discussion at the Departmental Board. The aim of the discussion is ... to consider in more detail the mitigations for a particular risk which might not otherwise be discussed. This quarter the risk of an outbreak of a major infectious disease has been selected for the first of these risk deep dives."

Sir Christopher, it is self-evident that the risk selected for a deep dive will only be those risks which pose the greatest threat to the department, otherwise there is no need --
A. Yes, that's correct, and as is shown in this presentation, there were in fact two risks that fell into this category, one which was the risk of an influenza pandemic, and one was what is known as the risk of a high consequence --
Q. Infectious disease.
A. -- infectious disease.
Q. And at the bottom of the page we can see:

"The key question for the [departmental board] is how much money, time and effort do we want to invest in our insurance against these risks?"

And the blurb sets out how the national risk assessment, that's no longer in existence because it was done away with and combined into the National Security Risk Assessment in 2019, to which my Lady has heard reference. It sets out a very severe reasonable worst-case scenario for pandemic flu. There is then the debate about the substantial expenditure on countermeasures. Then, at the second bullet point:

"In the event of a major disease outbreak the [Department of Health] ..."

Because you were known as the Department of Health then. Then the directorate to which you've already made reference:

"... [EPHPP] Directorate would very rapidly be overwhelmed. Should we do more to raise awareness of the risk and to plan for immediate mobilisation of a large number of staff ..."

And then this:

"The lack of a national forum to support and oversee planning and response in the social care sector poses challenges is there more that can be done to provide direction and strengthen co-ordination ..."

So important serious issues were being raised in the department --
A. Yeah.
Q. -- for consideration by its highest level board in this deep dive, all related to, in broad terms, pandemic planning?
A. That is correct. I would say pandemic and high-consequence infectious disease planning, which are separate but related.
Q. Yes. That is the minute, or rather the presentation.

If we could just have a quick look at page 8, please, on the document. If you could zoom in, please.

Some figures were provided to the board on the

likely consequences of a severe pandemic: 30 million people symptomatic; 300,000 to 1.2 million requiring hospital care; 75,000 to 300,000 requiring critical care; peak illness, 7.2 million people. Impact on the economy, massive. Lost working hours, huge. Societal disruption, extensive.

Could we have the minutes, please, of the meeting, INQ000057271.

This was a meeting dated 29 September, so one day later, at which these points were discussed:

"Departmental Board ...

"Draft Minutes

"Present:

"Chris Wormald ..."

That's you, of course. And members of your team.

"Apologies:

"Jeremy Hunt, Secretary of State for Health."

Could we have, please, page 1:

"Chris Wormald opened the meeting, noting apologies from members. There was no ministerial attendance due to the House of Commons summer recess and the upcoming party conference season."

Then page 3, please, and the second bullet point:

"Members agreed that the effectiveness of the Board was linked to ministerial engagement, as much as it was

to executive and non-executive engagement. It was thought that the balance between executive, non-executive and mistrial members was important, though there was a level of ambivalence amongst executive members at the proposed reduction in their membership. Some suggested it may be appropriate for them to attend the Board for the discussions on performance, risk and horizon scanning ..."

Then the next bullet point, please:

"Members were concerned by the Secretary of State's continuing lack of engagement with the Board. Chris Wormald explained to members that ministerial attendance at the Department for Education's Departmental Board had been compulsory and enforced by the Secretary of State. He also advised that the Ministerial Code requires Secretaries of State to chair their Departmental Boards. On the proposal that the Secretary of State nominate a junior minister to chair in his absence, members noted that both David Prior and Philip Dunne had appropriate board-level experience."

What steps did you take to ensure that the Secretary of State for your department attended future board members addressing matters of the highest importance, such as pandemic planning?

A. I don't recall having a specific conversation with the

Secretary of State on that point, and I don't have a record of doing so. The Secretary of State would have been aware of the meeting and would also have been shown the minutes of the meeting, I assume, but, as I say, I don't have a record of directly speaking to the Secretary of State about that matter.

Q. This was a board that you were the ex officio head of, at least by virtue of your name being first on the list of attendees. At that meeting members expressed concern about the Secretary of State's continuing lack of engagement. Why was that not a matter that you brought to his direct and immediate attention in this issue?

A. It's very difficult to comment on a negative. As I say, I don't recall having a conversation. We undoubtedly had conversations about the board. I don't recall discussing this particular board meeting, so we definitely had conversations about the board and ministerial attendance. As I say, I don't recall raising this one specifically.

Q. It can't be very usual, Sir Christopher, for members of a departmental board to express concern about their own Secretary of State?

A. No, I don't think it -- I don't think it is.

Q. So why didn't you bring it to his specific attention?

A. As I say, I don't have a record of doing so, and

I therefore cannot recall what was ... what was my thought process at the time. I hesitate to guess what I was thinking, but I suspect I was thinking that I would deal with it in the general rather than the specific, but that is a ... that is my post hoc rationalisation.

LADY HALLETT: By which you mean?

A. Well, as I say, we were at -- I remember having discussions with the Secretary of State about the board in general, and I suspect I was thinking that was the best way to address the issue, rather than a discussion about this specific board meeting. As I say, I don't have a record of having done that, so I can't claim that I did.

MR KEITH: Page 6, please. Then further down the page. Just a little bit further up, please -- I'm sorry, too far down. Paragraph 24:

"The Department had been planning for a major outbreak or pandemic for many years, and the UK is recognised as one of the most prepared countries in the world: for example it had invested more in anti-viral stockpiles than most other countries."

The antiviral stockpiles was, in the main, Tamiflu, the brand name for an anti-influenza pandemic antiviral; is that correct?

A. That's my understanding, yes.
Q. So although it had invested more in antiviral stockpiles than most other countries, the stockpiles for antivirals was concerned only with providing a countermeasure to pandemic influenza?
A. In that case, yes.
Q. Yes:

"The Department is taking part in Exercise Cygnus, which would take place between 1 and 20 October ... and be modelled on a pandemic scenario. It had been cancelled twice ..."

We will come to Cygnus in a moment. One paragraph further down, please:

"It was more likely than not that even a moderate pandemic would overrun the system. At the extreme, there would be significant issues if it became necessary to track or quarantine thousands of people. A decision to fund high-end quarantine facilities had already been deferred by ministers."

Sir Christopher, we will look in detail over the next two hours on what steps were taken by the department between now and 2016 and 2020 when the pandemic struck. Would you agree that by January of 2020 the system was not, even then, capable of dealing with even a moderate pandemic?

A. I would have quite a nuanced answer to that question.
Q. Well ...
A. Sorry.
LADY HALLETT: Let him try, Mr Keith. You can always come back with other questions.
MR KEITH: Please answer.
A. Sorry. I think a significant number of steps had been taken at the time. And this comes out in the paragraph that you emphasised before, we believed that we had good and very good, by international standards, procedures in place, and I believe that those were rational things to think, given the evidence, advice and resources that we had at the time.

If you ask me now, with the benefit of hindsight of having dealt with the pandemic, there are a -- well, a large number of things that I would have wanted to have added, as it were, but that is with the benefit of hindsight. So I would distinguish between what we thought was rational at the time, which was, as I say, set out in the previous paragraph that you said, and what we would think now, based on what we now know.

The other thing I would add about this, and this may have been an error, but it was certainly what we thought, was an awful lot of our thinking, and the thinking that was in place when I arrived at the

department, was focused on the Cygnus exercise, and that is where we expected all these questions to go, into that exercise, and the follow-up.

I'm sorry, that's a sort of nuanced answer, but I'm trying to set out what I think we thought at the time and why, separately from what we now think is an appropriate way forward, if that is understandable.
Q. Sir Christopher, it forms no part of this Inquiry to examine with hindsight what other decisions could have been made or were made or were not made. But in 2016, this departmental board was warning in the clearest terms it was more likely than not that even a moderate pandemic would overrun the system. So there is no issue of hindsight here. That was a prospective warning that the system would likely not cope.
A. Yes, which is exactly why there was the proposal, and indeed the actuality, of Exercise Cygnus.
Q. Yes. Exercise Cygnus, paragraph 6 of its final report said this:

"... the UK's preparedness and response, in terms of its plans, policies and capability, [were] ... not sufficient to cope with the extreme demands of a severe pandemic that [would] have a [United Kingdom-wide] impact across all sectors."

So Exercise Cygnus did not come in any way to

relieve the problem that was identified in paragraph 25; it reported again that systemically the system would not be sufficient. So what was done after Cygnus to ensure that the system would be sufficient?
A. Well, there was a whole programme of work post Cygnus that we have mentioned already, led by the pandemic influenza preparedness board that we discussed earlier, the cross-government board, whose job it was to take forward the findings of the exercise.
Q. Could we have, please, paragraph 26:

"All decisions in response to an outbreak or pandemic would need to be made by the Department, as a department of state, though [arm's length bodies] would have their role to play. There were, however, concerns about how resilient the somewhat fragmented system would be -- especially in light of previous or future funding cuts."

By January 2020, the system remained fragmented, did it not?
A. Its legal structure, as set out in the 2012 Act and the 2014 Care Act, the two governing pieces of legislation, hadn't changed, no.
Q. The legal structure under that Act and the legal structure under the Civil Contingencies Act 2004 had not materially altered, had it?

A. Those -- so the two Acts, which is, as it were, the governing acts of how we run the system, the 2012 Act and then the 2014 Act for health and then social care, remained in place, yes. And then, as you know, the Civil Contingencies Act hadn't changed.
Q. The whole system, having a lead government department, having local authorities and local resilience forums, being supervised and liaised with by the Resilience and Emergencies Division of the Department for Levelling Up, Housing and Communities hadn't changed?
A. No.
Q. The Cabinet Office position hadn't changed through its Resilience Directorate, it sought to exercise control by political persuasion and other means over other government departments?
A. A little more than political persuasion, but no, it hadn't changed.
Q. The Department of Health and Social Care was responsible for the funding and the general guidance -- funding of and general guidance for local authorities, but, of course, local authorities who are concerned with the adult social care sector fall outwith the direct functions of your department?
A. That's correct. So the 2014 Care Act, which broadly maintained the previous arrangements for adult social

care, sets out that it is a local authority-led and funded service, so it's not correct we oversaw the funding, the funding is locally raised, and it gives a -- quite a limited set of powers to central government, mainly through the inspection of care providers, not -- not local authority commissioners, as I say, because that is something we have changed. So it was a largely locally-led system, with the department having responsibilities around the legal framework and around the inspection, as implemented by CQC.
Q. So, Sir Christopher, having therefore accepted that in no significant regard had there been any change to the fragmented nature of the system as at 2016, would you agree that the system remained similarly fragmented still by January 2020?
A. As I say, the legal position on all those matters had not changed.
Q. In this board meeting, Sir Christopher, concerns weren't being expressed about the dry nature of the legal obligations being placed on the various parts of the government machine; concern was being expressed about how resilient the somewhat fragmented system would be, whether it would cope in practical terms. That wasn't just an issue about legal obligations, was it?
A. No, no, I was answering the specific question you asked

me.
Q. So there were no changes, were there, significantly, to how resilient the system would be between 2016 and 2020; it remained fragmented, didn't it?
A. That's true.
Q. Thank you.
LADY HALLETT: You are accepting it was fragmented? I got the feeling that maybe you weren't accepting, Sir Christopher, it was fragmented.
A. I don't think there is any dispute that it was fragmented, and indeed the whole point of the 2012 Act was to reduce the level of central control over particularly the NHS and to run the system much more as a -- and I apologise for using the jargon -- as a quasi-market. So the idea of that Act was to have operational freedom within the NHS, and for the system to be based around a series of commissioners and providers, as opposed to a top-down system of direct control as had existed prior to 2012.

Now, whether you believe fragmented to be a good or a bad thing, I don't think there's any dispute that that was the purpose of that set of reforms.
LADY HALLETT: Shall we pause there, Mr Keith?
A. In terms of -- I want to cover social care as well.
LADY HALLETT: Do finish the thought and then we'll pause,

break.
A. Yes -- where, again, it's not a matter of dispute that social care is a locally-run service and, therefore, divided amongst the top tier local authorities, as -- again, you can debate whether that is a good thing or a bad thing, but I don't think it's in doubt that it's a thing.
MR KEITH: And there we must leave it.
LADY HALLETT: Well, unless you particularly wanted anything else on this topic.
MR KEITH: As it happens I had one more question on this document and then perhaps we can put it to one side. Paragraph 25:

"... there would be significant issues if it became necessary to track or quarantine thousands of people."

Is this the position, Sir Christopher: that despite that issue, the important issue of quarantining, being raised in 2016, by January 2020, whilst there was and had been a continual debate as to how to isolate individuals in the event of a high-consequence infectious disease, there was -- and -- there never was any debate about mass quarantining, mass isolation, mass quarantining, was there?
A. Well, in the influenza plan, the basis of that is a series of voluntary what are known as NPIs, which

would have included those issues. What there was not --
Q. Sir Christopher, I'm so sorry to interrupt.
Quarantining is, as you know, of course, a mandatory thing. It's a mandatory restriction. Was there any debate between now, the issue having been raised, and 2020, of mandatory quarantining of significant numbers of the population?
A. Not in the context of a pandemic.
Q. Well, we're not really concerned with quarantining outside the pandemic in this Inquiry; so the answer is no?
A. Not in the context of a pandemic. I'm sure we will come on to, but there are important interactions between the strategy for high-consequence infectious diseases and the plans for a pandemic, which I'm sure we will discuss further.
LADY HALLETT: I think you said the issue having been raised in 2020; I think you meant 2016.
MR KEITH: Thank you, I did.
LADY HALLETT: Very well. We shall come back at 2.20, please.
(1.32 pm)
(The short adjournment)
(2.20 pm)
LADY HALLETT: Mr Keith.

MR KEITH: Sir Christopher, may we now turn, please, to the risk assessment process to which you referred earlier.
As you've helpfully stated, the Department of Health and Social Care was the lead government department for pandemic risk and infectious disease, and so it was, in the nomenclature, the risk owner for those risks in the National Security Risk Assessment. It provided information and was part of the process by which those risks were identified, debated, described in the paperwork, and also what the impacts would be likely to be from those risks. The department owned all aspects of the debate concerning those two risks: pandemic influenza risk and emerging infectious disease risk.
A. That's correct. I mean, the process of setting the risk and then agreeing reasonable worst-case scenarios and all those things I think has been described in other statements.
Q. Yes.
A. I mean, it's an iterative process between the department and the centre.
Q. The Inquiry is aware that the department obviously received advice from both its internal scientists, its departmental Chief Scientific Adviser, or government department Chief Scientific Adviser, from a number of external advisers, external bodies -- I mean, these risk

assessments were pored over by a multitude of people and bodies --
A. Yeah, that is -- that's correct. So the process --
Q. We don't need the full detail, would you just agree with the proposition that they were of course examined at great length by your department, which was responsible for them?
A. Yeah.
Q. And also with the assistance of internal and external advisers and scientists?
A. Yes, that's correct.
Q. All right.
Now, we need to look, then, at the actual documentation, so we could please have INQ000147769. This should be the -- what was then called the national risk assessment, and, my Lady, the government has kindly declassified parts of this internal National Risk Assessment for the purposes of this Inquiry.
That is why, Sir Christopher, it says "Official-Sensitive" at the top, but we are looking at it today.
A. Yeah.
Q. This is the 2016 version. It was the national risk assessment then, but in 2019 the two forms of the assessment, the national risk assessment and the

National Security Risk Assessment, were brought together, were they not?
A. That's my understanding, yes.
Q. All right.
Could we look, please, at page 7:
"The National Risk Assessment [towards the bottom of the page] is a strategic medium term planning tool. Risks captured within the NRA [the national risk assessment] are examples of civil emergencies that could plausibly affect the United Kingdom within its territorial boundaries in the next five years ... It is crucial all risks are assessed using a consistent, evidence-based approach."
What is an evidence-based approach?
A. I think it's exactly what it says on the tin, so that it should be on the basis of expert opinion, modelling and the available evidence.
Q. An approach that isn't based on available evidence isn't much of an approach, is it?
A. Well, I mean, government is sometimes in the situation where it has to take decisions despite lack of evidence, so that does happen.
Q. All right.
A. But if you're doing this kind of assessment, yes, you would expect it to be evidence based.

Q. "... each risk is considered on the basis of a 'Reasonable Worst Case Scenario' ... [it's] intended to provide an illustrative example of the worst plausible manifestation of the risk in question."

And it's based on two scores: impact, which determines the severity of the consequences; and likelihood -- which is more concerned with non-malicious risks/hazards -- or plausibility, which is concerned with malicious threats, "determining the expected recurrence rate of the risk over the next five years".

If you go down a bit further on the page, please, we can see that we have the heading "Impact":

"Impact is determined on the basis of collating information about the severity of economic losses ...".

And so on and so forth.

Page 9, please. There is a chart at the top of the page, and along the bottom of that chart we have Likelihood/Plausibility". We can ignore likelihood. We're concerned with plausibility, because we're dealing with hazards, a pandemic, rather than, for example, a terrorist threat. On the left-hand side, "Impact".

At the top we can see, for medium/high likelihood, but catastrophic impact, pandemic influenza. Thank you.

And for medium/high -- with medium/high likelihood, and moderate impact, emerging infectious diseases. Is

that correct?

A. That's correct.

Q. If we could scroll back out, please, and look at the bottom half of the page, you can see that there's a second chart, and in relation to pandemic influenza risk, because it falls in the top part of the above chart, in the catastrophic range, there is a circled area in this chart called "High impact risks" in relation to which the "Government is expected to supplement generic capabilities with specific contingency plans".

Scroll back out, please.

Because emerging infectious diseases was only a moderate impact as opposed to significant or catastrophic it didn't fall within the shaded area for which the government was expected to produce a specific contingency plan; that's correct?

A. Yes.

Q. All right.

Page 10, please. Planning assumptions were then drawn up. So once you'd identified likelihood and you'd identified impact and you could see where your risk came on the top chart, planning assumptions were then made on what the common consequences of a number of risks might be if they came to pass, so that everybody could

understand the realistic worst-case scenario and plan accordingly. Is that correct?

A. Yes.

Q. So there is an example given at the bottom of the page, "Risks that could lead to mass casualties", either an industrial accident or a terrorist attack or flooding or public disorder. If you group those risks together, the planning assumption would be therefore 1,000 casualties, because that's the worst of those four particular risks which are grouped together. Do you agree?

A. Yes.

Q. All right.

Could we then, please, have page 23.

Page 23 gives us, for 2016, the likelihood -- in the top chart -- and impact of the two risks with which we're most concerned: H23, which is, you agree, pandemic influenza, and, below it, H24, for moderate impact and medium likelihood, emerging infectious diseases?

A. That's correct.

Q. Then page 47, please. This is the more detailed description of the pandemic influenza risk, and we need to look at this in detail.

You see, Sir Christopher, on the top left the overall assessment is very high, is it not?

A. Yes.

Q. Is that because, in the top right-hand corner of the page, the chart for pandemic influenza provides that the reasonable worst-case scenario, which is that star, is right up at the top of the page with medium to high likelihood but catastrophic impact?

A. That's correct.

Q. Therefore, because of the medium/high likelihood and the catastrophic impact, together an overall assessment is made of it being very high?

A. That's correct.

Q. What does the arrow under the star signify?

A. Now, that I couldn't tell you.

Q. All right. That's easy then. In that case I won't pursue that particular point with you.

Then in the wording you can see there is a general description of the pandemic influenza risk, a novel flu virus emerges, up to 50% of the population may experience symptoms, 750,000 fatalities in total, absenteeism could reach 20%, and then these words, in the sixth line:

"Each pandemic is different and the nature of the virus and its impacts cannot be known in detail in advance."

That is a description which falls in this page under

the heading of "Pandemic influenza", but it is applicable to any pandemic, or any viral respiratory disease, because they all differ, and the nature of the virus and its impacts can't be known in detail in advance.

So my question to you is this, please, Sir Christopher: the risk assessment approach acknowledged that the pandemic influenza risk could be different in each case, its characteristics could vary, depending on transmission, severity, incubation period, available countermeasures and the like, and the impacts couldn't be known in detail in advance; why was that same approach not applied to a non-influenza pandemic, which is equally -- could be -- a virus or a coronavirus or some other type of infectious disease?

A. Well, I mean, as you have discussed with other witnesses, this is, of course, one of the great questions. Now, how it was discussed within the department while I have been in it, and this may have been a wrong approach but it was undoubtedly what people said to each other, was you had to have a basis for planning and influenza was the most likely, most dangerous and identified risk, and the approach ...

Q. I'm sorry, Sir Christopher --

A. I'm sorry, I lost my thread slightly.

And the approach taken was essentially "ready for flu, ready for anything", would be the summary of what was -- what was thought. And this was built in, as I'm sure you know, to the original 2011 flu plan, which mentions the possibility of other respiratory diseases, and that was certainly the thinking that was going on at the time, that you had to specify a risk, and influenza was chosen on that basis, and that then, were some other type of unpredictable pandemic break-out, you would adapt the flu plan based on that approach.

Now, as with some of my previous answers, obviously we have learned a lot, and in terms of our learning from the pandemic we are in a different place, but in terms of what was thought at the time and the answer to your question, that was the approach being taken.

Q. In the next paragraph it says:

"There is no known evidence of association between the rate of transmissibility and severity of infection, meaning it is possible that a new influenza virus could be both highly transmissible and cause severe symptoms."

What your own departmental risk assessment -- you owned this assessment -- was saying. Dealing with pandemic influenza, there is no known evidence of association between transmissibility and severity, which means just because something is high transmissibility

doesn't mean to say it's going to be necessarily low severity or high severity. They're two different issues.

So it stands to reason that any disease, viral disease, could be both highly transmissible and very deadly?

A. That is what it says, yes. I mean, you'd need to -- you have lots of them before the Inquiry -- you would need to ask our epidemiologists for the science behind that, but that's undoubtedly what it says on the page.

Q. But that is a statement of known evidence which applies to all infections, all viral respiratory diseases, not just influenza. So why didn't any single person in the plethora of individuals and entities who addressed this risk assessment, say, "Well, hang on, if an influenza disease, a pathogen, can vary quite significantly in its characteristics -- incubation period, transmissibility, stuttering or high transmissibility, asymptomatic, not symptomatic -- and therefore you just can't say what characteristics it's likely to have, surely that applies equally to non-influenza pathogens?

A. In that --

Q. Because it's based on the characteristics of a virus?

A. Yeah, and the Chief Medical Officers' witness statements cover these points in detail.

Q. Do you agree that it was open to anybody reading that paragraph to ask that question: surely this applies to non-influenza viruses as well?

A. Well, as I say, that was the thinking at the time, that you wrote a plan for flu, and that if you got another type of pandemic then you would be adapting the plan that you had for flu for the disease that did occur and, as I say, as is covered in the Chief Medical Officers' statement, a lot of that has to be done when you know what the disease you're facing is. That was, as I say, the thinking at the time.

Q. All right. Page 48, the next page, please.

So we're still in 2016. We're now dealing with emerging infectious diseases. The overall assessment, top left, is high, not very high; correct?

A. Yes.

Q. In the top right in the chart, for likelihood/plausibility -- again we're only here concerned with likelihood -- the reasonable worst-case scenario star reflects a medium/high likelihood, same as pandemic influenza, but the impact is moderate rather than catastrophic; that's the difference, isn't it?

A. Yes, though, as I was saying before the break, and perhaps this is the moment to talk about it, there isn't a hard and fast distinction between high-consequence

infectious diseases and then pandemics. Indeed, one can become the other. So the heart of this strategy across those two things is you can have an emerging infectious disease which you seek to contain. Where you fail to contain, it has the possibility to become an epidemic or a pandemic. And that is of course what happened, exactly what happened with Covid. It was originally defined as a high-consequence infectious disease and then declassified as it became a pandemic.

Q. The arrows on this page, page 48, signify, do they not, that because little may be known about the particular characteristics of the emerging infectious diseases, and because viral infections may differ radically in terms of their incubation period, transmissibility, severity and so on and so forth, there was actually a chance that the impact could be greater than the reasonable worst-case scenario, and that is why the top arrow is in "Significant" -- the row for "Significant"?

A. Yes, I think I've understood the arrows, now. That presumably is the bands of --

Q. Of possibility?

A. -- around the reasonable worst-case scenario.

Q. Right. So, actually, whoever drew up this chart was recognising that because with emerging infectious diseases, like all viruses, it's impossible to know in

advance with any degree of certainty what the characteristics may be and therefore how deadly or how transmissible the disease would be, it was important to identify the possibility that it could be more significant than the reasonable worst-case scenario?

A. Yes. And as I said, you have to -- and this is, as I understand it, how it has always been thought about -- think about those two strategies in parallel. So we had one strategy, this one, which covered a wide range of possible diseases, those classified as HCIDs, a number of which have the possibility, as was the case with Covid, of becoming a pandemic, most of which -- and as I'm -- as you'll know from several of the witness statements, we have had a number of HCID incidents, the vast majority of which don't.

Q. Yes.

A. So on the question that I know this Inquiry has been looking at, did we only have a plan for flu, that is not correct. We only had a pandemic plan for flu to be used in the way I described, adapted in the light of the pandemic that you had, and then a wider strategy, a lot of which flowed from the response to the Ebola crisis that you were describing earlier, about high-consequence infectious diseases, and I take the upper arrow in this case, that is the transmission from one category to the

other, that would be a disease that would be on its way to being --

Q. Yes --

A. -- pandemic, likewise the one going downwards the other way.

Q. Thank you, Sir Christopher. So the short answer is, if I may say so with respect, or suggest to you with respect, is that there was a specific pandemic plan for influenza --

A. Oh, yeah.

Q. -- but no specific pandemic plan for anything that wasn't influenza?

A. No, well, I mean, that is clearly factually correct, for the reason that I described earlier --

Q. Yes.

A. -- which I fully, fully appreciate may have not been the right approach -- and, as I say, we're taking a different approach now, but just in terms of what was the approach --

Q. We will come to now in a moment.

Could we scroll back out, please, from page 48.

If you look at the middle of the page there is then a reference to the fact that there had been more than 30 new or newly recognised diseases over the past 30 years, and there is a reference then to SARS and then

to MERS and Ebola.

A. Yeah.

Q. So the author of this document plainly recognises that there are a significant number of new or newly recognised diseases out there --

A. Yeah.

Q. -- and there had been over 30 years, and the arrows indicate properly that there was a risk of something worse happening than the reasonable worst-case scenario, because we are dealing here with a generic description trying to be applied to a specific future disease --

A. Yes.

Q. -- the nature of which you don't know?

A. Yep. That is correct.

Q. All right.

Could we look, please, at 2019, which is INQ000185135, on the eve of the pandemic. INQ000185135.

"Emerging Infectious Disease". The risk picture changes, does it not, between 2016 and 2019?

A. Yes.

Q. Because the chart now, top right-hand corner, has the top arrow for possible catastrophic outcome of emerging infectious disease two rows above the reasonable worst-case scenario.

A. Yeah, and I think I would say that is a more accurate

picture of the risk than the 2016 one, as was demonstrated in the pandemic that we did suffer. So clearly, and, as I said, a high-consequence infectious disease can be on the way to being a pandemic --

Q. Catastrophic in terms, Sir Christopher, of --

A. Oh, yeah.

Q. -- massive fatalities -- well, huge numbers of people infected, work absence, impact on economy, and the like?

A. Yes. Yes.

Q. Right.

A. So in the translation between something that begins as a high-consequence infectious disease and becomes an epidemic or pandemic, yes, then it would have the same risk profile as our pandemic risk, it has effectively become that, and, as I say, that is in practice what happened with --

Q. With Covid, right.

A. -- with Covid, yeah.

Q. Could we scroll back out, please.

Towards the bottom of the page, you will see a reference to a reasonable worst-case scenario, and a description of how the infection would likely develop outside the United Kingdom.

Could we scroll back out, please. And in the middle of the page there is a debate over means of

transmissibility and so on.

Could we go forward one page, please, to page 2. There is then a description of:

"What the [reasonable worst-case scenario] described above could lead to ..."

Increased demand on specialist intensive care. Localised disruption to routine healthcare activities if outbreaks occur in hospital settings.

Just emphasise, please, mentally, Sir Christopher, the reference to hospital settings.

Further down the page, "Specific Assumptions and strategic context". There is a likely high case fatality rate, for MERS it would be about 35%, there is no effective treatment, the main control measure is the implementation of effective infection control.

So the approach taken on this page is to say in terms: because the reasonable worst-case scenario -- that star -- only has medium impact, not catastrophic, even if we assume there is no antiviral, there is no vaccine, that there is a very high case fatality rate, 35%, the impact is not going to be of the same order as an influenza pandemic, it's of moderate impact, you'd be dealing with disease in health settings, healthcare settings --

A. Yeah.

Q. -- the possibility of infection there, but it's not going to run amok through the whole population, killing 35%?

A. No, that is the -- you have put your finger on the difference between a high-consequence infectious disease, where you are dealing with small numbers and you're seeking to contain it --

Q. Where the greatest risk is in hospital settings, because doctors and nurses have to be able to treat people who are infected and there is a greater risk of transmissibility there?

A. Yes. Now, I'm only -- I'm only cautious on my answers because you will get much better answers --

Q. It's all right.

A. -- a number of other witnesses in terms of the epidemiology. But in terms of the concept, the high-consequence infectious disease strategy is, as I say, for where you have small numbers and the intent is to contain and get it to zero, and a pandemic is effectively where contain has failed -- or, sorry, an epidemic, where contain has failed and you are into the question of: how do you mitigate something that has gone beyond your ability to contain it?

Q. We are focusing on for the moment on the risks, not how you deal with a pandemic once it's out there.

A. Well, the only thing I would say is those are at -- that question of: can you contain it and drive it to zero is central to the question of what the risk is, as it were.

Q. Well, Sir Christopher, the reason why it can be controlled and reduced to zero is because this risk assumption assumes that it is not highly transmissible, that it's not going to run amok through the population and it can be controlled.

A. Yes --

Q. Correct?

A. -- and that is the difference --

Q. Indeed.

A. -- between the two categories.

Q. Could we go forward, please, one page further to page 3. There is then more debate about MERS and SARS. Then in the middle of the page, or two-thirds of the way down the page:

"The emergence of new infectious diseases is unpredictable but appears to have become more frequent. This may be linked to a number of factors such as climate change, the increase in world travel ..."

And so on and so forth.

So there is a clear recognition there, isn't there, that new infectious diseases are unpredictable and have become more frequent; correct?

A. Yes.
Q. Yes. Can you scroll back out, please?
Then, at the bottom of the page, "Recovery and long term implications".
Could we go forward one page again, please, to page 4.
There is a description of variations, again a description of Ebola and reference to MERS and SARS.
Then, please, page 8.
The consequences of this particular risk, broadly identified as it was:
"Likelihood ... There is significant uncertainty about the frequency with which an emerging infection may develop the ability to transmit from person to person."
So there is a risk, is there not, recognised in this document that a non-influenza emerging infectious disease may be a high transmissibility pathogen, it may travel human to human readily?
A. Yes.
Q. Scroll back out, please. But the fatalities, the number of people which were assumed in this document to result from this disease, is put at -- under "Fatalities", 200, no notice and excess deaths.
Then further down the page, please:
"Casualties (UK)

"Total number
"2,000
"No notice and excess casualties.
"- Using the upper bounds, 20 no-notice, 1,800 excess."
So even though the arrows signified a risk of a catastrophic outcome to a non-influenza pandemic, or a non-influenza pathogen, even though the document recognised that there could be human-to-human rapid transmission and, by implication, that the disease could spiral out of all control, it concluded only -- and I apologise for using this language -- a relatively few deaths by comparison to the 820,000 deaths assumed in an influenza pandemic?
A. Now, I think we're in a slight danger of getting lost in the terminology, so ...
Q. Well --
A. As I --
Q. Sir Christopher, are you able to answer that question, why did -- those things being recognised, being apparent on the face of this document, was such a relatively limited conclusion reached in terms of impact?
A. Because of the interrelationship between those two identified risks, and so that's the reason why the two risks are on the National Risk Register. So if you are

successful at containing a disease via your HCID mechanisms, then you would be containing the risk at these sorts of level --
Q. But, Sir Christopher, I apologise for interrupting, if the emerging infection does develop the ability to transmit rapidly human to human, as those arrows identify, as that paragraph under the heading "Likelihood - confidence assessment" states, there will be no question of containment, will there, because it won't be --
A. Oh, no, until you are into your epidemic/pandemic risk, with the kind of reasonable worst-case scenarios identified for that -- sorry, that's what I mean by --
Q. So why, why, why, were the number of deaths put at 2,000 not 820,000?
A. Well, sorry, this is where I think we may be at risk of becoming lost in the terminology. Then you have two identical risks. You have effectively two epidemic/pandemic risks --
Q. For which the outcomes will be the same: massive loss of life?
A. Yeah.
Q. Collapse of the economy? Huge -- millions of people infected?
A. Yes, and, as I say, and --

Q. That is not this outcome on page 8, is it?
A. No, because, as you correctly identified, these would be the outcomes if you have successfully contained the disease. The outcomes if you have not successfully contained the disease would be in the reasonable worst-case scenario that we had identified for pandemic influenza, ie the disease in that case would have translated -- as Covid did -- from one being managed as an HCID, with these sorts of implications, into something that was in the pandemic risk category with those sorts of implications.
Now, as I say, I don't -- I'm not trying to get lost in the terminology, what I'm trying to do is explain the translation between those two.
So your point, I think, is entirely correct, but it's the way it's reflected in the risk register is how I have described it, it's the translation of a disease from one category to another category.
Sorry, I'm not sure I'm explaining myself very well.
Q. Sir Christopher, in your own witness statement you accept that any new pathogen transmitted by the respiratory route is likely to share characteristics with influenza, in that it may spread rapidly via close proximity --
A. Yes.

Q. -- can travel rapidly and there are few easy intermediate countermeasures?
A. Yes.
Q. If that is so, then there is not likely to be any control. As you correctly said, the non-influenza virus will react and be apparent in just the same way as an influenza pandemic: widespread, devastating, deadly. But that is simply not on the face of this page, is it?
A. No, it's not on this page, but it is --
Q. Is it on any page, Sir Christopher, that you know of?
A. Well, it's in the -- as I say, I'm not sure I'm explaining myself terribly well -- but that is in the pandemic scenario. So if you look at the --
Q. Is it in any --
LADY HALLETT: Mr Keith, let Sir Christopher finish.
A. Yeah. So if you look at the types of diseases discussed in this risk, MERS, SARS, Ebola, et cetera, the ones that you quoted, they all were contained in the HCID category. Now -- and I have already pointed to this may have been a flaw in the approach, and you have heard this from other witnesses, but that was the thinking, that you have a risk that is about: can you contain the disease? Then you have a risk about a disease that you have not contained, which you would manage in the same way as an influenza pandemic.

Now, as I say, it may have been incorrect thinking that "ready for flu, ready for anything", but that was how we were -- or how it was being thought about, the relationship between these two things, between the thing that you want to contain and you try as hard as you can to contain and is the policies and procedures that flow out of this risk, and then what you were doing to try to mitigate the effect of a disease for where these approaches of containment have not worked.
Now, my final point --
MR KEITH: Please.
A. -- I do, and as we've discussed this within the department, I think there is a very key issue for us about the threshold between those two things. So there has been a lot of discussion, rightly, of some of the countries that handled Covid extremely well, such as South Korea. Effectively what they had was a much higher threshold of containment for HCID than we were able to do, and that was the key difference.
So I do think what we are talking about points to some of the key issues about the management of the disease, of diseases. I don't actually think the risks were identified incorrectly, and I do think those two stages of you try and contain a new disease so that it doesn't lead to a pandemic, and then if it does you try

and mitigate the effect so that the impacts on society are as small as possible, I do think that is the right thinking. I do think in retrospect the questions about what the thresholds are between those two things is a very important thing.
Q. Sir Christopher, just a few moments ago you said "there was a flaw in the [thinking]".
A. Erm, well, so in that we have changed our thinking, as I think our KC set out in our opening statement. I will continue to distinguish between what we thought was reasonable at the time and what we think now with the light of experience. We have changed our approach on some of these issues, so it is only fair that I reflect that.
Q. Well, my Lady will always ensure that the process is fair.
A. Sorry, that was not the implication, that it was not. No, I chose my words badly. That we have changed our thinking in the light of what we have learned in the pandemic, I think I am supposed to say when that is the case. And almost by definition, as we have changed our thinking based on our learning, that causes us to ask questions about our previous approach.
Is that a better way of framing it? I wasn't trying to suggest anything about fairness.

Q. Well, happily, Sir Christopher, in this process, I ask the questions, so I can't answer your question, I'm afraid.
A. Sorry. I'm sorry.
LADY HALLETT: Happily for you, Mr Keith.
MR KEITH: Happily for me.
Sir Christopher, one last question on this topic. You have accepted now there was a flaw in the thinking. Those three or four pages that my Lady has looked at show quite clearly that on the one hand it was well recognised that a non-influenza pathogen would be unpredictable, potentially with catastrophic consequences, that you couldn't say in advance what the incubation period would be, what the transmissibility would be, what the severity would be, that there was a risk that it would be as deadly as an influenza pandemic.
A. Yes.
Q. Was not that thinking obvious? You say it's now flawed, but it was obvious at the time, wasn't it?
A. No, so let me be very clear indeed.
So the bit of this where we have adapted our thinking is what I said earlier about the piece of orthodoxy, which was "ready for flu, ready for anything", as it were. So, as I say, the thinking at

the time was: you made a plan for influenza as the most likely risk, and still one of the most dangerous risks, and then you adapted that plan for what was in front of you. And that is some of the things it says in the original 2011 version, that this would be adapted for a SARS-like disease.

Now, that is thinking that we have moved on from. I don't actually think that the difference between an HCID -- sorry, a high-consequence infectious disease -- that you are trying to contain and a disease that you are trying to mitigate, I don't think that is flawed thinking.

I do think the question of what's the top of what you try to contain, as opposed to mitigate, that is a clear lesson of the pandemic, and from some of the countries that you correctly quoted in some of your opening statements about who we should -- who we should learn from, one; and, two, the other area where I think your questions are right on the button are on the levels of uncertainty about the emergences of these diseases.

So the question is asked: were we overreliant on an influenza plan? My view is we were overreliant on plans, period. Our thinking now is much more in terms of: what are the flexible capabilities that allow you to put together the correct type of response, given the

type of disease that happens to be in front of you? As opposed to: can we write a plan for a specific outcome and then identify it? And then, second, as has been discussed with a number of your witnesses already, and I'm sure will come up a lot more: what is the underlying resilience of your system?

Q. All right. Sir Christopher, I'm going to interrupt, I'm afraid, just to try to allow you to draw breath. It's a very, very long answer.

A. I'm sorry it's long, but we have thought about this quite a lot -- as you would expect -- and what I'm describing does flow out of the questions that you are correctly -- correctly asking about these types of strategies.

So I do think your questions get us to those questions. I don't draw exactly the same conclusions as you, which is perhaps unsurprising, but I do think we get to those sorts of -- the sorts of learning that I have just described.

Q. All right, Sir Christopher, you made a reference in the course of that answer to the 2011 document.

A. Yes.

Q. Do I take it you mean the 2011 United Kingdom influenza pandemic strategy?

A. Yes.

Q. This was a strategy which was designed, was it not, by your department?

A. Yes.

Q. It was a strategy, as it says in the title, for dealing with an influenza pandemic strategy?

A. Yes.

Q. And, as you've rightly acknowledged, if I may say so, there was, perhaps, too great a dependency upon plans and, as we've discovered, too great a dependency upon an influenza pandemic plan.

Was that strategy in 2011, which formed the basis for this risk assessment thinking, ever updated?

A. As in a new one published? No. There was a plan to, but the pandemic struck before it was. So --

Q. Was that --

A. So --

Q. Was the plan not published because of the pandemic, Sir Christopher, or some other reason?

A. The work was not finished. So --

Q. Sorry, the work was not finished?

A. The work was in flight at the time. Now --

Q. No, Sir Christopher, I'm so sorry, what do you mean "the work was in flight at the time"?

A. Right, so we -- I'm getting confused around the word "plan".

Our intention in 2019 was that we were working on an update of the -- and a refresh of the influenza plan, not a wholesale rewrite. There was not proposals for new strategic thinking, but a refresh of the plan. Those plans had not finished -- sorry, those -- that work had not finished at the time that the pandemic broke out.

Q. Sir Christopher, is the answer correctly to my question this: the 2011 document was never updated or refreshed, and the reason why it was not refreshed in 2019 was nothing to do with the pandemic, which is what you said a few moments ago, but because your department's work was significantly interfered with by the diversion of resources to dealing with a no-deal EU exit?

A. Oh, yeah. Yes. No, and I think we've been explicit about this, that this is one of the areas of work that we paused while we were looking very specifically at the consequences of a no-deal Brexit.

Q. So the work was not in flight, as you said, and the work was not interrupted by virtue of the pandemic, as you said?

A. Well, it was delayed by the work on Brexit and then the pandemic broke out, more specifically. Sorry, I've chosen my words badly there.

Q. Did the 2011 strategy, the sole strategy for dealing

with the detailed plans for a pandemic, pay any regard to overseas experience, from the experience of the other countries to which you made reference a few moments ago, who had dealt with MERS and SARS?

A. Well, the plan makes an explicit reference to SARS. I think it is correct that in the 2011 plan and in the substantial work that was done post that, we were not looking at the examples of some of the countries that you mentioned in your opening statement.

Q. So if I may suggest, the correct answer is that whilst there was a reference to SARS in the 2011 strategy, there was no reference at all to how other countries had coped with SARS?

A. There certainly wasn't in the 2011 plan, and you are correct that our plans were what you might describe as in the European and western mainstream. We were not looking at the examples that -- particularly of the countries you reference. That's simply a fact.

Q. But the countries which had dealt, in your own words, perhaps more efficiently and appropriately with Covid were the countries that had dealt with SARS and MERS to which that very risk assessment makes reference, there were repeated references to SARS and MERS.

A. Yeah.

Q. So why was there no reference or thought given to the

experiences of other countries who had been there before us?

A. Well, and I am ... in terms of 2011, I am partly hypothesising, because obviously this was before my time, but --

Q. Have you read the document?

A. Yes -- no, well, as I say, I'm quite happy to comment, I am merely setting out.

So I think this comes into the conversation we were having about the management of high-consequence infectious diseases versus the management of pandemics.

So in terms of MERS and SARS, and including Exercise Alice, which was for a high-consequence infectious disease, we were looking at those sorts of containment and elimination strategies.

What South Korea and some other countries very successfully did in Covid was apply those to much more widespread diseases than SARS and MERS, and that was the thing -- and a number of people have pointed to this -- that we had not built a system to do, was to do that sort of containment at the sort of scale that they did.

So, as I say, the difference is not: were one set of people thinking about containment and the other not? It was the scale to which they were -- and I'd say very

successful and everyone is correct to point to them on -- the scale at which they were able to carry that out compared to the much lower scale of containment that was based in our plans.

Q. You said earlier and you say in your witness statement at paragraph 96:

"... the capabilities developed for an influenza pandemic are often the most transferable for use in response to other pandemics, should that be required ..."

And the point you made earlier and the point you make in your statement is: well, all right, as a country we didn't prepare for a coronavirus pandemic, we had only a generic plan for emerging infectious disease, it failed to have regard to the likely or possible characteristics of such a disease, namely that it would be as devastating as an influenza pandemic, but that's all right, the capabilities developed for an influenza pandemic can be transferred in use -- in response to other pandemics.

Could you please itemise, shortly, list the capabilities which can be transferred for use in other influenza pandemics?

A. There was one -- before I do, I don't think it's the case that we only had a generic plan for

high-consequence infectious diseases, we only required to have a generic plan by the National Risk Register, but there was in fact an extensive programme of work led by the NHS on how you deal with high-consequence infectious diseases. So I don't think that word is correct.

We used quite a lot of the flu plan in Covid. We used the legislation, we used the surge capacity of the NHS, we used the response function that we had built up, we used the thinking on public communications, and the voluntary versions of non-pharmaceutical interventions. And absolutely crucially, and very successfully, we used the investments that had been made in vaccines, via the UK Vaccine Network, which provided the platform technologies that turned into the Oxford/AZ vaccines.

So there were a whole series of things from the influenza plans and the work flowing from it that we used.

There were then some things that we didn't use, as your question points to.

Q. The stockpile of personal protective equipment for an influenza pandemic had a duration of about three months. Was that a capability which was transferred to Covid or did we run out?

A. It was undoubtedly transferred in that we used the

pandemic stockpile that we had built up for influenza in the early months --

Q. Did the stockpile run out, Sir Christopher?

A. We never nationally ran out of PPE. We were very short and we had significant logistical issues. The -- so the stockpile that we had built up was (inaudible) useful in the pandemic. Was it big enough for the pandemic that we had? It would have been much better were it to have been larger.

Q. Were the --

LADY HALLETT: Can I just interrupt there?

MR KEITH: Yes.

LADY HALLETT: I think a lot of medics would be surprised at your comment "we never nationally ran out of PPE".

A. Yes, and I chose my words very carefully, and it's a debate we have had before. There were huge pressures on PPE and we had, as I said, significant challenges getting PPE to the right place. So the department has never said, and it would not be true to say, that in individual places there were shortages of PPE and people having to use not the right PPE. That's different from it having run out nationally. So, in terms of all the reports people make of the struggles with PPE and the right PPE in an individual place not being available, that was clearly true.

MR KEITH: Sir Christopher, the stockpile which existed on 1 January 2020 ran out. Obviously further PPE had to be procured --

A. Yes.

Q. -- but the stockpile for an influenza pandemic was not sufficient, was it?

A. Well, the --

Q. Was that stockpile sufficient, Sir Christopher?

A. The stockpile was never intended to cover the whole of a pandemic, it was supposed to create a buffer while you ramp up production --

Q. But you're the one who said the capabilities developed for influenza are transferable for use?

A. Yeah, and the stockpile was transferred.

Now, I did not, and this was a very deliberate answer to your question, I did not put PPE on my list of things that we transferred. While the stockpile we had was useful, and prevented us from running out of PPE at various points, there was a clear difference between the PPE we needed for this type of pandemic and the one we had built up, which is why I didn't put it on my list of transferables.

Q. The antiviral medicine Tamiflu was a capability developed for influenza pandemic. Was that of any use at all in a non-influenza pandemic?

A. No. And again, that is why I didn't put it on my list.

Q. I believe that you've answered the question.

A. Okay.

Q. You'll have an opportunity in a moment, no doubt, of answering other questions on this.

A. I'm sorry.

Q. In relation to contact tracing on a mass level, or of quarantining, or of lockdowns, or any of the more severe social restrictions, were those capabilities that were designed in relation to an influenza pandemic?

A. So wide-scale contact tracing was never part of the influenza plan, and lockdowns, as in legal lockdowns, they were not what we had planned for.

Q. No.

Exercise Alice, to which you've referred --

LADY HALLETT: Sorry, just before you go on, was there anything else you wanted to add earlier, Sir Christopher?

A. Just on antivirals, obviously you can only stockpile antivirals that exist for diseases that you know about. So in that case I would absolutely defend stockpiling, where you do have antivirals that are relevant to a disease -- well, you can't stockpile, as I say, an antiviral that doesn't exist. So there were no antivirals for coronavirus, just like there was no

vaccine, so the choice to stockpile it never arose. I don't think that should -- I don't think we should take the lesson that we should therefore not stockpile antivirals that we can use were we to have a flu pandemic, was my point.

MR KEITH: Sir Christopher, with respect, has anybody suggested that we shouldn't stockpile antivirals?

A. No.

Q. The question to you was because you said "There are capabilities for a pandemic influenza that may be readily transferred to a non-influenza", I was asking you about what capabilities --

A. Sorry, yeah.

Q. -- could not be transferred.

A. I'm sorry if I misunderstood.

LADY HALLETT: Exercise Alice.

MR KEITH: Exercise Alice.

There were a number of recommendations made in the Exercise Alice, and in light of the time I'm not going to take you through them, but lessons or actions 5, 7, 8 and 9 were concerned with producing a briefing paper on the South Korea MERS outbreak to consider the policy relating to port of entry screening.

Action 7: produce an options plan using extant evidence and cost benefits for quarantine on a mass

scale.
Action 8: community sampling.
Action 9: develop a live tool or system to collect data from MERS coronavirus contacts.
I appreciate this is a very broad question, but can you say, in general terms, whether or not any of those actions were actually pursued by your department following the conclusion of Exercise Alice?
A. Yes, some of them were partially, but you are correct that not all of them were completely. I should say that was, of course, a test of our HCID mechanisms, not our pandemic mechanisms.
Q. You referred to the experience of Asian countries. In a lessons learned report after the pandemic, in September 2020, do you agree that your own department stated that it would have benefitted from a fuller understanding of the response by Asian countries, which might have enabled us to start building testing systems earlier in January 2020?
A. Yes.
Q. Could we please have up INQ000057430.
This is a memo dated 27 March 2019 to Professor Sir Chris Whitty, the Chief Scientific Adviser, from your department, or the DHSC, headed "Pan flu preparedness & high-consequence infectious disease

policy ..."
If you look at paragraphs 1, 2 and 3 they say this:
"You are aware that, following reorganisation and re-prioritisation of DHSC work due to EU Exit no deal planning, pan flu preparedness and high-consequence infectious disease ... policy has moved to your portfolio of responsibilities on a temporary basis."
Then there is a reference to corporate memory in paragraph 2.
Then in paragraph 3:
"... Emma Reed and Clara Swinson agreed a range of work related to pan flu and HCID that would be scaled back or paused before this policy area transferred across to you."
Then may we have, please, page 3.
This is an annex, annex A:
"Pan flu preparedness and HCID policy. Area of work continuing, slowing or pausing as a result of EU Exit prioritisation."
Sir Christopher, would you cast your eye down, please, the left-hand side of that document, the column "Work area", and broadly identify how many areas were either stopped, reduced or paused, just broadly?
A. Quite a lot.
Q. In your statement at paragraph 416, could we have,

please, INQ000184643, page 79:
"While it is a matter of judgement, the Department's view is that the UK was better prepared for health-related emergencies as a result of the work conducted on EU Exit. For example, on supply, the Department had a far deeper understanding of global medical supply chains and stronger relationships with industry, heightened stockpiles of critical medicines and medical products which provided an increased buffer ... and an improved emergency response function, including provision for emergency logistics to mitigate disruption ..."
So there is a reference there to supply chains and emergency response function.
Do you agree that that sentence, those sentences in that paragraph, if we could go back, please, to the phrase "UK was better prepared for health-related emergencies", is a proper and correct reflection of that annex and the number, sheer number of workstreams for pandemic planning that were paused or stopped?
A. Yes. Now, as I made clear in my statement, this is entirely a matter of judgement, I could not, you know, arithmetically prove. However, what we -- essentially happened -- and I should say this was not -- this was not a plan or a strategy, I'm merely trying to assist

with what happened. We stopped a whole load of work which was about enhancing the flu plan and taking forward chunks of the flu plan, and we -- and that's clearly a negative, I'm not trying to imply that that is not a negative -- and we added a whole series of generic capabilities that we then used in the Covid response, and my reflection on that is that the capabilities that we built up as a byproduct of our no-deal Brexit work were extremely valuable to us in the pandemic.
So, as I say, and just to be very clear, I am not trying to suggest that reducing the work that you showed earlier in some way enhanced us, it clearly didn't, it was -- clearly in an ideal world, if you had all the resources you want, you would do both, I am simply saying, in the balance of weighing up, those capabilities that I quote in my witness statement turned out to be, in my judgment, more valuable than more work on the influenza plan.
Q. Do you agree that the Exercise Cygnus report concluded that the United Kingdom's preparedness and response in terms of its plans, policies and capability were not sufficient to cope with the extreme demands of a severe pandemic?
A. Yes, that is what it found and, as I said earlier, there was then a programme of work that followed Cygnus.

Q. You must have been very concerned when you read the Cygnus report and its conclusion at paragraph 6 that the preparedness and response, both in terms of plans and policies and capability, were not sufficient to cope?
A. I thought Cygnus had done its job properly --
Q. Were you concerned, Sir Christopher?
A. Yes, and this was an area where I took specific meetings and reports in the follow-up beginning in late 2017, which I haven't done for similar subjects. So ...
Q. But many of the workstreams which you ultimately put into place as a result of Cygnus were not, ultimately, actioned, as we have just seen, because of the competing demands of Operation Yellowhammer, the plans for a no-deal exit, and many of the workstreams were never finished or only partially completed, were they not?
A. Yes, no, I mean, that is correct. I think a lot of progress was made after Operation Cygnus, but you are completely correct that not all actions were completed and that we changed our departmental priorities at the point that it says.
Q. So where between 2018, when Operation Yellowhammer was first conceived, the planning for EU exit no-deal, and the end of 2019, when it became apparent there would be no no-deal exit, do you express your continuing concerns that the workstreams to make the United Kingdom

compliant with that core recommendation from Exercise Cygnus were not being completed or had been stopped and that our country's system for preparedness and response was imperilled?
A. I'm sorry, I'm not quite sure I understood the question.
Q. Did you express in a way that mattered your continuing concern that the outcome of Exercise Cygnus was not being addressed because the workstreams designed to address it were being interrupted or had been stopped altogether?
A. Well, they were decisions that were not taken lightly at all, and our intention all along was, once we had come out of the period when we had to plan for EU exit, that those things would continue. I couldn't point you to a thing I wrote on that subject, but that was our expectation.
Q. Exercise Cygnus was a multi-phase exercise, a Tier 1 exercise, was it not?
A. Yes.
Q. It took place over two days, it was preceded by another exercise, Exercise Cygnet, it involved more than 950 people, it was a serious test of the United Kingdom's response capacity, and it largely failed, did it not?
A. No, I don't think that's --

Q. The outcome, Sir Christopher, in paragraph 6, was that our systems, plans, policies and capability were not sufficient to cope with a severe pandemic.
A. Well --
Q. The country failed that test, did it not?
A. The point of exercising is to identify where your plans are already strong and where they need enhancing.
Q. And they were not strong, because the Cygnus report was to the effect that, whether in terms of policies or capability, the system was not sufficient?
A. There was work to do on the system, yes, and the purpose of the exercise is to identify those.
Q. The preparedness and response of the United Kingdom was not sufficient, Sir Christopher?
A. Yeah.
Q. Do you agree?
A. I mean, that is what the report says, yes.
Q. So, over the subsequent three years, the workstreams that were put in place to deal with Cygnus and that conclusion about the systemic lack of capacity, preparedness and response, were then themselves paused, interrupted or stopped.

Where is your expression of concern that we were, therefore, by the end of 2019, in largely no better a position than we had been in 2016, October?

A. Well, I don't think that is correct, because a number of workstreams did go forward, and, as I said earlier, I couldn't point you to a piece of paper that I wrote expressing those concerns.
Q. Workstreams continued in relation to the ability to deal with just the fact of excess deaths and the sheer number of deaths that might be anticipated; correct?
A. Well, that was one of the workstreams.
Q. Workstream continued in relation to how a severe pandemic might impact on prisons?
A. Yes.
Q. Work continued on how the health sector, the NHS, would cope with the surge demand of a severe pandemic?
A. Yes.
Q. But in every other regard, whether it was to do with the adult social care sector, to do with public health measures, to do with a central repository of information for how to deal with a severe pandemic, for dealing with the loss of institutional memory, for dealing with the plans relating to dealing with a pandemic, that list in annex A, no further work was done in the main by December of 2019, was it?
A. Between the point that we paused it and that date, yes. A number of actions before that date had taken place. So if you take the example of social care, the

follow-up, in terms of further discussions and seminars with local authorities that my colleagues at MHCLG carried out took place, as did the commissioning of guidance from the Association of Directors of Social Services for the social care sector, which was created and published in 2018.

So it is not correct that nothing was taken forward between 2016 and 2020. It is correct, as your exhibit correctly identifies, that a number of things were paused in mid-2018, for the reasons that we have set out.

Q. By June of 2020 your department reported, after the pandemic, that 14 lessons of the 22 recommendations had not been completed; is that correct?

A. Yes, that's correct.

Q. 14 of 22?

A. Not been completed. A large number of those were ongoing.

Q. Yes, they had not been completed by the time six months before the pandemic had struck, had they?

A. That's correct.

Q. And in relation to social care policy implications, one of the objectives of Exercise Cygnus, objective 5, was to develop plans for the social care facilities to be used to support clients who were discharged from

hospital as part of the sector's surge capacity, and whilst there were meetings held in relation to that important workstream, that was one of the workstreams that was not completed, was it?

A. No, that wasn't completed, no.

Q. Sorry?

A. That was not completed, no.

Q. In relation to another recommendation, that adult social care should be better integrated into all aspects of the DHSC's emergency response system, was that completed?

A. It wasn't completed, although work was done on that subject, as I have just --

Q. Some meetings were held, were they not?

A. Well, and guidance produced by the Association of Directors of Social Services.

Q. Was the system for adult social care better integrated into the department's emergency response?

A. Well, in the light of what happened in the pandemic, I couldn't, hand on heart, say yes. There was, as I've described, a programme of work post Cygnus, but, as I think is well known, this is one of the areas where we adapted our approach most during the pandemic and we were most challenged in how we dealt with that sector. So I think I couldn't -- I couldn't say in the light of what happened that that had been successful.

Q. I think you've accepted, and a number of bodies have said this in the clearest terms, including Care England, that some social care providers did run out of PPE. Do you agree?

A. Yes, and, as I was describing earlier, we had two levels of challenge: one was the national supply, where it was exceptionally tight, but at no point did we actually run out; and two was the logistics of delivering to a much larger number of settings than we had anticipated, which was a huge, huge struggle, as your witnesses have pointed to.

Q. Your own departmental conclusion was, in December 2020, the Covid pandemic has shown that the clinical countermeasures, including PPE, held for an influenza pandemic had limited applicability to non-influenza pandemic threats.

Is that a way of saying that the PPE held for influenza pandemic was of little assistance to the coronavirus pandemic?

A. No, it was of -- it was of assistance. What it was not designed for, and I know you've discussed this with other witnesses, was for a disease with a significant amount of asymptomatic transmission, which required us to provide PPE into a lot more settings than had been planned for. So yes, I recognise that conclusion.

Q. NERVTAG, the committee for New and Emerging Respiratory Virus Threats Advisory Group, you say in your own statement -- the seventh statement, at paragraph 76 -- recommended to DHSC that surgical gowns be stockpiled and they did so in advance of the pandemic.

Were surgical gowns stockpiled?

A. The process of scoping the procurement was under way at the point when the pandemic broke out. So that had been accepted, but the procurement was not complete at the time that the pandemic broke out.

Q. In relation to the just-in-case contracts which the department had been involved in or had arranged, and which of course was a basis of one of the workstreams post Exercise Cygnus, did the just-in-case provision of stockpiles and supplies meet the demands in January 2020?

A. No, they didn't, and I think you reference the report, those contracts didn't work largely because other countries introduced bans on the exports of PPE, and we were therefore -- and I'm sure we will cover this in much more detail in other modules -- forced to go to the general market at considerable expense.

Q. Did your own departmental briefing paper for oversight and assurance in July 2020 report that the respirators which had been provided for frequently fitted white

faces but the ones which were better off for black staff were purchased in much smaller quantity and there had been no provision for that in the post Exercise Cygnus pre-pandemic planning?

A. Yeah, that is a finding that the department found during the pandemic and acted on during the pandemic, that is correct.

LADY HALLETT: Mr Keith, sorry to interrupt, but I was asked to break at about half past or 25 to.

MR KEITH: That's a convenient moment.

LADY HALLETT: Thank you very much. I shall return at 3.55.

(3.40 pm)

(A short break)

(3.55 pm)

MR KEITH: Sir Christopher, it appears to be common ground that, insofar as your department considered, when planning for a pandemic, the potential impact on protected groups, ethnic minorities, vulnerable sectors of society, the marginalised, the position was that plainly a pandemic would have different impacts but that those impacts would be of a clinical nature, so a pandemic would affect those who have heart disease or diabetes or some other comorbidity in a different way to a healthier member of the population; is that correct?

A. Yes. So when we've looked at what we did on equalities

beyond what we did for legal compliance, the focus was exactly as you say, it was on the clinical elements of inequality and how those would be impacted by a disease, that is correct.

Q. It follows, does it not, that neither your department, nor, in fact, any pre-Covid exercise, considered the issue of how a pandemic in reality, or as part of a test, would impact vulnerable people or those with health inequalities or related factors, other than insofar as they may be impacted clinically?

A. Yes, there is obviously a very large overlap between the two, as you heard from other witnesses.

Q. Yes.

A. There was a lot of thinking in the department, and still is, about the issues that you point to. They were, as you say, not thought of directly in the context of pandemic preparation. So there was lots of work on those areas, but I couldn't point you to specific parts of pandemic preparation.

Q. Well, you say, "There was a lot of thinking in the department, and still is, about the issues that you point to". There was no thinking, was there, in the department, or as part of any single exercise between 2007 and 2018, Exercise Pica, about the impact of plans or the pandemic or the response to the pandemic, planned

for or tested on vulnerable people, ethnic minorities or any sector of the population other than insofar as they may be affected clinically; is that correct?

A. In the exercise programme, yes, I think that is correct.

Q. So it's not right to say there was a lot of thinking about these issues then. There was no thinking about these issues then?

A. Oh, sorry, I'm not explaining myself correctly. In wider health policy, there is a lot of thinking --

Q. Of course.

A. -- about health disparities, was my point. As I said, what there wasn't was that specifically in pandemic preparation.

Q. My Lady's Inquiry is not into healthcare, it is into the planning for pandemics?

A. Yeah, sorry, I --

Q. Yes.

A. As I say, I chose my words badly. I apologise.

Q. It follows also, doesn't it, that at no time did the department ever obtain specialist advice on health inequalities and the implications of health inequalities on pandemic planning impacts and mitigation strategies?

A. No, I don't think we ever commissioned advice on that, until actually during the pandemic, when of course we did a lot.

Q. A bit late, Sir Christopher?

A. Sorry, I'm not -- I am merely setting out -- I'm sorry, I'm merely setting out what happened.

MR KEITH: I've no further questions, thank you.

Would my Lady give me one moment?

(Pause)

My Lady, in relation to the Rule 10 process, I believe that whilst a number of questions were posed by one core participant, you have not provisionally indicated that any of them should be posed, and therefore, in light of that provisional indication, now that we've actually heard Sir Christopher, are you minded to confirm your provisional indication and not allow any further questions to be asked?

LADY HALLETT: Unless there are any further submissions, yes, I am.

MR KEITH: Thank you very much.

Questions from THE CHAIR

LADY HALLETT: May I ask a couple questions, please, Sir Christopher?

A. Yes.

LADY HALLETT: Roughly how many staff did you have to allocate to Operation Yellowhammer and the Brexit no-deal?

A. I believe in total we allocated, in the process we were

talking about earlier, approximately 70. I will have to go and confirm that, but I think it was about 70.

LADY HALLETT: That happened across government departments? Everyone was told: you've got to provide a number of staff?

A. Well, no, this was the internal re-prioritisation going on within DH --

LADY HALLETT: So this is not the general response to a no-deal Brexit, this is the health department's response?

A. Yeah, so we had a number of workstreams of which we were responsible, by miles the biggest of which, and our biggest worry, was about the supply of pharmaceuticals during the -- during a no-deal Brexit, and particularly the number that came through the short straits. So we owned a number of workstreams. And when Yellowhammer, as I set out in my statement, became the principal focus of government, departments re-prioritised within. There was also a re-prioritise across government as a whole, but the one here which affected our pandemic preparations was the internal DHSC exercise, if that's clear.

LADY HALLETT: Thank you.

You said that, as a result of the pandemic, there are things that you would have done differently, with

the benefit of hindsight and whatever other element of judgement you may want to use. Can you give some practical examples of what you would have done differently if you had known what you know now?

A. Yeah, so obviously the report done by the Chief Medical Officer and the Government Chief Scientific Adviser gives a very comprehensive list of the learnings from the pandemic. When we'd discussed this within the department, it comes down to five things.

The two biggest ones I've mentioned already, which is the focus on capabilities and underlying resilience, as opposed to plans and systems.

Third is what's become known as the pathogen agnostic approach to planning, which is moving away from the "ready for flu, ready for anything" philosophy I was describing earlier towards a "Let's look at the roots of transmission". That's the third one.

The fourth is a focus on surge capacity, which was clearly a big problem for us at the beginning of the pandemic, getting from the initial response phase to the when you've deployed the full armaments of the state, focusing on that phase.

Fifth, as I think has been widely reported, and I think Government Office for Science also made this point, we were short of testing, we did not have the

testing capacity that some of our European or other counterparts had.

So, in terms of how we're thinking about pandemic preparation going forward compared to what I have described, it's those five areas which we see as the biggest ones.

That's obviously not an exhaustive list, and it's not a complete list, in that of course the government will -- well, it set up this Inquiry because it wishes to get to lessons learnt, so we're not trying to finalise what we think, but in terms of where our thinking is, it is those five areas that we think would make the biggest differences in our approach to planning.

LADY HALLETT: Thank you. That's all I ask.

MR KEITH: Thank you, my Lady.

LADY HALLETT: Thank you very much indeed, Sir Christopher. Sorry you have been so long in the witness box.

(The witness withdrew)

LADY HALLETT: Yes, Ms Blackwell.

MS BLACKWELL: My Lady, the next witness is Clara Swinson, who I understand is in the process of being brought into the witness box.

(Pause)

MS BLACKWELL: Thank you, Ms Swinson, would you like to take

the oath, please.

MS CLARA SWINSON (affirmed)

Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: I'm sorry you have been waiting for most of the day.

MS BLACKWELL: Will you give your full name to the Inquiry, please.

A. Yes, Clara Jane Swinson.

Q. Thank you. Please keep your voice up and speak into the microphone -- I can see you are adjusting them, thank you very much -- so that the stenographer can hear you for the transcript. If I'm not clear in my questioning, please, by all means, ask me to repeat it.

First of all, Ms Swinson, may we have on the screen, please, both of your witness statements.

Firstly, INQ000182608. Can you confirm, please, that that is your first witness statement?

A. Correct, it is.

Q. And it's true to the best of your knowledge and belief?

A. It is.

MS BLACKWELL: May we have permission to publish that, please, my Lady?

LADY HALLETT: Yes.

MS BLACKWELL: Secondly, INQ000212314. Thank you. Is that your second witness statement?

A. It is.
Q. Again, is it true to the best of your knowledge and belief?
A. It is, yes.
Q. Thank you. We can take that down.
I'm going to begin by setting out briefly an overview of your career history as it's relevant to the Inquiry.
A. Okay.
Q. You have been a senior civil servant since 2006, you are Director General within the Department of Health and Social Care, covering international health and domestic public health issues, and you have held that role since November 2016?
A. Yes.
Q. Since this appointment, you have reported to the Permanent Secretary, Sir Christopher Wormald, who has just given evidence?
A. Yes.
Q. You are a member of the DHSC executive committee and a senior sponsor for UKHSA, formerly PHE?
A. That's right.
Q. Thank you.
You are responsible for three directorates, including the directorate on emergency preparation and

health protection, to which we'll turn in a moment.
A. Yes.
Q. You're chair of the PIPP board, now newly renamed the Pandemic Preparedness Portfolio board, and you've been --
LADY HALLETT: Why?
MS BLACKWELL: Perhaps we'll come to that, my Lady.
And you have been chair of the PIPP board since 2017, until it was re-formed under its new name in 2022.
You were also responsible for preparations for the EU exit?
A. That's right, and if I could just add, I'm responsible for more than three directorates that you said at the start. My responsibilities have changed a little bit since 2016, for exactly -- but that is set out in my witness statement.
Q. All right, thank you. You're responsible for international policy, bilateral relationships and health work on a multilateral basis?
A. Correct.
Q. For example, at the World Health Organisation, G7 summit, et cetera?
A. Yes.
Q. Finally you are a UK senior official on the Global Health Security Action Group?

A. I am.
Q. Thank you.
I want, first of all, please, Ms Swinson, to deal with emergency preparedness and health directorate, and the EPRR function.
The directorate has day-to-day responsibility for pandemic preparedness, doesn't it?
A. That's right, among other things.
Q. All right. And what, specifically, does that entail in terms of emergency planning?
A. Pandemic preparedness?
Q. Yes, within the directorate.
A. Yes, so that requires oversight of the health and care system responsibilities, so across the department, NHS England and Public Health England -- as was, UK Health Security Agency now. It means preparing for any exercises there are, it also means with emergency planning being responsible for plans for non-pandemic threats.
Q. Yes.
A. That might be biological or they might be chemical or they might be terrorist attacks or so on.
Q. All right.
It exists to respond, then, to a wide range of emergencies, including pandemic and infectious disease

outbreaks, but isn't limited to that, as you've just explained.
A. Yes.
Q. Is its role to support an emergency response?
A. It would depend slightly on what the incident was. So we would stand up an incident team. That could be anything from, you know, a major cyber attack, it could be the Manchester Arena attacks, or it could be something that was health-specific, and it would depend exactly whose responsibilities -- or whether for -- so on, but it is -- for whatever the impact is on the health and care system, it is to co-ordinate and oversee the response of the system.
Q. All right.
Were you confident that the EPRR function, to be stood up in response to the risk from a pandemic, would be sufficient to meet the risk of a significant pandemic whilst you were in that role?
A. So the function itself I've set out. In terms of -- in a response phase --
Q. Yes.
A. -- it would need to be scaled according to the incident.
Q. All right.
A. So that could be something that a small team could do, it could be something that we would need to expand.

Q. Does the directorate and does the organisation have within it the capacity to upscale in the event of a large emergency?
A. Yes. That would require resources across the department, as happened in the Covid-19 pandemic.
Q. Right.

In terms of the pandemic preparedness programme, I want to ask you some questions about the UK influenza pandemic strategy of 2011, brought into force following the Hine review and the recommendations within Dame Deirdre Hine's report, and largely untouched until the coronavirus pandemic hit. Because isn't it right, Ms Swinson, that the coronavirus action plan published in March 2020 drew very heavily on the 2011 strategy?
A. It is correct, yes.
Q. Right.

Isabel Oliver, the interim Chief Scientific Adviser at the UKHSA, has confirmed -- and this Inquiry has already heard quite a lot of evidence even so far about this -- that the only pandemic scale plan in place at the time that Covid hit was the one set out in the strategy, that was for pandemic influenza.

Do you agree with that?
A. The only plan in place, did you say?
Q. Yes, the only plan in place, the only strategy to be

followed and the only plan that was in place was --
A. Yes. UK-wide. Obviously some other organisations had their own plans but, yes, UK-wide it was -- the 2011 strategy was still existing.
Q. Right. Do you think, knowing what you do now, that there was good reason for that plan to have been updated between 2011 and when the pandemic hit?
A. So there were reasons to update it, for example, it was before the 2012 Act, to be clear about roles and responsibilities, and so on.
Q. Yes.
A. In terms of its overall approach in terms of the principles, the main areas, there would have been some things that were worth updating and refreshing --
Q. Such as what?
A. So, for example, you know, technology had changed since 2011, vaccine manufacturing and so on, but the basic premise of the plan, there was not a different strategy that was in place that we needed to publish. The basic premise of the principles is as set out in the 2011 plan.
Q. What about the fact that it only dealt with pandemic influenza, what do you say about that?
A. Yes, I mean, that is, it flows from the National Risk Register that you have been talking about today. We

have reflected, and the new pandemic portfolio that you referred to in the opening is a recognition that now we are doing -- we would like the strategy to be along all of the different routes of transmission, not just a respiratory pandemic.
Q. So was that a mistake for it only to be limited to that? Do you think in hindsight, and knowing what happened in the intervening period, especially with other coronaviruses across the world, that perhaps that should have been drafted more widely?
A. I think it was a reasonable decision at the time. I think it was in line with expert advice, and there was not a response to it saying it should have been extended. But clearly, knowing what we do now, as set out, we are changing our approach to cover all the routes of transmission.
Q. All right.

I would like to look, please, at the witness statement of Professor Mark Woolhouse at INQ000182616. Thank you very much. Paragraph 10, which is on the previous page, I think. Thank you.

"In the event, our go-to response to Covid-19 became lockdown ... Of itself, that highlights a striking deficiencies in the UK's pandemic preparedness: we had no plans to implement lockdown at all. On the contrary

[and here is the point] the UK's 2011 pandemic influenza strategy document ... states: 'During a pandemic, the Government will encourage those who are well to carry on with their normal daily lives for as long as and as far as that is possible, whilst taking basic precautions to protect themselves from infection and lessen the risk of spreading influenza to others. The UK Government does not plan to close borders, stop mass gatherings or impose controls on public transport during any pandemic'. Lockdown was an ad hoc public health intervention contrived in real time in the face of a fast-moving public health emergency. We had not planned to introduce lockdown and this had two serious consequences."

Which he goes on to deal with.

It's right, isn't it, Ms Swinson, that the 2011 strategy did not include any plans for mitigation measures such as lockdown, closing borders, stopping mass gatherings or controls on public transport?
A. It's true what it says here and elsewhere in the document, it says it's the working assumption that there wouldn't be restrictions on some of the things you've mentioned. It does say that there might be restrictions on some mass events and some school closures, but the working assumption is as set out, yes.

Q. Other than mentioning those matters which you have just set out, there are no plans to mitigate, there is no discussion about the potential outcome of, for instance, controlling mass gatherings or closing schools, is there?

A. There are a range of things to mitigate when one doesn't have medicines or treatments, so there is advice to people if they're unwell, for example, to stay at home, through to some of the more extreme measures that you've just mentioned. But yes, that is what is set out in the strategy.

Q. All right. But there is no discussion of the impact of the imposition of those sorts of restrictions?

A. There is no discussion of legally enforced stay at home, no.

Q. What Professor Mark Woolhouse goes on to say is the lack of such measures is a striking deficiencies in the UK's pandemic preparedness. Do you agree with him?

A. I'm not aware of any country that had a lockdown plan. Obviously it's what happened in the pandemic, and we, both in the department and across society, need to reflect on that. But it was not something that was in the UK plan or any other country that I'm aware of.

Q. No, nor discussion of any of the other measures which we've set out. Other than mass gatherings and school

closures, there is no discussion about any of the other mitigating impositions?

A. In terms of social distancing?

Q. Yes, in terms of closing borders, in terms of controls of public transport, that sort of thing; and what Mark Woolhouse is saying is the lack of that sort of information in the strategy is a striking deficiency. The question to you is: do you agree with that?

A. The strategy did not have those things in it. I think that was reasonable at the time. It was not something -- there was a consultation on this document, for example. Clearly, as the pandemic occurred, actions that were taken in other countries, and then in the UK, did lead to legal restrictions on daily life.

Q. Do you agree that the 2011 strategy also didn't plan for a whole-system effect, with wide-ranging impacts on society, the economy, public services, that sort of thing?

A. Well, I believe it has a section on the whole-system effect, the fact that it would effect the whole of society, it would have societal and economic impacts, as set out in the strategy.

Q. All right.

Thank you, we can take that down.

Jeremy Hunt in his statement to the Inquiry has

said:

"... I believe with the benefit of hindsight that our preparations ... were affected by an element of 'groupthink'. By that I mean that the spread of many distinct types of virus could create a pandemic, yet our shared belief was that the most likely scenario was a pandemic flu."

What do you say about that?

A. So it's true that our expert advice was that pandemic flu was and actually continues to be the biggest risk. You've talked at some detail today about the range of other pandemics --

Q. Yes.

A. -- and I've explained how learning what -- from what happened that we wish to take -- setting out a different approach.

I think a number of witnesses, experts have also set out in their statements for you that they think flu was a reasonable scenario, but clearly there was not different expert advice before the pandemic. Expert advice and our experience would now show that we should plan for a wider group of viruses.

Q. Do you think there is a need for more robust challenge and diverse expertise or perspectives in terms of what may happen?

A. So in terms of expert advice and groupthink, yes, there are, you know, a whole range of advisory groups which we've set out in our witness statements.

Q. Yes.

A. You've got evidence from the chairs of some of those. Both in terms of expertise in the UK, our Chief Scientific Advisers, and in terms of learning from other countries, you know, I don't think it was groupthink in a very small number of people, I think that is the case across the UK and for most of our European and American colleagues, or counterparts. Clearly, as Jeremy Hunt set out, learnings particularly from South East Asia and maybe expanding the expert input from what we've learnt now showed that there were some other ways of thinking about containment of a new novel disease and how to respond to it.

Q. On that point alone, that could have been done, couldn't it, at some point past 2016, when it was recommended from the fallout of Exercise Alice that South Korea, for instance, should have been contacted and the way in which they responded to MERS could be analysed and the UK could take from that indications of how best for them to react in a similar position, but that wasn't done?

A. I don't know whether -- I would be surprised if there

was no contact between public health experts in this country and South Korea on MERS, for example, but in terms of the learning at the very extensive contact tracing and so on, that did not lead to a change in policy in this country.

Q. All right. And are you aware of the analysis of contact tracing and precision lockdown and that sort of thing being carried out?

A. I'm not, no.

Q. No.

I'd like to turn now to the Pandemic Influenza Preparedness Programme, otherwise known as PIPP. Bearing on the Chair's question, why has that now been renamed the Pandemic Preparedness Portfolio board?

A. So that it covers in scope all the routes of transmission, not just respiratory viruses and, within that, not just influenza.

LADY HALLETT: I still question whether it was necessary to change the name, but that's probably for another time, Ms Swinson.

A. The "I" stood for influenza, so --

MS BLACKWELL: That needed to be removed?

A. Yeah.

Q. Right.

In any event, PIPP was the central DHSC led

programme involved in organising, directing and managing pandemic preparedness amongst the DHSC and other bodies, and it worked together with Public Health England and NHS England; is that correct?

A. That's right. In my witness statement I set out 12 areas -- and the corporate statement -- of pandemic preparedness, but PIPP is one very important one of those.

Q. All right, thank you. And it was in operation from October 2007 until July 2022.

In terms of the work of PIPP, was it initially shaped by the approach set out in the UK influenza strategy, or certainly since 2011?

A. Since 2011, yes.

Q. Yes, and you have been kind enough to provide to us a series of minutes from the PIPP board meetings. In July of 2017, we can see that a series of five workstreams were set out during the course of that meeting. I don't think we need to look at the meeting notes themselves, but you'll be familiar with them, Ms Swinson.

Can you confirm that the first four workstreams were as follows: surge and triage, community care, excess deaths, and sector resilience, and that those four workstreams were themselves derived from the findings of

Exercise Cygnus?

A. I can. They were workstreams of the Cabinet Office/DHSC joint board, the Pandemic Flu Readiness Board, and so some of those were not purely about the health and care system --

Q. Yes.

A. -- but the health and care system aspects, yes, were --

Q. Were taken across and formed into the workstreams, thank you.

A. Correct.

Q. Can we look, please, at a paper prepared for a PIPP meeting regarding exercises in October 2018. It's at INQ000023017. Thank you very much.

We can see page 1 sets out that this is an exercising paper and the first paragraph deals with background. I want to focus in, please, on the next paragraph which is headed "Principles":

"To support in the development of future pandemic flu exercises and assist in the prioritisation of areas to exercise, this paper proposes the following principles:

"Exercises should be co-ordinated across DHSC, NHSE and PHE to prevent duplication;

"Exercises should test existing plans and strategies, rather than known gaps in knowledge;

"There should be a regular programme of tier 1 exercises to coincide with each new parliament and ensure continuity in preparedness;

"Where possible exercises should include Devolved Administration colleagues to ensure a joined up approach across the Four Nations (including in observer roles where active participation is not appropriate); and

"Lessons learned should be shared with other relevant Government departments to ensure continued cross-Government approach to pandemic flu preparedness."

Now, I'd just like to return to number 2:

"Exercises should test existing plans and strategies, rather than known gaps in knowledge."

Is it right that the exercises following on from this meeting in October 2018 were only to test existing plans rather than gaps in knowledge?

A. Yes, in terms of the exercise programme.

Q. Okay. How, then, did PIPP examine its known unknowns? How did it deal with matters that weren't known at all or were barely known about if, as this principle suggests, the exercises should only test existing plans and strategies?

A. Yes. So PIPP did exactly as you say and that was in response to the government strategy, the learnings from Cygnus. There are other elements of our pandemic

preparedness, for example our research base or our clinical countermeasures, which could go wider, but there was not, in terms of a -- there was not work to completely re-look at the plan or strategy. It was not something that our expert advice said in terms of going wider than flu, for example, and so in terms of the work we were doing, that was to test existing plans.

Q. Should there have been, in your opinion, wider work done on the unknowns or the barely knowns?

A. The unknowns in terms of pandemic preparedness are very great, and they would be -- they are also set out in a large section of the 2011 strategy. Where there are unknowns, that's about research and development, that's about having flexible resources, it's about scientific advice, all of those things. So there are other elements of the programme that -- or the preparedness that would do that, but it is fair to say, looking back, that we now wish that scope to be wider.

Q. Thank you.

Now, at some point during the life of PIPP, it began to create what are known as PIPP risk registers. You have been kind enough to provide to us the registers for 2016, 2017, 2018, 2020 and 2021.

The first question, Ms Swinson, is: why did this system only get going in 2016?

A. I don't know whether that's the case. It certainly was from when I took over the board --

Q. Right.

A. -- chair in 2016. So I couldn't confirm whether -- in fact, I'm pretty sure, in fact I know that those risk registers do include risks that were closed and go back before 2016.

Q. All right.

A. So I think they would have existed --

Q. In some shape or form.

A. -- from at least 2011, yes.

Q. All right, thank you. Are you able to say why there appears to be a gap in 2019?

A. A gap of what, sorry?

Q. Well, we haven't been provided with the risk register for 2019. There is a two-year gap between 2018 and 2020. Is there a reason for that?

A. So in 2019 there were planned to be two meetings each year. There was one meeting in 2019, one meeting was taken out of the schedule to allow for resources on Operation Yellowhammer, as you've discussed --

Q. That was the EU exit?

A. It was, apologies, the no-deal EU exit plans.

Q. Yes.

A. I would have to check the minutes of that meeting to see

whether there was a risk register tabled or not.

Q. All right. But it sounds very much as if its absence may have had to do with the Operation Yellowhammer planning?

A. Possibly.

Q. Yes. All right.

I'm not going to display the risk registers, they are extremely --

A. They are detailed.

Q. -- large, aren't they? They're very wide and they have an enormous amount of information in them. But could you please, Ms Swinson, explain to the Chair --

(Alarm)

I'm just going to pause, my Lady. That may have been generated by the thought of putting the risk registers on the screen.

Ms Swinson, could you kindly explain to the Chair, please, what the purpose of the risk register is and the sort of information that they contained? And I will, as I think I've indicated to you, just take you briefly through the --

(Alarm)

I'm going to continue.

A. Okay.

Q. -- the ongoing risk to health and social care systems

and use that as an example. So with that in mind, please explain what they are.

A. Of course.

Q. Thank you.

A. So I think they're quite usual programme documentation that would be recognisable to people working on programmes. It would set out the issue, the impact that would have if it occurred, a risk owner and a RAG rating -- red, amber green -- for how it was in the previous period and now, and where you're hoping to get to.

Q. And what was the purpose of the risk register? Who was going to use it once it was compiled?

A. So it was brought to the regular PIPP meetings and it set out the actions, I should have added, that needed to be taken in order to try and improve the work against those risks.

Q. All right, thank you.

So in 2016, there was a risk identified that the health and social care system may be unable to cope with an extreme surge in demand for services in the event of a pandemic. That's right, isn't it?

A. Yes.

Q. And are you able to remember without looking at the risk register what sort of action was taken away in order to

try and mitigate that risk?
A. Not from memory, no. There was work obviously arising from Cygnus in terms of NHS surge. The risk registers would also cover relative lower-level detail from teams in terms of funding, resourcing, business cases and so on.
Q. All right. So once that risk had been identified and the rating had been given to it and an action had been raised --
A. Yes.
Q. -- what would you expect to have taken place between the time that that risk register had been drafted and the following year when the next risk register was drafted? In other words, would any action that had been taken be carried forward to the next risk register in the following year?
A. There should be, yes. It would depend obviously on resourcing and priorities across the department. I also note that the risk you pick up is a very large one that has been identified, you know, over many years and it's not that two or three actions would be able to be taken forward in a six-month period that would completely resolve it. It would be completely normal that the risk registers were highlighting major issues that were red, or marked red, and would be very difficult things to

change.
Q. All right. Well, I think you know where I'm going: the same risk is present in 2017 and 2018, and in 2018 in relation to this it confirms that the plans have not been fully tested and that is still an issue.
Now, I'm going to skip over 2019 because, as we've established, we don't have the risk register for that year. But in 2020, December 2020, that risk is still present: that the health and social care system may be unable to cope in the event of a pandemic.
What, if at all, is the interconnection between that being raised as one of the issues in the risk register and the recommendations that we see in Exercise Cygnus that there may be concerns about surge capacity particularly in health and social care? Is there a connection between the two? Did one formulate the other, or what?
A. Yes, I -- I think there's a link between the two.
Q. Yes.
A. I mean, I think that risk, that probably existed before the recommendations of Cygnus. It's a risk that I think, as I say, would never be completely mitigated with full confidence.
Q. Are you able to say over the period of time between 2016 and 2020 what actions were completed in terms of

mitigating that risk?
A. The risk being NHS surge?
Q. Yes, health and social care capacity.
A. Sure.
So it would be made up of, you know, a whole range of things. There were some things that we did -- for surge capacity, you both want to -- or the options are both to decrease demand and they're to increase capacity. So for example in their draft Pandemic Flu Bill, we prepared powers to have regulatory easements on the demand side, for example from CQC, the regular -- the Care Quality Commission, sorry -- and to increase capacity, so in order to bring -- be able to bring back workforce who might have been recently retired or hadn't kept up their registration.
Q. Yes.
A. So that those are two examples. You would need obviously, both on scale and number, to have, you know, a whole range of things, but that's one example of the work that we did take forward on the draft legislation.
Q. In terms of surge capacity of staff, apart from acknowledging that that was something which would need to happen in order to mitigate the risk --
A. Yes.
Q. -- were there any practical arrangements made, as far as

you are aware, that were in place by the time that Covid hit, relating to that surge capacity of staff?
A. So I would say surge is a spectrum, there are things that the NHS does every year to surge; in winter to open new wards, for example, for parts of the year. Of course in terms of the overall funding and capacity of the NHS, that was something that was looked at in exactly the time period you're talking about, in terms of the spending review, the funding, both for workforce and for beds and capacities. So there would have been things both on the large scale --
Q. Yes.
A. -- in terms of overall capacity and, as I say, preparations, for example, on legislation.
Q. Right.
Well, in relation to the progress of implementing the Cygnus recommendations relating to social care, could we look at, please, INQ000057522. Can we go to page 14, please. Thank you. If we look at the entry just below the mid-line, it's LI18:
"A methodology for assessing social care capacity and surge capacity during a pandemic should be developed. This work should be conducted by DCLG, DH and Directors of Adult Social Services ... and with colleagues in the devolved administrations."

If we look at the column on the right-hand side, we can see it was identified as a two-year programme of work by the PFRB: year 1, to develop the policy options, and, year 2, to agree reporting routes.

A policy paper had been completed and, on community care during a pandemic, a draft strategy had been developed, but moving down to the penultimate paragraph there:

"Work to develop robust data and operational relationships with the social care sector did continue through EU exit preparedness work despite the pause in the PFRB programme.

"Plans to issue guidance to the Adult Social Care sector are linked to a wider refresh of the guidance and strategy documentation for a future influenza pandemic."

So it looks as if work had been done but that the whole of the methodology and the implementation of that was still being worked upon at the time that the pandemic struck; is that fair?

A. That's fair, yes.

Q. Thank you. We can take that down now.

Before we leave Operation Cygnus, it's come to the attention of the Inquiry that the report itself from the exercise was not published until very recently. You're nodding your head. You're aware of that, of course?

A. Yes.

Q. Are you able to explain why that report was not published until fairly recently?

A. Yes. I mean, it was made available to all the participants and it was also put on ResilienceDirect, which is the website for all of the local resilience fora and wider, that's led by the Cabinet Office. So it went out widely --

Q. Sorry to interrupt. Was that in an unredacted form?

A. There might have been some names redacted, for example, but yes, that was the report that went out. In terms of publishing it so that anyone could access it on a website, that was not done. We also -- I think that is common or was common across all of the exercises through the tier 1 programme, not just health, partly because they're -- for reasons about it being, you know, going to the people who most needed to know, I think that is one thing that in terms of transparency, in terms of a forward programme -- and I think this will be in the minutes of one of the more recent boards from me -- that there ought to be a presumption to make these things widely public to a wider audience.

Q. Thank you.

I'd like to look, please, at one of the ORC lessons learned reviews, it's at INQ000087227. Can we go to

page 6, please, and paragraph 6.4. Thank you.

"We have identified four specific areas where respondents indicated that action would help stand the Department in a stronger position ahead of any future health emergency."

Going down to the second paragraph headed "Preparedness of the Adult Social Care Sector", we see this:

"Some commented that emergency planning had assumed that care providers would be responsible for their own response, and a centralised government role had not been anticipated. Initial government expectation stemmed from the complex and largely private nature of adult social care in the UK.

"Though contingency plans were in place and tested, some respondents stated that the pandemic highlighted glaring omissions in strategic direction of integration and preparedness meaning that the social care system was not able to respond to a major health emergency."

Ms Swinson, do you accept that there were glaring omissions in strategic direction of integration and preparedness which meant that the social care system could not respond?

A. There were certainly -- I mean, this is a report of what people said from the team.

Q. Yes.

A. We were not self-congratulatory about everything going well. We wanted to learn from wave 1 for wave 2, and it reflects --

Q. Which is to be commended, yes.

A. -- it completely reflects that feedback.

Of course, in terms of understanding about adult social care data and the national system, that was the legal and regulatory system that was set up, since in the 2022 Act there are additional powers the government has taken, it was not something that in terms of data sharing, for example, in the legal system that was in place in 2020. It was not a system that was a nationally directed one. Social care is managed through local authorities and responsibility of upper tier local authorities.

Q. So do I summarise your evidence in this way: you wouldn't use the phrase "glaring omissions", but you do accept that those involved in the system acknowledged here that there were difficulties in strategic direction of integration and preparedness within the system?

A. I think that's -- that's fair, and the social care system not being able to respond to a major health emergency --

Q. Yes.

A. -- is obviously -- you know, there are very many different providers and that would be varied, but I think how you have explained it is fair.

Q. Thank you.

Moving finally, then, on to clinical countermeasures and PPE. This will of course form part of a future module, but I just want to ask you some questions, please, about your responsibility and involvement in the provision of stockpiles and for you to explain to us really how Public Health England managed stockpiles relating to pandemics.

A. Okay.

Q. So you've provided your evidence on the review of countermeasures for pandemic influenza and infectious diseases. Now, that's a document -- we don't need to put it up, and we can take down the one that's currently on the screen, please -- but that's a document which opens with the following:

"The Covid-19 pandemic has shown clinical countermeasures held for an influenza pandemic have limited applicability to non-influenza pandemic threats."

That is something which you would accept, and that the PPE stockpile has been designed with influenza in mind, restricting its utility for other infectious

diseases.

Beyond pandemic influenza, what is the current position regarding stockpiles for HCIDs, and what is the planning in terms of a future pandemic?

A. Yes, so we are bringing together an assessment with our Deputy Chief Medical Officer that looks at obviously what was already in place before the pandemic for some things that are still there, for example for flu, where stocks have been used through the Covid pandemic and where there are different stockpiles, for example antibiotics, for a whole range of things.

So we are reviewing those countermeasures, both kind of the wind-down from Covid ones, we've got Covid treatments and antivirals now as well, to say what is the -- what are the countermeasures we wish to keep on an ongoing basis, compared to the wider scope of not just flu but pandemics. And, indeed, on the points you raise, for example on PPE, that is also relevant for chemical or biological non-pandemics but other high-consequence infectious diseases, as you've mentioned, and other major threats that could be chemical, biological, radio, nuclear.

Q. Has there been an improvement, do you think, in the systems that are now in place in terms of the provision of PPE both in stockpiles and the range of PPE which is

now being considered?

A. Yes, I think that is fair. It is now managed by the NHS supply chain.

Q. Yes.

A. In terms of countermeasures, there are things that are used in day-to-day health and care, and so it is about having a stock that you can rotate and use. There's another set of things for how they're stored and how we should approach them where you would not expect to use it day-to-day, it is actually an insurance policy against a threat that may or may not happen. So there's both what to stockpile --

Q. Yes.

A. -- on what expert advice, how to hold it, and what is rotated through normal use in the NHS.

Q. Thank you.

Professor Banfield of the BMA has told the Inquiry in his witness statement at paragraph 33 -- no need to display it, please -- that the government's actions meant that PPE at the time was not available to suit a diverse range of facial features, including for smaller, often female face shapes and for staff who wear a beard or hair covering for religious reasons.

Do you accept that there is a need to consider sufficient supplies of PPE to fit a wide range of face

shapes and sizes, and that that wasn't perhaps adequately considered as part of pandemic planning prior to Covid-19?

A. Yes, I do.

Q. Was that foreseeable and should it have been done?

A. In terms of the assumptions about PPE, before the pandemic there were a number of assumptions that turned out not to be the case. It was never the case that the assumption was that it would be above business as usual volumes, so it would be an additional stockpile for people to draw on, but that business as usual stocks would continue.

Clearly, because of the global demand and in fact the pandemic starting in China and there being lockdowns there, and that's where a lot of the manufacturing was, that the overall supply chain collapsed.

So that was one assumption.

The behavioural use and the fact that the other -- a second assumption is that PPE would be used just for symptomatic patients.

Q. Yes.

A. Actually very much more was needed in Covid-19, as we've set out I think in Chris Wormald's statement number 6 or 7, as it is now -- it was used in the pandemic for asymptom -- for all health and care, and so the volumes

were very, very much greater than we had ever assumed.
Q. Was one of the problems in planning in this way a lack of data? The reason that I ask you that is, returning to the ORC lessons learned review which we have already touched upon, there is a statement in there as follows:
"There was insufficient data available to consider equality issues around PPE provision. A retrospective equality impact assessment is now being undertaken and will help address these concerns."
A. Yes, and my apologies, because you asked about the different types of face masks --
Q. Yes, yes.
A. -- that is something that definitely came out in wave 1. Kevin Fenton from Public Health England --
Q. Yes.
A. -- carried out a review. It was evident in the first few months that that is something where there were not enough different types of face mask, and that is something both in business as usual and in our stockpiles of course we need to make sure are covered in future, now and in the future.
MS BLACKWELL: Right. Thank you very much.
Those are all the questions which I have for Ms Swinson. Would you excuse my back, my Lady.
(Pause)

In the usual way, I think my Lady has provided a provisional consent for certain questions to be asked, and I will turn to Ms Munroe King's Counsel to ask those questions if, my Lady, that is appropriate.
LADY HALLETT: Yes.
MS BLACKWELL: Thank you very much.
LADY HALLETT: Ms Munroe, thank you.
Questions from MS MUNROE KC
MS MUNROE: Thank you.
Good afternoon, Ms Swinson. My name's Allison Monroe and I represent Covid Bereaved Families UK. Just a few questions.
In relation to the World Health Organisation research and development blueprint reports, we don't need to have these brought up, but for reference, my Lady, they are found -- the 2017 report is at INQ000149108.
Just to contextualise those reports for you, Ms Swinson, the 2017 and the 2018 reports, the WHO Research and Development Blueprints, as they're called, determined that there was an urgent need for research and development into MERS and SARS and other highly pathogenic coronaviral diseases.
The 2018 Blueprint report also prioritised Disease X, and both reports noted the importance of

cross-cutting research and development which would help to address a range of different pathogens or diseases at the same time.
Finally, Professor Sir Peter Horby of NERVTAG and Dr Miles Carroll of the PHE were members of these prioritisation committees.
Now, at the time of their publications, would you have read those reports?
A. I had not read those reports, no.
Q. You've not read them.
A. I have, they were in -- the 2017 I think was in my witness bundle, I'm aware of what it is and aware of some of the work flowing from it, but I don't think that I had read that at the time.
Q. Would any of the information in those reports have been brought to your attention at the time?
A. So, in terms of the research that the UK would do, that isn't just my job, but in terms of the department, and in fact the Foreign and Commonwealth Office, where we would prioritise research funding, that would definitely be brought to the government's attention, and indeed the government took some actions that I think do link back exactly to the research and development blueprint.
Q. Right. But in terms of your role and in the course of your role as Director General in the DHSC, how important

would those documents, those reports -- because they talk about prioritising --
A. Absolutely.
Q. -- in particular MERS and SARS.
A. Yes. So the Chief Scientific Adviser in the department is the DG level responsible for our research and development. I think these are very important documents for all countries, because they list the diseases where there could be a major public health international event and where there is not a pipeline or incentives on industry currently to have -- to develop vaccines, therapeutics or diagnostics. So that would have been, I'm sure, within our Chief Scientific Adviser and our Foreign Office, Chris Whitty, through the chair of the UK Vaccine Network, for example, had prioritised a list -- which was not identical to the WHO one but had similarities -- for where to invest research into vaccines.
Q. From those answers, am I to gather, then, that in terms of the work and strategies of your own department, a prioritisation in terms of research and development of MERS and SARS and Disease X would not be something that you would have done or prioritised?
A. No, I don't think that's correct. The UK Vaccine Network prioritised a vaccine into MERS that became the

Oxford/AZ platform. I think most of the research would be funded by overseas development assistance money, ODA money, and that is -- there is some in the Department of Health and also in the Foreign and Commonwealth Development Office.

Q. I'm more thinking at the time of their publication, though, 2017 --

A. Yeah.

Q. -- and 2018 in terms of research and development and particularly this question of prioritising those diseases. Was that part of the strategy of your department at all?

A. It was, in terms of prioritising research and development, where there are very substantial budgets across government, both in the Department of Health and in the Foreign and Commonwealth Office and DfID, yes, that would have been taken into account.

Q. Right.

These reports also agreed on the value, where possible, of developing countermeasures for multiple diseases or for families of pathogens.

What, if any, action did your department take in relation to this and how was that monitored?

A. So I've given one example, which is the research and development funding that went to Oxford on the MERS

vaccine. We would have to look further for others. As I say, that would be through our Chief Scientific Adviser, both in the department and the network across government.

Q. Can you assist on this, please: what, if any, action was there taken to update the UK's list of high-consequence infectious diseases to include Disease X or highly pathogenic coronaviral diseases following those reports in 2017 and 2018?

A. So the high-consequence infectious disease list is kept under review by groups or the Chief Medical Officer, the Medical Director of the NHS, and the Advisory Committee on Dangerous Pathogens. It's not a static list, it does change. It is pathogens that actually exist, and there's quite a long list.

Disease X, as you have put in your question, is the idea of a novel pathogen that would arise. Clearly you need to do research into a whole -- have flexible research in order to be able to respond to a pathogen that doesn't yet exist.

Q. In terms of the findings from those two reports from 2017 and 2018, to what extent were they considered or reflected in the national risk assessment, in particular, again, going back to this point about the prioritisation of SARS and MERS?

A. Yes. So for the high-consequence infectious diseases, the risk that you were discussing earlier on an emerging infectious disease, obviously was based -- or the scenario was a SARS or MERS type of coronavirus. But in terms of other threats listed there, there would be some that would be very relevant for the UK; there would be others on that list that would be much more likely to have -- to occur in other bits of the world, and I think Sir Chris Whitty's statement sets out those diseases in part of his statement.

Q. But the question was: how were they reflected in the national risk assessment?

A. So they would have -- so the type of diseases which had a potential for international spread, a public health event of emergency concern, as the WHO calls it, would be reflected in the emerging infectious disease risk that went on a Covid/SARS/MERS scenario.

Q. Finally, was NERVTAG asked to comment on the blueprint at any point, either the 2017 or the 2018 WHO blueprint reports?

A. So those reports were, and the process was run by the World Health Organisation, they brought together an expert group to do so. I think it was from individuals rather than groups, so I don't think NERVTAG themselves would have been asked, but that would have

been up to the World Health Organisation.

Q. But from your perspective within your department, obviously there are individuals such as we mentioned at the beginning Professor Horby, who was a member of NERVTAG, who is also part of that prioritisation committee for the research and development blueprint.

So following from that, he is a member of that committee, he is a member of NERVTAG; would NERVTAG, as a group themselves, be discussing the findings and the observations of the report?

A. You would have to check with NERVTAG themselves.

MS MUNROE: All right. Thank you very much, Ms Swinson.

Thank you, my Lady.

LADY HALLETT: Thank you, Ms Munroe.

MS BLACKWELL: That concludes the questioning for Ms Swinson, and indeed today's business.

LADY HALLETT: Thank you very much indeed.

Thank you very much for your help, Ms Swinson, sorry again for the delay.

(The witness withdrew)

We will start again tomorrow at 10 o'clock.

MS BLACKWELL: Thank you, my Lady.

(5.05 pm)

(The hearing adjourned until 10 am on Tuesday, 20 June 2023)

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