

Monday, 19 June 2023

1
2 (11.00 am)
3 **LADY HALLETT:** Yes, Mr Keith.
4 **MR KEITH:** Good morning, my Lady.
5 As sometimes happens, I know the next witness, and
6 so he will be examined by Ms Blackwell.
7 **MS BLACKWELL:** Thank you. May I call David William Donald
8 Cameron, please.
9 Mr Cameron, will you please take the oath.
10 **MR DAVID CAMERON (sworn)**
11 **Questions from COUNSEL TO THE INQUIRY**
12 **MS BLACKWELL:** May I begin, Mr Cameron, by thanking you for
13 the assistance you have so far given to this Inquiry and
14 for coming to give evidence today.
15 May I also ask you to keep your voice up and speak
16 into the microphone so that the stenographer can hear
17 you for the transcript.
18 Is your full name David William Donald Cameron?
19 **A.** Yes.
20 **Q.** You were leader of the Conservative Party and the Leader
21 of the Opposition from 2005 until 2010, when you became
22 Prime Minister of the United Kingdom, leading
23 a coalition government with the Liberal Democrats, with
24 Nick Clegg as your Deputy Prime Minister and
25 George Osborne as your Chancellor.

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1 Thank you, we can take that down, please.
2 So dealing first of all, please, Mr Cameron, with
3 the architecture in place to deal with large scale
4 emergencies in 2010 and changes implemented during your
5 time in office.
6 When you became Prime Minister in 2010, you tell us
7 in your witness statement that, in your opinion, the
8 existing architecture to deal with large-scale
9 emergencies such as pandemics derived in large part from
10 the Civil Contingencies Act of 2004, and since 2008 had
11 included the national risk assessment and the National
12 Risk Register assessment. So by "architecture", you
13 mean framework including legislation?

14 **A.** Yes.

15 **Q.** Yes.

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

22 In what ways did you think it should be improved?

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

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1 **A.** Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 a National Security Adviser?

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

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

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

24 **Q.** Thank you.

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

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1 more respiratory diseases, like Covid turned out to be.

2 **Q.** Yes.

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

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

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

21 **A.** Yes.

22 **Q.** This Inquiry has heard about multiple outbreaks of SARS
23 and MERS, both of which were coronaviruses. I'd like to
24 put on screen, please, the following document:

25 INQ000149116, which is a note of a meeting of experts,

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

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

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

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

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

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

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1 mortality rates posed, and in the --

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

13 **Q.** Yes.

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

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

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

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

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

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1 Alice in 2016 --

2 **Q.** Yes, we'll come to that.

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

9 **Q.** Yes.

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

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

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

21 **A.** Yes, sorry.

22 **Q.** Not at all.

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

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

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

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

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

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1 to me is in the bundle somewhere --

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

3 In fact, can we put that on screen now, please,

4 INQ000017451.

5 Now, this is in fact the contingencies forward look,

6 because the threats committee, as you explain in your

7 statement, had a six-month forward look, didn't it,

8 which was a much shorter term to -- when compared to the

9 National Risk Register, which was five years, and the

10 National Security Risk Assessment, which had a 20-year

11 timeline.

12 This is one of the updates which, as the man in

13 charge of the threats committee, he would give to you.

14 Can we look at page 22, please, and paragraph 6.2,

15 and we will come on to the letter in a moment.

16 At paragraph 6.2, we can see here "An outbreak of

17 a novel strain of an infectious disease causing serious

18 illness (excluding pandemics)" is raised within this

19 forward look. He tells you here that:

20 "The risk of an emerging infection becoming

21 prominent is always present, particularly at the

22 interface between animals and humans (ie zoonotic

23 infections). Globally, there are currently three main

24 areas of concern: the ongoing cases of MERS-CoV in the

25 Middle East and Eastern Africa; the large number of

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1 Nationals and broader UK interests in the affected

2 countries; and

3 "- receive expert advice on clear and flexible UK

4 responses and mitigation arrangements:

5 "A monthly report will be issued to the Health

6 Secretary, the International Development Secretary and

7 me. This will outline: key international health risks,

8 departmental assessments of the impacts, and actions to

9 mitigate the risks. I have asked the Chief Medical

10 Officer to approve each monthly report before it is

11 presented. Attached is an illustrative example of the

12 report for your reference

13 "To avoid this becoming just 'business as usual',

14 I suggest that, rather than sending these reports each

15 month to the NSC(THRC), I shall write whenever officials

16 have flagged a health risk of particular concern."

17 Then he goes on to talk about the implementation in

18 April.

19 Were you concerned, Mr Cameron, that rather than --

20 using this as an example -- these bodies which you set

21 up extending pandemic preparedness to a whole-government

22 procedure, that what this was doing was encouraging

23 working in a silo, so that fewer people rather than

24 larger departments were going to be involved?

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

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1 avian and human cases of influenza ... particularly in

2 Egypt; and the epidemic of Ebola Virus Disease (EVD) in

3 West Africa."

4 We can take that down, please, and can we go to the

5 letter which you've made mention of, Mr Cameron, which

6 is at INQ000146550.

7 This was a letter sent to you by Oliver Letwin the

8 following year. We can see that it's dated

9 22 March of 2016, and we can read through this together.

10 It's titled "Horizon scanning for international health

11 risks":

12 "Diseases like Ebola and Zika can constitute major

13 risks to our national security.

14 "I have therefore asked the Civil Contingencies

15 Secretariat to develop a new scanning system for

16 international health risks."

17 So this is the horizon scanning group.

18 **A.** Yes.

19 **Q.** "The results of this work have now been agreed with all

20 relevant departments and have been endorsed by the Chief

21 Medical Officer.

22 "I am confident that the new system will enable

23 ministers to:

24 "- spot major emerging diseases across the world.

25 "- understand the direct risks to the UK, British

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1 excellent idea of Oliver's, and I think it came out of

2 Ebola, because -- we'll come on to the World Health

3 Organisation I'm sure -- you know, I don't think there

4 really was very timely information coming out of the WHO

5 about Ebola, and this was Oliver saying, "Let's have our

6 own horizon scanning to look across the globe for

7 emerging problems". And the next one that comes along,

8 of course, is the Zika virus, and this -- the horizon

9 scanning unit spots that quite early and then there are

10 conversations in government.

11 So, no, I think this was saying: we can make the

12 national security architecture work even better if we

13 scan the horizons and look for novel pathogens and

14 problems coming down the tracks. And I think that was

15 a thoroughly good thing.

16 I don't know what happened to this organisation

17 after I left, whether it continued, but I think this was

18 a really good idea and I think it -- I don't think it

19 was in a silo at all.

20 **Q.** All right. Well, I'd like to ask you some questions

21 about placing Mr Letwin charge. You deal with this in

22 paragraph 21 of your statement, in which you say:

23 "In terms of oversight of our resilience planning,

24 I found that civil servants were very good at

25 enumerating risks, setting them out and getting them in

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

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

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

15 What's your view of that, Mr Cameron?

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

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

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

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

18 **A.** Yeah.

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

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

25 He says:

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

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

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

23 **Q.** Thank you.

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

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

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

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

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

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

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

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

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

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

12 **A.** Yes. I can't --

13 **Q.** Yes?

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

17 **Q.** Thank you.

18 Can we put it up, please, on screen, INQ000035085.

19 We can go, please, to page 96, paragraph 5.38.

20 Thank you.

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

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

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

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

21 **Q.** All right.

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

25 So within a couple of months of you taking up

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

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

11 "The worst case in the planning framework is for
 12 750,000 additional deaths. Given pressures on
 13 resources, ministers will need to consider whether they
 14 wish to make any additional investment required to cope
 15 with the full worst-case scenario. I have no
 16 recommendation to make on what the correct figure might
 17 be for the worst-case scenario, although in Chapter 4
 18 I have recommended that the Government Chief Scientific
 19 Adviser convene a working group to review the
 20 calculation of planning scenarios. However, I do
 21 believe that it would be unsatisfactory if the National
 22 Framework implied that government and local responders
 23 were prepared to cope with many more thousands of deaths
 24 than they were in fact equipped to handle."

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

24

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

10 A. I --

11 Q. They were never amended.

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

15 Q. You've seen the report now though?

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

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

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

25

1 mention MERS and SARS and other types of pandemic.

2 Q. Yes.

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

9 Q. Yes.

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

12 Q. Yes.

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

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

27

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

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

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

14 A. Yes.

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

18 A. Well --

19 Q. -- no practical solutions?

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

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

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

26

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

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

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

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

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

17 Indeed, your plan that you set out included
18 a UK vaccines research and development network, with
19 £20 million invested from the outset, and also what you
20 described as a rapid reaction unit, ready to deploy to
21 help countries suffering such devastating epidemics in
22 the future.

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

28

1 improve for next time?
 2 **A.** Yes. I mean, I -- you know, the reason I chose to raise
 3 that at the G7 was I had become really concerned about
 4 this whole issue and Ebola was, you know, one example of
 5 it, and it was through conversations with
 6 Dame Sally Davies and others that I became more and more
 7 interested in this. You know, I thought we had taken
 8 important steps at home, and this was, you know,
 9 genuinely trying to put on the table the UK Vaccine
 10 Network and the rapid reaction force that you mentioned,
 11 saying that these were going to be our contributions, as
 12 well as this horizon scanning unit.

13 **Q.** Yes.

14 **A.** So I thought we were putting in place good steps and it
 15 was important to say to other countries: we all need to
 16 do this.

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

29

1 having observer status. So does that mean that the
 2 Cabinet Office was not actively involved but was there
 3 in order to observe?

4 **A.** I'm afraid I don't know the answer to that question.
 5 I mean, I think -- these exercises are good and it's
 6 important they take place. I think Oliver Letwin's
 7 evidence about they should happen with great regularity
 8 and at a senior level I think is absolutely right
 9 because --

10 **Q.** Yes.

11 **A.** -- as I said earlier, you want in the end to have
 12 ministers asking questions about: right, well, what will
 13 we actually do? What needs to change? What needs to be
 14 put in place? And you want their attention to be
 15 focused on this.

16 **Q.** Yes. Well, let's have a look, please, at the
 17 recommendations of Exercise Alice.

18 They are in document INQ000056239. Thank you.

19 If we can go to page 16, please.

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

23 At number 1:

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

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

9 **Q.** Yes, thank you.

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

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

25 The Cabinet Office is described in the report as

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1 Number 4, to:

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

5 Number 7, to:

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

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

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

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

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

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1 **A.** Yes, I do. And, I mean, I think it's -- having read
2 through, now, Alice, I -- because ministers weren't
3 involved.
4 **Q.** Yes.
5 **A.** But, you know, there is a sentence in Alice which is
6 "access to sufficient levels of PPE was also considered
7 and pandemic stockpiles were suggested". That's
8 a sentence in Alice but it doesn't make it into the
9 recommendations. So, I mean, if you're asking were
10 there failures -- does it look like there were failure
11 to follow through from this --
12 **Q.** Yes.
13 **A.** -- I think the answer to that is yes.
14 **Q.** Thank you.
15 At the same time -- we can take that down, please --
16 there was another exercise being planned,
17 Exercise Cygnus. Now, although this was not delivered
18 by Public Health England until you had left office, in
19 fact it took place over two days between 18 and
20 20 October of 2016, planning for this exercise began
21 in 2014 but was postponed due to the Ebola response.
22 Were you aware at the time that Exercise Cygnus was
23 being planned, Mr Cameron?
24 **A.** I'm afraid I just don't recall. I haven't -- in the
25 papers, I haven't --

33

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

6 So we can see at KL 4:
7 "An effective response to pandemic influenza
8 requires the capability and capacity to surge resources
9 into key areas, which in some areas is currently
10 lacking."

11 LI 5, please, further down the page:

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

16 LI 16, please. Thank you.

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

21 LI 17, please:

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

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1 **Q.** Yes.
2 **A.** -- seen anything, sort of a note from an official
3 saying, "There's this exercise going on". I mean, I've
4 seen notes of me saying to Jeremy Hunt, "Let's do
5 an exercise on Ebola", and I do remember that, but
6 I don't remember -- that doesn't mean I didn't get
7 a note about it, but I haven't been able to find one and
8 I don't think you have.
9 **Q.** All right. Well, we haven't, no. But this was
10 an exercise designed to assess the UK's preparation and
11 response to an influenza pandemic. The Inquiry has
12 heard about it already and no doubt will continue so to
13 do throughout the course of these public hearings. But
14 it involved 950 representatives from the devolved
15 administrations, the Department of Health, 12 other
16 government departments, NHS Wales, NHS England, Public
17 Health England, and eight local resilience forums, and
18 six prisons took part in the exercise. Huge, then, in
19 terms of organisation.
20 I'd like to look briefly, please, at some of the
21 recommendations from this exercise, whilst acknowledging
22 again that you had left office by the time this report
23 was produced.

24 **A.** Yes.

25 **Q.** Could we go, please, to page 30. Now, we can see that

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1 If we can have LI 18, please:

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

7 And finally LI 20:

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

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

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

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

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

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

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

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

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

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

10 **Q.** Yes.

11 **A.** After I'd left office.

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

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

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

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

39

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

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

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

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

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

20 **Q.** Yes.

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

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

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

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

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

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

25 **A.** Yeah.

40

1 Q. -- level of preparedness. Do you accept that you failed
2 in that desire? By the time you left government in 2016
3 there wasn't wholesale preparation and resilience, was
4 there?
5 A. I don't accept that, because we set up a much superior
6 architecture for looking at risks, for judging risks,
7 and planning for risks, and that's what the National
8 Risk Register, the National Security Secretariat, the
9 National Security Council did, and I think there was
10 more attention, including more attention of senior
11 politicians, onto those sorts of risks than there had
12 been previously. But, as I've said, the problem was
13 that when pandemics were looked at, there was too much
14 emphasis on pandemic flu, and when other pandemics were
15 looked at, including Ebola, including MERS, they tended
16 to be high fatality but low infection, and, you know,
17 the regret -- and you see it in Oliver Letwin's
18 evidence, you see it in George Osborne's evidence -- is
19 more questions weren't asked about the sort of pandemic
20 that we faced. But I think many other countries were in
21 the same boat, of not knowing what was coming. But
22 I would argue we did more than many to try and scan the
23 horizon, to try and plan. We did act on Ebola, we did
24 carry out these exercises, we did try to change some of
25 the international dynamic about these things, and we

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1 So my answer is: it's the Prime Minister.
2 Q. Thank you.
3 We've dealt with your concerns around the World
4 Health Organisation and how you sought to deal with
5 those, so I'm now going to move on to the final area of
6 questioning, the impact of austerity on the health and
7 social care service and underlying health inequalities.
8 I'd like to display, please, paragraph 26 of
9 George Osborne's witness statement, which we have at
10 INQ000187308. Paragraph 26, please.
11 "Reducing the deficit and placing debt as
12 a percentage of GDP on a downward path was also
13 essential to rebuild fiscal space to provide scope to
14 respond to future economic shocks. A responsible
15 approach to repairing the UK's public finances following
16 the financial crisis was essential. I have no doubt
17 that taking those steps to repair the UK's public
18 finances in the years following the financial crisis of
19 2008/09 had a material and positive effect on the UK's
20 ability to respond to the Covid-19 pandemic. The most
21 urgent task facing the UK economy, as stated in Budget
22 2010 ... was therefore to implement an accelerated plan
23 to reduce the deficit. Indeed, there was cross-party
24 consensus on the need to reduce the deficit following
25 the financial crisis."

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1 planned and prepared in accordance with that.
2 Q. The evidence of Mr Mann and Professor Alexander that was
3 received by the Inquiry last Thursday included them
4 posing this question: who is in charge of keeping the
5 country safe?
6 What is your answer to that question?
7 A. Well, the Prime Minister is always in charge of keeping
8 the country safe, and under my reforms the
9 Prime Minister was much more actively involved because
10 he was chairing the National Security Council, the
11 National Security Adviser was appointed by him, reported
12 to him, and in my case I'd set up a specific
13 subcommittee on threats, hazards and resilience that
14 looked exactly at this area with a highly capable
15 minister in. I'm sure there are further improvements we
16 can make, and the government has announced some which
17 seem to me sensible, with the proviso that I made.
18 But at the pinnacle of it must be the
19 Prime Minister, because, from all my experience of
20 chairing COBRs, whether it was during terrorist problems
21 or Fukushima nuclear disasters or Ebola or anything
22 else, the system works extremely well, but the system
23 works better when the Prime Minister is in the chair
24 asking questions, driving changes and making sure
25 decisions are made.

42

1 You have also made reference, Mr Cameron, to the
2 need for this to happen and, in your view, for the
3 positive effect that that had on the state of the
4 country's finances going into the Covid-19 pandemic.
5 I make it clear -- we can take that down, please --
6 that the purpose of the following questions that I have
7 for you is not to explore whether that policy was right
8 or wrong. That is no part of this Inquiry, to descend
9 into those political areas. But what we are interested
10 in are the impacts and consequences of that policy in
11 three areas, please: health, inequality and societal
12 resistance.
13 The Health and Social Care Act of 2012 changed the
14 landscape of public health, did it not, because it
15 transferred to local authorities public health features,
16 and the involvement of directors of public health?
17 So from that time, from 2012, those areas of public
18 health were no longer funded through the
19 Department of Health, in the way that they had been
20 before.
21 Mr Osborne says, at paragraph 71 of his witness
22 statement -- we don't need to put this up -- that the
23 Department of Health's budget from 2011 to 2012 until
24 2014 to 2015 was to increase in real terms in each
25 financial year, and that that growth occurred in

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

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

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

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

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

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

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

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

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

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1 I don't think you can separate the two.

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

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

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

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

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

6 **Q.** Do you accept, Mr Cameron, that the government was
7 repeatedly warned about growing pressures on the NHS?
8 Firstly, from the Nuffield Trust annual statement in
9 2015, which detailed growing concerns that demand was
10 outstripping capacity and "the warning lights on care
11 quality now glow even more brightly", and finally, in
12 2016, in the Nuffield Trust annual statement, before you
13 left office, which stated:

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

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

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1 ranking it as one of the most successful health systems
 2 in the world. We'd virtually abolished mixed sex wards,
 3 we'd got hospital infections down, we were carrying out
 4 40% more diagnostic tests every week. There were
 5 successes in the NHS as well as pressures. But there
 6 are -- you know, there are always pressures on these
 7 services, and our job was to try and sort out the
 8 economy, which we did, so we could then have bigger
 9 increases in health spending, which then followed.

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

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

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

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

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

14 **Q.** Yes.

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

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1 resulted in a lack of capacity for pandemic
 2 preparedness.

3 What's your response to that, please?

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

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

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

10 **Q.** So you don't agree with it?

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

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

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

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

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

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

25 **Q.** Yes.

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

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

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

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

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

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

3 **Q.** All right.

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

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

11 **Q.** Yes.

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

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

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

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

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

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

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1 **MS BLACKWELL:** Thank you.
 2 My Lady, that concludes my questions of Mr Cameron.
 3 I know that prior to today permission has been given to
 4 Ms Mitchell King's Counsel on behalf of Scottish Covid
 5 Bereaved Families for Justice to ask a short series of
 6 questions. May she be allowed to do that?
 7 **LADY HALLETT:** Certainly. I would normally break now, but
 8 if the stenographer can carry on for Ms Mitchell's
 9 questions?
 10 Thank you very much.
 11 Ms Mitchell.

12 **Questions from MS MITCHELL KC**

13 **MS MITCHELL:** I'm obliged.
 14 Mr Cameron, I'm senior counsel instructed by
 15 Aamer Anwar & Co for the Scottish Covid Bereaved.
 16 You have made it clear both in your written evidence
 17 and your evidence here today that you understood that
 18 pandemics were a very real threat, and you might not
 19 have understood or remembered the phrase "clear and
 20 present danger", but you would agree with me that, as
 21 a Tier 1 risk, is certainly was something that was
 22 immediate, important and potentially grave in terms of
 23 risk?
 24 **A.** Yes.
 25 **Q.** We've also heard that, given pandemics have happened

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1 government response to Covid-19".
 2 Now, I'd like to draw your attention, please -- I'll
 3 wait until it arrives on screen -- to the heading
 4 "Conclusions and recommendations".
 5 **MR KEITH:** My Lady, I'm extremely sorry to have to get to my
 6 feet. My learned friend knows very well that we're
 7 constrained by the rules of Parliamentary privilege, not
 8 to be able to put Parliamentary material which includes
 9 NAO reports in a way which calls into debate the merits
 10 of whatever conclusions have been drawn by the
 11 particular Parliamentary body or anything in fact said
 12 in the chamber of the House of Commons.
 13 So I'm just a bit concerned that we may be breaching
 14 Parliamentary privilege by going down this line of
 15 examination.

16 **MS MITCHELL:** Well, there's certainly a way, my Lady, that
 17 I can ask the questions without having to refer to those
 18 documents, so I'll be able to do that in that way.
 19 I'm obliged to my learned friend for highlighting
 20 that before that route was gone down.
 21 **LADY HALLETT:** Thank you.
 22 **MS MITCHELL:** While you were in government and when you were
 23 Prime Minister, did you make any plans for the effect
 24 economically on individuals in the United Kingdom?
 25 **A.** Well, I think, as I answered earlier, there are two

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1 throughout history, it was a matter of when and not if
 2 a pandemic would occur?
 3 **A.** Yes.
 4 **Q.** Your language, indeed, "We will face an outbreak like
 5 Ebola", made it clear that you understood effectively
 6 that a pandemic was inevitable?
 7 **A.** Yes.
 8 **Q.** You also referred to it I think here and also in your
 9 statement about taking a longer-term strategic view and
 10 trying to fix the roof while the sun is shining.
 11 Presumably because whilst things are good you put plans
 12 in place so that when the pandemic arrives, it will
 13 allow those to deal with it, to weather the storm
 14 safely?
 15 **A.** Yes.
 16 **Q.** Because presumably you appreciated that failure to
 17 properly plan would be likely to have a catastrophic
 18 effect for the United Kingdom?
 19 **A.** Yes.
 20 **Q.** Can I ask you to look at the following document. It's
 21 document INQ000087193, and we're looking at page 7 of
 22 that document.
 23 While we're waiting for that document to come up on
 24 screen, this is a document from the Public Accounts
 25 Committee of the House of Commons entitled "The whole of

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

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

24 So to that extent, yes, there was a plan.
 25 **Q.** Well, your plan was about the country. What I was

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

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

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

16 **A.** Yes.

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

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

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1 people.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 **MS BLACKWELL:** Thank you, my Lady.
 7 (12.30 pm)

8 (A short break)

9 (12.45 pm)

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

13 **LADY HALLETT:** I do.

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

16 **LADY HALLETT:** Thank you very much.

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

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

19 **THE WITNESS:** No problem.

20 **SIR CHRISTOPHER WORMALD (affirmed)**
 21 **Questions from LEAD COUNSEL TO THE INQUIRY**

22 **MR KEITH:** Are you Sir Christopher Wormald?

23 **A.** I am.

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

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

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

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

20 **LADY HALLETT:** Thank you very much, Ms Mitchell.

21 **MS BLACKWELL:** That concludes Mr Cameron's evidence.

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

24 (The witness withdrew)

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

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

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

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

15 **A.** Yes.

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

18 **A.** Yes.

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

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

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1 in the civil service.

2 **A.** Yes, thank you.

3 If I may, before I start, I would like to reiterate
4 the department's heartfelt sympathy for everyone who
5 suffered in the Covid epidemic, both directly and
6 indirectly, and also our thanks to the amazing staff in
7 the health and care sector who helped us get through.
8 I wanted to put both those things on record.

9 Yes, I am Permanent Secretary of the
10 Department of Health and Social Care, which position
11 I have held since 2016. Prior to that, I was the
12 Permanent Secretary of the Department for Education,
13 between 2012 and 2016, and before that I worked in
14 a variety of roles at the Cabinet Office between 2009 --
15 yes, 2009 and 2012, where I should put on record that
16 a number of the conversations you had with the last
17 witness I was supporting the coalition, including on
18 a number of the decisions they took around austerity and
19 the issues that were discussed this morning, which
20 I ought to note.

21 Prior to the Cabinet Office, I was Director
22 General for Local Government and Regeneration at the
23 Department of Communities and Local Government, as it
24 was then called, and then a whole series of other roles
25 in the civil service at more junior levels prior to

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1 **Q.** The Inquiry has heard evidence that the
2 Department of Health and Social Care was designated as
3 what is known as a responder, in fact a Category 1
4 responder, under the Civil Contingencies Act 2004. In
5 fact, the Secretary of State --

6 **A.** Yes.

7 **Q.** -- in the Department of Health and Social Care is the
8 designated responder.

9 Can you just assist the Inquiry with the extent to
10 which it is understood in a department what the extent
11 of those obligations are under the Civil Contingencies
12 Act? Is this an obligation which is placed on the
13 Secretary of State personally, or is it an obligation
14 that is discharged by the department as a whole?

15 **A.** Well, legally the department is an emanation of the
16 Secretary of State, so in almost all cases the legal
17 powers of the department are vested in the
18 Secretary of State personally. Secretaries of state
19 discharge those functions, normally via their
20 department. So they are effectively indivisible. So if
21 you asked people within the department, they would say
22 that the department is a Category 1 responder, in the
23 way that you describe.

24 **Q.** Every Secretary of State has any number of ministerial
25 obligations, both by way of being in charge of

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1 that.

2 **Q.** All right, thank you.

3 In the general scheme of things, in a department,
4 particularly one as important as the
5 Department of Health and Social Care, where does
6 a permanent secretary come in the order of things?

7 **A.** Well, you have three roles as a permanent secretary.
8 Well, I will say this, in a department like the
9 Department of Health at this time, which is largely
10 a strategy and policy department in this period. We've
11 already heard some discussion about the changes in the
12 2012 Act. Before that it was a much more operational
13 department --

14 **Q.** Sir Christopher, I'm so sorry to interrupt. The
15 question really was: where is the permanent secretary in
16 the general order of things? I'm going to ask you
17 questions about the role of the Department of Health and
18 Social Care, and of course we'll go into those issues.

19 **A.** Yeah. Okay. Sorry, it's important to the role that you
20 play, but yes. You do largely three things: so you are
21 chief executive of the organisation, which means you
22 lead the staff of the department, you are the chief
23 adviser on policy to the Secretary of State, and you are
24 the accounting officer for the budgets that Parliament
25 delegates to the department.

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1 a department, both by way of discharging obligations
2 imposed on him or her under our constitutional
3 structures, but also a fair few number of legal
4 obligations --

5 **A.** Yeah.

6 **Q.** -- of the type to which I have just made reference under
7 the Civil Contingencies Act.

8 So what extent are secretaries of state reminded or
9 constantly informed that they are subject to direct
10 legal obligations as well as their normal ministerial
11 obligations?

12 **A.** You would normally be -- have your legal
13 responsibilities explained to you when you come into
14 office. That would be the most important moment. And
15 then obviously if you're an experienced
16 Secretary of State, you will largely be aware of what
17 your legal responsibilities are.

18 **Q.** So as a department, but then directly as the
19 Secretary of State, the department was under a legal
20 obligation, as a Category 1 responder, to assess the
21 risk of emergencies occurring, plan for contingency
22 planning, put into place emergency plans and business
23 continuity arrangements, make information available to
24 the public, share information and co-operate with local
25 responders to enhance emergency response co-ordination

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1 and efficiency measures.

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

4 **A.** Yes, that's correct.

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

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

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

21 **Q.** Indeed.

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

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

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1 concerned with health emergencies?

2 **A.** Yes, that's correct.

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

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

12 **Q.** Yes.

13 **A.** -- but yes.

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

18 **A.** Yes.

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

20 **A.** Yes, that's correct.

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

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

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

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

19 **A.** Yeah.

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

22 **A.** Yes.

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

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

7 **A.** That's correct.

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

10 **A.** That's correct.

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

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

17 **Q.** It does.

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

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

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1 anything to do with pandemics, this was, during the
 2 ten years leading up to the pandemic, of core importance
 3 to your department?
 4 **A.** Yes. I mean, obviously, as you said earlier, the
 5 department has many, many responsibilities across the
 6 health and care sector, which is of course a huge
 7 sector, but this is one of the very important
 8 responsibilities that we hold.
 9 **Q.** In your department there is a directorate called the
 10 EPHP directorate, I think it's the Emergency
 11 Preparedness and Health Protection Directorate?
 12 **A.** Yes, it's had a variety of names and acronyms, which I'm
 13 sure you have identified, but basically, yes, there is
 14 a directorate that is responsible for emergency
 15 preparedness and oversight of health protection, as you
 16 describe, pretty much throughout.
 17 **Q.** Including pandemic preparedness?
 18 **A.** Yes, correct.
 19 **Q.** Obviously we've seen that there were a significant
 20 number of bodies and entities and boards and so on and
 21 so forth, both within your department and also connected
 22 to your department, arm's length bodies and so on --
 23 **A.** Yeah.
 24 **Q.** -- which were focusing on pandemic flu preparedness?
 25 **A.** Yes.

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1 **Q.** Was that a board on which the DHSC had a place --
 2 **A.** Yes.
 3 **Q.** -- and which considered directly influenza planning?
 4 **A.** Yeah, I mean, it was a -- it was the part of the
 5 follow-up to the Cygnus exercise, and it was the main
 6 body charged with taking forward the learning and
 7 actions from that exercise, and it was co-chaired
 8 between the Cabinet Office and DHSC, recognising that
 9 there were recommendations that went directly into the
 10 health service and those for wider government.
 11 **Q.** Within the internal management of your department, did
 12 the various individuals and employees who were
 13 contributing to these and other boards report up to,
 14 through you, a departmental board?
 15 **A.** I'm not sure "report up to" is the correct terminology,
 16 so --
 17 **Q.** Forgive me.
 18 **A.** Well, no, I mean, this is a ... I'm not quite sure what
 19 the right word -- I'll simply --
 20 **Q.** Sir Christopher, will you allow me to rephrase the
 21 question?
 22 **A.** Yeah.
 23 **Q.** In your department, as part of its internal management
 24 structure, is there an overarching body called the
 25 departmental --

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1 **Q.** So one of them, and we heard evidence of this last week,
 2 the Pandemic Influenza Preparedness Board, PIPP. Was
 3 that a DHSC-led programme or was that a cross-government
 4 programme?
 5 **A.** That one is the DHSC-led programme. There was a second
 6 board, which I'm sure we'll come on to, which was
 7 cross-government.
 8 **Q.** Was that PIPP board chaired in fact by Clara Swinson, to
 9 whom you've referred, who was the then Director
 10 General for Global Health, and health protection, from
 11 whom we'll be wearing perhaps later today, this
 12 afternoon?
 13 **A.** Yes, from the point of her appointment, which I think
 14 was towards the end of 2016.
 15 **Q.** That board first met in October 2007, you may recall?
 16 **A.** Well, I don't --
 17 **Q.** Take it from me, Sir Christopher.
 18 **A.** I'm told by the record that -- yes.
 19 **Q.** Another board was the Pandemic Influenza Preparedness
 20 board and, as we've heard in evidence, that was a board
 21 which was a cross-government board which was set up by
 22 order of the National Security Council THRC, Threats,
 23 Hazards, Resilience and Contingencies committee, chaired
 24 by the then Prime Minister Theresa May, in 2017?
 25 **A.** That's correct.

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1 **A.** Yes, there is. Now, as I said earlier, all the legal
 2 powers are in fact vested in the Secretary of State, so
 3 departmental boards -- and sorry, this is why I was
 4 struggling to find the correct words -- they are not
 5 like the boards of arm's length bodies or the boards of
 6 private companies or charities, in that they do not hold
 7 any decision-making or fiduciary(sic) responsibilities.
 8 So they are, legally, purely advisory boards to the
 9 Secretary of State, who exercises all the --
 10 **Q.** The legal powers?
 11 **A.** -- all the legal powers. So they are important, but
 12 they are important in that advisory function, as opposed
 13 to being a decision-making body.
 14 **Q.** But subject to the legal powers vested in and imposed
 15 upon the Secretary of State personally, the departmental
 16 board is the most senior board or advisory group within
 17 the whole department, is it not?
 18 **A.** Yes, but it's very important to note that that does not
 19 mean it is the conduit of advice that goes to the
 20 Secretary of State in the vast majority of cases. As
 21 I think I set out in my first witness statement, the
 22 basis of departmental decision-making is the submission
 23 system to the Secretary of State. So what I don't want
 24 to give the impression of is that Secretary of State
 25 decision-making is particularly advised by the board.

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1 Q. No.

2 A. It doesn't meet that often. But you are correct that it
3 is the highest committee in the department.

4 Q. May I just observe that I didn't suggest that it was
5 a body for giving advice to the Secretary of State.

6 A. No, I'm sorry.

7 Q. It is, however, a body which addresses matters of the
8 greatest import, of the greatest importance to the
9 department as a whole, matters which could imperil the
10 very existence of the department. For example, the
11 major risks to its functioning, its operation, go to
12 that level, do they not?

13 A. Yes, so the department's risk register is normally
14 a standing item of the board, and one of the board, and
15 particularly the non-executive members of the board's
16 role is to critique what the department is doing on all
17 those issues as a challenge function. As I say,
18 decision-making sits elsewhere.

19 Q. Like many entities and boards, the board has a risk
20 register which it has half an eye on --

21 A. Yeah.

22 Q. -- or a full eye, which tells it which risks pose the
23 greatest threat to the whole entity, the whole
24 department, which risks need to be focused upon by the
25 board, and a register is of course kept of where the

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1 Sir Christopher, it is self-evident that the risk
2 selected for a deep dive will only be those risks which
3 pose the greatest threat to the department, otherwise
4 there is no need --

5 A. Yes, that's correct, and as is shown in this
6 presentation, there were in fact two risks that fell
7 into this category, one which was the risk of
8 an influenza pandemic, and one was what is known as the
9 risk of a high consequence --

10 Q. Infectious disease.

11 A. -- infectious disease.

12 Q. And at the bottom of the page we can see:

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

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

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

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1 risks come in the general order of things and what is
2 being done to mitigate those risks?

3 A. That's correct, and --

4 Q. In a general sense?

5 A. Yeah, and as you correctly identified earlier, what the
6 board does is it sits on top of a structure that
7 assesses those risk and subcommittees that do so.

8 Q. So the board examines matters that are of the gravest
9 importance to the department, and one such matter it
10 examined by way of a risk deep dive was the issue of
11 major infectious diseases, which it did in
12 September 2016?

13 A. Yes.

14 Q. Could we have, please, INQ000022738. "Departmental
15 Board: Risk Deep Dive" dated, we can see,
16 28 September 2016, and then page 2, please, paragraph 1:
17 "In keeping with the departmental risk guidance,
18 each quarter a risk from the Departmental High Level
19 Risk Register is to be selected for a more in depth
20 discussion at the Departmental Board. The aim of the
21 discussion is ... to consider in more detail the
22 mitigations for a particular risk which might not
23 otherwise be discussed. This quarter the risk of
24 an outbreak of a major infectious disease has been
25 selected for the first of these risk deep dives."

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

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

8 And then this:

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

13 So important serious issues were being raised in the
14 department --

15 A. Yeah.

16 Q. -- for consideration by its highest level board in this
17 deep dive, all related to, in broad terms, pandemic
18 planning?

19 A. That is correct. I would say pandemic and
20 high-consequence infectious disease planning, which are
21 separate but related.

22 Q. Yes. That is the minute, or rather the presentation.

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

25 Some figures were provided to the board on the

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

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

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

11 "Departmental Board ...

12 "Draft Minutes

13 "Present:

14 "Chris Wormald ..."

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

16 "Apologies:

17 "Jeremy Hunt, Secretary of State for Health."

18 Could we have, please, page 1:

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

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

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

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

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

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

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

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

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

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

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

9 Then the next bullet point, please:

10 "Members were concerned by the Secretary of State's
11 continuing lack of engagement with the Board.

12 Chris Wormald explained to members that ministerial
13 attendance at the Department for Education's
14 Departmental Board had been compulsory and enforced by
15 the Secretary of State. He also advised that the
16 Ministerial Code requires Secretaries of State to chair
17 their Departmental Boards. On the proposal that the
18 Secretary of State nominate a junior minister to chair
19 in his absence, members noted that both David Prior and
20 Philip Dunne had appropriate board-level experience."

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

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

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

7 **LADY HALLETT:** By which you mean?

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

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

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

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

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1 **A.** That's my understanding, yes.

2 **Q.** So although it had invested more in antiviral stockpiles
3 than most other countries, the stockpiles for antivirals
4 was concerned only with providing a countermeasure to
5 pandemic influenza?

6 **A.** In that case, yes.

7 **Q.** Yes:

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

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

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

20 Sir Christopher, we will look in detail over the
21 next two hours on what steps were taken by the
22 department between now and 2016 and 2020 when the
23 pandemic struck. Would you agree that by January of
24 2020 the system was not, even then, capable of dealing
25 with even a moderate pandemic?

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

4 I'm sorry, that's a sort of nuanced answer, but I'm
5 trying to set out what I think we thought at the time
6 and why, separately from what we now think is
7 an appropriate way forward, if that is understandable.

8 **Q.** Sir Christopher, it forms no part of this Inquiry to
9 examine with hindsight what other decisions could have
10 been made or were made or were not made. But in 2016,
11 this departmental board was warning in the clearest
12 terms it was more likely than not that even a moderate
13 pandemic would overrun the system. So there is no issue
14 of hindsight here. That was a prospective warning that
15 the system would likely not cope.

16 **A.** Yes, which is exactly why there was the proposal, and
17 indeed the actuality, of Exercise Cygnus.

18 **Q.** Yes. Exercise Cygnus, paragraph 6 of its final report
19 said this:

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

25 So Exercise Cygnus did not come in any way to

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1 **A.** I would have quite a nuanced answer to that question.

2 **Q.** Well ...

3 **A.** Sorry.

4 **LADY HALLETT:** Let him try, Mr Keith. You can always come
5 back with other questions.

6 **MR KEITH:** Please answer.

7 **A.** Sorry. I think a significant number of steps had been
8 taken at the time. And this comes out in the paragraph
9 that you emphasised before, we believed that we had good
10 and very good, by international standards, procedures in
11 place, and I believe that those were rational things to
12 think, given the evidence, advice and resources that we
13 had at the time.

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

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

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1 relieve the problem that was identified in paragraph 25;
2 it reported again that systemically the system would not
3 be sufficient. So what was done after Cygnus to ensure
4 that the system would be sufficient?

5 **A.** Well, there was a whole programme of work post Cygnus
6 that we have mentioned already, led by the pandemic
7 influenza preparedness board that we discussed earlier,
8 the cross-government board, whose job it was to take
9 forward the findings of the exercise.

10 **Q.** Could we have, please, paragraph 26:

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

18 By January 2020, the system remained fragmented, did
19 it not?

20 **A.** Its legal structure, as set out in the 2012 Act and the
21 2014 Care Act, the two governing pieces of legislation,
22 hadn't changed, no.

23 **Q.** The legal structure under that Act and the legal
24 structure under the Civil Contingencies Act 2004 had not
25 materially altered, had it?

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1 A. Those -- so the two Acts, which is, as it were, the
 2 governing acts of how we run the system, the 2012 Act
 3 and then the 2014 Act for health and then social care,
 4 remained in place, yes. And then, as you know, the
 5 Civil Contingencies Act hadn't changed.

6 Q. The whole system, having a lead government department,
 7 having local authorities and local resilience forums,
 8 being supervised and liaised with by the Resilience and
 9 Emergencies Division of the Department for Levelling Up,
 10 Housing and Communities hadn't changed?

11 A. No.

12 Q. The Cabinet Office position hadn't changed through its
 13 Resilience Directorate, it sought to exercise control by
 14 political persuasion and other means over other
 15 government departments?

16 A. A little more than political persuasion, but no, it
 17 hadn't changed.

18 Q. The Department of Health and Social Care was responsible
 19 for the funding and the general guidance -- funding of
 20 and general guidance for local authorities, but,
 21 of course, local authorities who are concerned with the
 22 adult social care sector fall outwith the direct
 23 functions of your department?

24 A. That's correct. So the 2014 Care Act, which broadly
 25 maintained the previous arrangements for adult social

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1 me.

2 Q. So there were no changes, were there, significantly, to
 3 how resilient the system would be between 2016 and 2020;
 4 it remained fragmented, didn't it?

5 A. That's true.

6 Q. Thank you.

7 LADY HALLETT: You are accepting it was fragmented? I got
 8 the feeling that maybe you weren't accepting,
 9 Sir Christopher, it was fragmented.

10 A. I don't think there is any dispute that it was
 11 fragmented, and indeed the whole point of the 2012 Act
 12 was to reduce the level of central control over
 13 particularly the NHS and to run the system much more as
 14 a -- and I apologise for using the jargon -- as
 15 a quasi-market. So the idea of that Act was to have
 16 operational freedom within the NHS, and for the system
 17 to be based around a series of commissioners and
 18 providers, as opposed to a top-down system of direct
 19 control as had existed prior to 2012.

20 Now, whether you believe fragmented to be a good or
 21 a bad thing, I don't think there's any dispute that that
 22 was the purpose of that set of reforms.

23 LADY HALLETT: Shall we pause there, Mr Keith?

24 A. In terms of -- I want to cover social care as well.

25 LADY HALLETT: Do finish the thought and then we'll pause,

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1 care, sets out that it is a local authority-led and
 2 funded service, so it's not correct we oversaw the
 3 funding, the funding is locally raised, and it gives
 4 a -- quite a limited set of powers to central
 5 government, mainly through the inspection of care
 6 providers, not -- not local authority commissioners, as
 7 I say, because that is something we have changed. So it
 8 was a largely locally-led system, with the department
 9 having responsibilities around the legal framework and
 10 around the inspection, as implemented by CQC.

11 Q. So, Sir Christopher, having therefore accepted that in
 12 no significant regard had there been any change to the
 13 fragmented nature of the system as at 2016, would you
 14 agree that the system remained similarly fragmented
 15 still by January 2020?

16 A. As I say, the legal position on all those matters had
 17 not changed.

18 Q. In this board meeting, Sir Christopher, concerns weren't
 19 being expressed about the dry nature of the legal
 20 obligations being placed on the various parts of the
 21 government machine; concern was being expressed about
 22 how resilient the somewhat fragmented system would be,
 23 whether it would cope in practical terms. That wasn't
 24 just an issue about legal obligations, was it?

25 A. No, no, I was answering the specific question you asked

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1 break.

2 A. Yes -- where, again, it's not a matter of dispute that
 3 social care is a locally-run service and, therefore,
 4 divided amongst the top tier local authorities, as --
 5 again, you can debate whether that is a good thing or
 6 a bad thing, but I don't think it's in doubt that it's
 7 a thing.

8 MR KEITH: And there we must leave it.

9 LADY HALLETT: Well, unless you particularly wanted anything
 10 else on this topic.

11 MR KEITH: As it happens I had one more question on this
 12 document and then perhaps we can put it to one side.
 13 Paragraph 25:
 14 "... there would be significant issues if it became
 15 necessary to track or quarantine thousands of people."
 16 Is this the position, Sir Christopher: that despite
 17 that issue, the important issue of quarantining, being
 18 raised in 2016, by January 2020, whilst there was and
 19 had been a continual debate as to how to isolate
 20 individuals in the event of a high-consequence
 21 infectious disease, there was -- and -- there never was
 22 any debate about mass quarantining, mass isolation, mass
 23 quarantining, was there?

24 A. Well, in the influenza plan, the basis of that is
 25 a series of voluntary what are known as NPIs, which

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1 would have included those issues. What there was not --

2 **Q.** Sir Christopher, I'm so sorry to interrupt.

3 Quarantining is, as you know, of course, a mandatory

4 thing. It's a mandatory restriction. Was there any

5 debate between now, the issue having been raised, and

6 2020, of mandatory quarantining of significant numbers

7 of the population?

8 **A.** Not in the context of a pandemic.

9 **Q.** Well, we're not really concerned with quarantining

10 outside the pandemic in this Inquiry; so the answer is

11 no?

12 **A.** Not in the context of a pandemic. I'm sure we will come

13 on to, but there are important interactions between the

14 strategy for high-consequence infectious diseases and

15 the plans for a pandemic, which I'm sure we will discuss

16 further.

17 **LADY HALLETT:** I think you said the issue having been raised

18 in 2020; I think you meant 2016.

19 **MR KEITH:** Thank you, I did.

20 **LADY HALLETT:** Very well. We shall come back at 2.20,

21 please.

22 (1.32 pm)

23 (The short adjournment)

24 (2.20 pm)

25 **LADY HALLETT:** Mr Keith.

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1 assessments were pored over by a multitude of people and

2 bodies --

3 **A.** Yeah, that is -- that's correct. So the process --

4 **Q.** We don't need the full detail, would you just agree with

5 the proposition that they were of course examined at

6 great length by your department, which was responsible

7 for them?

8 **A.** Yeah.

9 **Q.** And also with the assistance of internal and external

10 advisers and scientists?

11 **A.** Yes, that's correct.

12 **Q.** All right.

13 Now, we need to look, then, at the actual

14 documentation, so we could please have INQ000147769.

15 This should be the -- what was then called the national

16 risk assessment, and, my Lady, the government has kindly

17 declassified parts of this internal National Risk

18 Assessment for the purposes of this Inquiry.

19 That is why, Sir Christopher, it says

20 "Official-Sensitive" at the top, but we are looking at

21 it today.

22 **A.** Yeah.

23 **Q.** This is the 2016 version. It was the national risk

24 assessment then, but in 2019 the two forms of the

25 assessment, the national risk assessment and the

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1 **MR KEITH:** Sir Christopher, may we now turn, please, to the

2 risk assessment process to which you referred earlier.

3 As you've helpfully stated, the Department of Health

4 and Social Care was the lead government department for

5 pandemic risk and infectious disease, and so it was, in

6 the nomenclature, the risk owner for those risks in the

7 National Security Risk Assessment. It provided

8 information and was part of the process by which those

9 risks were identified, debated, described in the

10 paperwork, and also what the impacts would be likely to

11 be from those risks. The department owned all aspects

12 of the debate concerning those two risks: pandemic

13 influenza risk and emerging infectious disease risk.

14 **A.** That's correct. I mean, the process of setting the risk

15 and then agreeing reasonable worst-case scenarios and

16 all those things I think has been described in other

17 statements.

18 **Q.** Yes.

19 **A.** I mean, it's an iterative process between the department

20 and the centre.

21 **Q.** The Inquiry is aware that the department obviously

22 received advice from both its internal scientists, its

23 departmental Chief Scientific Adviser, or government

24 department Chief Scientific Adviser, from a number of

25 external advisers, external bodies -- I mean, these risk

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1 National Security Risk Assessment, were brought

2 together, were they not?

3 **A.** That's my understanding, yes.

4 **Q.** All right.

5 Could we look, please, at page 7:

6 "The National Risk Assessment [towards the bottom of

7 the page] is a strategic medium term planning tool.

8 Risks captured within the NRA [the national risk

9 assessment] are examples of civil emergencies that could

10 plausibly affect the United Kingdom within its

11 territorial boundaries in the next five years ... It is

12 crucial all risks are assessed using a consistent,

13 evidence-based approach."

14 What is an evidence-based approach?

15 **A.** I think it's exactly what it says on the tin, so that it

16 should be on the basis of expert opinion, modelling and

17 the available evidence.

18 **Q.** An approach that isn't based on available evidence isn't

19 much of an approach, is it?

20 **A.** Well, I mean, government is sometimes in the situation

21 where it has to take decisions despite lack of evidence,

22 so that does happen.

23 **Q.** All right.

24 **A.** But if you're doing this kind of assessment, yes, you

25 would expect it to be evidence based.

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1 Q. "... each risk is considered on the basis of
2 a 'Reasonable Worst Case Scenario' ... [it's] intended
3 to provide an illustrative example of the worst
4 plausible manifestation of the risk in question."
5 And it's based on two scores: impact, which
6 determines the severity of the consequences; and
7 likelihood -- which is more concerned with non-malicious
8 risks/hazards -- or plausibility, which is concerned
9 with malicious threats, "determining the expected
10 recurrence rate of the risk over the next five years".
11 If you go down a bit further on the page, please, we
12 can see that we have the heading "Impact":
13 "Impact is determined on the basis of collating
14 information about the severity of economic losses ...".
15 And so on and so forth.
16 Page 9, please. There is a chart at the top of the
17 page, and along the bottom of that chart we have
18 Likelihood/Plausibility". We can ignore likelihood.
19 We're concerned with plausibility, because we're dealing
20 with hazards, a pandemic, rather than, for example,
21 a terrorist threat. On the left-hand side, "Impact".
22 At the top we can see, for medium/high likelihood,
23 but catastrophic impact, pandemic influenza. Thank you.
24 And for medium/high -- with medium/high likelihood,
25 and moderate impact, emerging infectious diseases. Is
101

1 understand the realistic worst-case scenario and plan
2 accordingly. Is that correct?
3 A. Yes.
4 Q. So there is an example given at the bottom of the page,
5 "Risks that could lead to mass casualties", either
6 an industrial accident or a terrorist attack or flooding
7 or public disorder. If you group those risks together,
8 the planning assumption would be therefore
9 1,000 casualties, because that's the worst of those four
10 particular risks which are grouped together. Do you
11 agree?
12 A. Yes.
13 Q. All right.
14 Could we then, please, have page 23.
15 Page 23 gives us, for 2016, the likelihood -- in the
16 top chart -- and impact of the two risks with which
17 we're most concerned: H23, which is, you agree, pandemic
18 influenza, and, below it, H24, for moderate impact and
19 medium likelihood, emerging infectious diseases?
20 A. That's correct.
21 Q. Then page 47, please. This is the more detailed
22 description of the pandemic influenza risk, and we need
23 to look at this in detail.
24 You see, Sir Christopher, on the top left the
25 overall assessment is very high, is it not?
103

1 that correct?
2 A. That's correct.
3 Q. If we could scroll back out, please, and look at the
4 bottom half of the page, you can see that there's
5 a second chart, and in relation to pandemic influenza
6 risk, because it falls in the top part of the above
7 chart, in the catastrophic range, there is a circled
8 area in this chart called "High impact risks" in
9 relation to which the "Government is expected to
10 supplement generic capabilities with specific
11 contingency plans".
12 Scroll back out, please.
13 Because emerging infectious diseases was only
14 a moderate impact as opposed to significant or
15 catastrophic it didn't fall within the shaded area for
16 which the government was expected to produce a specific
17 contingency plan; that's correct?
18 A. Yes.
19 Q. All right.
20 Page 10, please. Planning assumptions were then
21 drawn up. So once you'd identified likelihood and you'd
22 identified impact and you could see where your risk came
23 on the top chart, planning assumptions were then made on
24 what the common consequences of a number of risks might
25 be if they came to pass, so that everybody could
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1 A. Yes.
2 Q. Is that because, in the top right-hand corner of the
3 page, the chart for pandemic influenza provides that the
4 reasonable worst-case scenario, which is that star, is
5 right up at the top of the page with medium to high
6 likelihood but catastrophic impact?
7 A. That's correct.
8 Q. Therefore, because of the medium/high likelihood and the
9 catastrophic impact, together an overall assessment is
10 made of it being very high?
11 A. That's correct.
12 Q. What does the arrow under the star signify?
13 A. Now, that I couldn't tell you.
14 Q. All right. That's easy then. In that case I won't
15 pursue that particular point with you.
16 Then in the wording you can see there is a general
17 description of the pandemic influenza risk, a novel flu
18 virus emerges, up to 50% of the population may
19 experience symptoms, 750,000 fatalities in total,
20 absenteeism could reach 20%, and then these words, in
21 the sixth line:
22 "Each pandemic is different and the nature of the
23 virus and its impacts cannot be known in detail in
24 advance."
25 That is a description which falls in this page under
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1 the heading of "Pandemic influenza", but it is
2 applicable to any pandemic, or any viral respiratory
3 disease, because they all differ, and the nature of the
4 virus and its impacts can't be known in detail in
5 advance.

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

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

24 **Q.** I'm sorry, Sir Christopher --

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

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

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

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

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

22 **A.** In that --

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

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

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

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

16 **Q.** In the next paragraph it says:

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

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

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

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

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

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

16 **A.** Yes.

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

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

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

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

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

21 **Q.** Of possibility?

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

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

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

3 **Q.** Yes --

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

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

10 **A.** Oh, yeah.

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

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

15 **Q.** Yes.

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

20 **Q.** We will come to now in a moment.

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

22 If you look at the middle of the page there is then
 23 a reference to the fact that there had been more than
 24 30 new or newly recognised diseases over the past
 25 30 years, and there is a reference then to SARS and then

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

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

16 **Q.** Yes.

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

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1 to MERS and Ebola.

2 **A.** Yeah.

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

6 **A.** Yeah.

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

12 **A.** Yes.

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

14 **A.** Yep. That is correct.

15 **Q.** All right.

16 Could we look, please, at 2019, which is
 17 INQ000185135, on the eve of the pandemic. INQ000185135.
 18 "Emerging Infectious Disease". The risk picture
 19 changes, does it not, between 2016 and 2019?

20 **A.** Yes.

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

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

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1 picture of the risk than the 2016 one, as was
 2 demonstrated in the pandemic that we did suffer. So
 3 clearly, and, as I said, a high-consequence infectious
 4 disease can be on the way to being a pandemic --
 5 **Q.** Catastrophic in terms, Sir Christopher, of --
 6 **A.** Oh, yeah.
 7 **Q.** -- massive fatalities -- well, huge numbers of people
 8 infected, work absence, impact on economy, and the like?
 9 **A.** Yes. Yes.
 10 **Q.** Right.
 11 **A.** So in the translation between something that begins as
 12 a high-consequence infectious disease and becomes
 13 an epidemic or pandemic, yes, then it would have the
 14 same risk profile as our pandemic risk, it has
 15 effectively become that, and, as I say, that is in
 16 practice what happened with --
 17 **Q.** With Covid, right.
 18 **A.** -- with Covid, yeah.
 19 **Q.** Could we scroll back out, please.
 20 Towards the bottom of the page, you will see
 21 a reference to a reasonable worst-case scenario, and
 22 a description of how the infection would likely develop
 23 outside the United Kingdom.
 24 Could we scroll back out, please. And in the middle
 25 of the page there is a debate over means of

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1 **Q.** -- the possibility of infection there, but it's not
 2 going to run amok through the whole population, killing
 3 35%?
 4 **A.** No, that is the -- you have put your finger on the
 5 difference between a high-consequence infectious
 6 disease, where you are dealing with small numbers and
 7 you're seeking to contain it --
 8 **Q.** Where the greatest risk is in hospital settings, because
 9 doctors and nurses have to be able to treat people who
 10 are infected and there is a greater risk of
 11 transmissibility there?
 12 **A.** Yes. Now, I'm only -- I'm only cautious on my answers
 13 because you will get much better answers --
 14 **Q.** It's all right.
 15 **A.** -- a number of other witnesses in terms of the
 16 epidemiology. But in terms of the concept, the
 17 high-consequence infectious disease strategy is, as
 18 I say, for where you have small numbers and the intent
 19 is to contain and get it to zero, and a pandemic is
 20 effectively where contain has failed -- or, sorry, an
 21 epidemic, where contain has failed and you are into the
 22 question of: how do you mitigate something that has gone
 23 beyond your ability to contain it?
 24 **Q.** We are focusing on for the moment on the risks, not how
 25 you deal with a pandemic once it's out there.

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1 transmissibility and so on.
 2 Could we go forward one page, please, to page 2.
 3 There is then a description of:
 4 "What the [reasonable worst-case scenario] described
 5 above could lead to ..."
 6 Increased demand on specialist intensive care.
 7 Localised disruption to routine healthcare activities if
 8 outbreaks occur in hospital settings.
 9 Just emphasise, please, mentally, Sir Christopher,
 10 the reference to hospital settings.
 11 Further down the page, "Specific Assumptions and
 12 strategic context". There is a likely high case
 13 fatality rate, for MERS it would be about 35%, there is
 14 no effective treatment, the main control measure is the
 15 implementation of effective infection control.
 16 So the approach taken on this page is to say in
 17 terms: because the reasonable worst-case scenario --
 18 that star -- only has medium impact, not catastrophic,
 19 even if we assume there is no antiviral, there is no
 20 vaccine, that there is a very high case fatality rate,
 21 35%, the impact is not going to be of the same order as
 22 an influenza pandemic, it's of moderate impact, you'd be
 23 dealing with disease in health settings, healthcare
 24 settings --
 25 **A.** Yeah.

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1 **A.** Well, the only thing I would say is those are at -- that
 2 question of: can you contain it and drive it to zero is
 3 central to the question of what the risk is, as it were.
 4 **Q.** Well, Sir Christopher, the reason why it can be
 5 controlled and reduced to zero is because this risk
 6 assumption assumes that it is not highly transmissible,
 7 that it's not going to run amok through the population
 8 and it can be controlled.
 9 **A.** Yes --
 10 **Q.** Correct?
 11 **A.** -- and that is the difference --
 12 **Q.** Indeed.
 13 **A.** -- between the two categories.
 14 **Q.** Could we go forward, please, one page further to page 3.
 15 There is then more debate about MERS and SARS. Then in
 16 the middle of the page, or two-thirds of the way down
 17 the page:
 18 "The emergence of new infectious diseases is
 19 unpredictable but appears to have become more frequent.
 20 This may be linked to a number of factors such as
 21 climate change, the increase in world travel ..."
 22 And so on and so forth.
 23 So there is a clear recognition there, isn't there,
 24 that new infectious diseases are unpredictable and have
 25 become more frequent; correct?

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1 **A.** Yes.

2 **Q.** Yes. Can you scroll back out, please?

3 Then, at the bottom of the page, "Recovery and

4 long term implications".

5 Could we go forward one page again, please, to

6 page 4.

7 There is a description of variations, again

8 a description of Ebola and reference to MERS and SARS.

9 Then, please, page 8.

10 The consequences of this particular risk, broadly

11 identified as it was:

12 "Likelihood ... There is significant uncertainty

13 about the frequency with which an emerging infection may

14 develop the ability to transmit from person to person."

15 So there is a risk, is there not, recognised in this

16 document that a non-influenza emerging infectious

17 disease may be a high transmissibility pathogen, it may

18 travel human to human readily?

19 **A.** Yes.

20 **Q.** Scroll back out, please. But the fatalities, the number

21 of people which were assumed in this document to result

22 from this disease, is put at -- under "Fatalities", 200,

23 no notice and excess deaths.

24 Then further down the page, please:

25 "Casualties (UK)

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1 successful at containing a disease via your HCID

2 mechanisms, then you would be containing the risk at

3 these sorts of level --

4 **Q.** But, Sir Christopher, I apologise for interrupting, if

5 the emerging infection does develop the ability to

6 transmit rapidly human to human, as those arrows

7 identify, as that paragraph under the heading

8 "Likelihood - confidence assessment" states, there will

9 be no question of containment, will there, because it

10 won't be --

11 **A.** Oh, no, until you are into your epidemic/pandemic risk,

12 with the kind of reasonable worst-case scenarios

13 identified for that -- sorry, that's what I mean by --

14 **Q.** So why, why, why, were the number of deaths put at 2,000

15 not 820,000?

16 **A.** Well, sorry, this is where I think we may be at risk of

17 becoming lost in the terminology. Then you have two

18 identical risks. You have effectively two

19 epidemic/pandemic risks --

20 **Q.** For which the outcomes will be the same: massive loss of

21 life?

22 **A.** Yeah.

23 **Q.** Collapse of the economy? Huge -- millions of people

24 infected?

25 **A.** Yes, and, as I say, and --

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1 "Total number

2 "2,000

3 "No notice and excess casualties.

4 "- Using the upper bounds, 20 no-notice, 1,800

5 excess."

6 So even though the arrows signified a risk of

7 a catastrophic outcome to a non-influenza pandemic, or

8 a non-influenza pathogen, even though the document

9 recognised that there could be human-to-human rapid

10 transmission and, by implication, that the disease could

11 spiral out of all control, it concluded only -- and

12 I apologise for using this language -- a relatively few

13 deaths by comparison to the 820,000 deaths assumed in

14 an influenza pandemic?

15 **A.** Now, I think we're in a slight danger of getting lost in

16 the terminology, so ...

17 **Q.** Well --

18 **A.** As I --

19 **Q.** Sir Christopher, are you able to answer that question,

20 why did -- those things being recognised, being apparent

21 on the face of this document, was such a relatively

22 limited conclusion reached in terms of impact?

23 **A.** Because of the interrelationship between those two

24 identified risks, and so that's the reason why the two

25 risks are on the National Risk Register. So if you are

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1 **Q.** That is not this outcome on page 8, is it?

2 **A.** No, because, as you correctly identified, these would be

3 the outcomes if you have successfully contained the

4 disease. The outcomes if you have not successfully

5 contained the disease would be in the reasonable

6 worst-case scenario that we had identified for pandemic

7 influenza, ie the disease in that case would have

8 translated -- as Covid did -- from one being managed as

9 an HCID, with these sorts of implications, into

10 something that was in the pandemic risk category with

11 those sorts of implications.

12 Now, as I say, I don't -- I'm not trying to get lost

13 in the terminology, what I'm trying to do is explain the

14 translation between those two.

15 So your point, I think, is entirely correct, but

16 it's the way it's reflected in the risk register is how

17 I have described it, it's the translation of a disease

18 from one category to another category.

19 Sorry, I'm not sure I'm explaining myself very well.

20 **Q.** Sir Christopher, in your own witness statement you

21 accept that any new pathogen transmitted by the

22 respiratory route is likely to share characteristics

23 with influenza, in that it may spread rapidly via close

24 proximity --

25 **A.** Yes.

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

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

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1 Now, as I say, it may have been incorrect thinking
2 that "ready for flu, ready for anything", but that was
3 how we were -- or how it was being thought about, the
4 relationship between these two things, between the thing
5 that you want to contain and you try as hard as you can
6 to contain and is the policies and procedures that flow
7 out of this risk, and then what you were doing to try to
8 mitigate the effect of a disease for where these
9 approaches of containment have not worked.

10 Now, my final point --

11 **MR KEITH:** Please.

12 A. -- I do, and as we've discussed this within the
13 department, I think there is a very key issue for us
14 about the threshold between those two things. So there
15 has been a lot of discussion, rightly, of some of the
16 countries that handled Covid extremely well, such as
17 South Korea. Effectively what they had was a much
18 higher threshold of containment for HCID than we were
19 able to do, and that was the key difference.

20 So I do think what we are talking about points to
21 some of the key issues about the management of the
22 disease, of diseases. I don't actually think the risks
23 were identified incorrectly, and I do think those two
24 stages of you try and contain a new disease so that it
25 doesn't lead to a pandemic, and then if it does you try

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1 Q. Well, happily, Sir Christopher, in this process, I ask
2 the questions, so I can't answer your question,
3 I'm afraid.

4 A. Sorry. I'm sorry.

5 **LADY HALLETT:** Happily for you, Mr Keith.

6 **MR KEITH:** Happily for me.

7 Sir Christopher, one last question on this topic.

8 You have accepted now there was a flaw in the thinking.
9 Those three or four pages that my Lady has looked at
10 show quite clearly that on the one hand it was well
11 recognised that a non-influenza pathogen would be
12 unpredictable, potentially with catastrophic
13 consequences, that you couldn't say in advance what the
14 incubation period would be, what the transmissibility
15 would be, what the severity would be, that there was
16 a risk that it would be as deadly as an influenza
17 pandemic.

18 A. Yes.

19 Q. Was not that thinking obvious? You say it's now flawed,
20 but it was obvious at the time, wasn't it?

21 A. No, so let me be very clear indeed.

22 So the bit of this where we have adapted our
23 thinking is what I said earlier about the piece of
24 orthodoxy, which was "ready for flu, ready for
25 anything", as it were. So, as I say, the thinking at

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

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

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

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

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

3 **A.** Yes.

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

6 **A.** Yes.

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

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

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

15 **Q.** Was that --

16 **A.** So --

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

19 **A.** The work was not finished. So --

20 **Q.** Sorry, the work was not finished?

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

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

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

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

7 **Q.** All right. Sir Christopher, I'm going to interrupt,
8 I'm afraid, just to try to allow you to draw breath.

9 It's a very, very long answer.

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

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

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

22 **A.** Yes.

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

25 **A.** Yes.

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1 Our intention in 2019 was that we were working on
2 an update of the -- and a refresh of the influenza plan,
3 not a wholesale rewrite. There was not proposals for
4 new strategic thinking, but a refresh of the plan.

5 Those plans had not finished -- sorry, those -- that
6 work had not finished at the time that the pandemic
7 broke out.

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

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

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

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

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

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

5 **A.** Well, the plan makes an explicit reference to SARS.

6 I think it is correct that in the 2011 plan and in the
7 substantial work that was done post that, we were not
8 looking at the examples of some of the countries that
9 you mentioned in your opening statement.

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

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

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

24 **A.** Yeah.

25 **Q.** So why was there no reference or thought given to the
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1 successful and everyone is correct to point to them
2 on -- the scale at which they were able to carry that
3 out compared to the much lower scale of containment that
4 was based in our plans.

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

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

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

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

24 **A.** There was one -- before I do, I don't think it's the
25 case that we only had a generic plan for
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1 experiences of other countries who had been there before
2 us?

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

6 **Q.** Have you read the document?

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

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

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

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

23 So, as I say, the difference is not: were one set of
24 people thinking about containment and the other not? It
25 was the scale to which they were -- and I'd say very
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1 high-consequence infectious diseases, we only required
2 to have a generic plan by the National Risk Register,
3 but there was in fact an extensive programme of work led
4 by the NHS on how you deal with high-consequence
5 infectious diseases. So I don't think that word is
6 correct.

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

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

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

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

25 **A.** It was undoubtedly transferred in that we used the
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1 pandemic stockpile that we had built up for influenza in
 2 the early months --
 3 **Q.** Did the stockpile run out, Sir Christopher?
 4 **A.** We never nationally ran out of PPE. We were very short
 5 and we had significant logistical issues. The -- so the
 6 stockpile that we had built up was (inaudible) useful in
 7 the pandemic. Was it big enough for the pandemic that
 8 we had? It would have been much better were it to have
 9 been larger.
 10 **Q.** Were the --
 11 **LADY HALLETT:** Can I just interrupt there?
 12 **MR KEITH:** Yes.
 13 **LADY HALLETT:** I think a lot of medics would be surprised at
 14 your comment "we never nationally ran out of PPE".
 15 **A.** Yes, and I chose my words very carefully, and it's
 16 a debate we have had before. There were huge pressures
 17 on PPE and we had, as I said, significant challenges
 18 getting PPE to the right place. So the department has
 19 never said, and it would not be true to say, that in
 20 individual places there were shortages of PPE and people
 21 having to use not the right PPE. That's different from
 22 it having run out nationally. So, in terms of all the
 23 reports people make of the struggles with PPE and the
 24 right PPE in an individual place not being available,
 25 that was clearly true.

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1 **A.** No. And again, that is why I didn't put it on my list.
 2 **Q.** I believe that you've answered the question.
 3 **A.** Okay.
 4 **Q.** You'll have an opportunity in a moment, no doubt, of
 5 answering other questions on this.
 6 **A.** I'm sorry.
 7 **Q.** In relation to contact tracing on a mass level, or of
 8 quarantining, or of lockdowns, or any of the more severe
 9 social restrictions, were those capabilities that were
 10 designed in relation to an influenza pandemic?
 11 **A.** So wide-scale contact tracing was never part of the
 12 influenza plan, and lockdowns, as in legal lockdowns,
 13 they were not what we had planned for.

14 **Q.** No.
 15 Exercise Alice, to which you've referred --
 16 **LADY HALLETT:** Sorry, just before you go on, was there
 17 anything else you wanted to add earlier,
 18 Sir Christopher?
 19 **A.** Just on antivirals, obviously you can only stockpile
 20 antivirals that exist for diseases that you know about.
 21 So in that case I would absolutely defend stockpiling,
 22 where you do have antivirals that are relevant to
 23 a disease -- well, you can't stockpile, as I say,
 24 an antiviral that doesn't exist. So there were no
 25 antivirals for coronavirus, just like there was no

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1 **MR KEITH:** Sir Christopher, the stockpile which existed on
 2 1 January 2020 ran out. Obviously further PPE had to be
 3 procured --
 4 **A.** Yes.
 5 **Q.** -- but the stockpile for an influenza pandemic was not
 6 sufficient, was it?
 7 **A.** Well, the --
 8 **Q.** Was that stockpile sufficient, Sir Christopher?
 9 **A.** The stockpile was never intended to cover the whole of
 10 a pandemic, it was supposed to create a buffer while you
 11 ramp up production --
 12 **Q.** But you're the one who said the capabilities developed
 13 for influenza are transferable for use?
 14 **A.** Yeah, and the stockpile was transferred.
 15 Now, I did not, and this was a very deliberate
 16 answer to your question, I did not put PPE on my list of
 17 things that we transferred. While the stockpile we had
 18 was useful, and prevented us from running out of PPE at
 19 various points, there was a clear difference between the
 20 PPE we needed for this type of pandemic and the one we
 21 had built up, which is why I didn't put it on my list of
 22 transferables.
 23 **Q.** The antiviral medicine Tamiflu was a capability
 24 developed for influenza pandemic. Was that of any use
 25 at all in a non-influenza pandemic?

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

6 **MR KEITH:** Sir Christopher, with respect, has anybody
 7 suggested that we shouldn't stockpile antivirals?
 8 **A.** No.
 9 **Q.** The question to you was because you said "There are
 10 capabilities for a pandemic influenza that may be
 11 readily transferred to a non-influenza", I was asking
 12 you about what capabilities --

13 **A.** Sorry, yeah.
 14 **Q.** -- could not be transferred.
 15 **A.** I'm sorry if I misunderstood.

16 **LADY HALLETT:** Exercise Alice.

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

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

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1 scale.

2 Action 8: community sampling.

3 Action 9: develop a live tool or system to collect

4 data from MERS coronavirus contacts.

5 I appreciate this is a very broad question, but can

6 you say, in general terms, whether or not any of those

7 actions were actually pursued by your department

8 following the conclusion of Exercise Alice?

9 **A.** Yes, some of them were partially, but you are correct

10 that not all of them were completely. I should say that

11 was, of course, a test of our HCID mechanisms, not our

12 pandemic mechanisms.

13 **Q.** You referred to the experience of Asian countries. In

14 a lessons learned report after the pandemic, in

15 September 2020, do you agree that your own department

16 stated that it would have benefitted from a fuller

17 understanding of the response by Asian countries, which

18 might have enabled us to start building testing systems

19 earlier in January 2020?

20 **A.** Yes.

21 **Q.** Could we please have up INQ000057430.

22 This is a memo dated 27 March 2019 to

23 Professor Sir Chris Whitty, the Chief Scientific

24 Adviser, from your department, or the DHSC, headed "Pan

25 flu preparedness & high-consequence infectious disease

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1 please, INQ000184643, page 79:

2 "While it is a matter of judgement, the Department's

3 view is that the UK was better prepared for

4 health-related emergencies as a result of the work

5 conducted on EU Exit. For example, on supply, the

6 Department had a far deeper understanding of global

7 medical supply chains and stronger relationships with

8 industry, heightened stockpiles of critical medicines

9 and medical products which provided an increased

10 buffer ... and an improved emergency response function,

11 including provision for emergency logistics to mitigate

12 disruption ..."

13 So there is a reference there to supply chains and

14 emergency response function.

15 Do you agree that that sentence, those sentences in

16 that paragraph, if we could go back, please, to the

17 phrase "UK was better prepared for health-related

18 emergencies", is a proper and correct reflection of that

19 annex and the number, sheer number of workstreams for

20 pandemic planning that were paused or stopped?

21 **A.** Yes. Now, as I made clear in my statement, this is

22 entirely a matter of judgement, I could not, you know,

23 arithmetically prove. However, what we -- essentially

24 happened -- and I should say this was not -- this was

25 not a plan or a strategy, I'm merely trying to assist

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1 policy ..."

2 If you look at paragraphs 1, 2 and 3 they say this:

3 "You are aware that, following reorganisation and

4 re-prioritisation of DHSC work due to EU Exit no deal

5 planning, pan flu preparedness and high-consequence

6 infectious disease ... policy has moved to your

7 portfolio of responsibilities on a temporary basis."

8 Then there is a reference to corporate memory in

9 paragraph 2.

10 Then in paragraph 3:

11 "... Emma Reed and Clara Swinson agreed a range of

12 work related to pan flu and HCID that would be scaled

13 back or paused before this policy area transferred

14 across to you."

15 Then may we have, please, page 3.

16 This is an annex, annex A:

17 "Pan flu preparedness and HCID policy. Area of work

18 continuing, slowing or pausing as a result of EU Exit

19 prioritisation."

20 Sir Christopher, would you cast your eye down,

21 please, the left-hand side of that document, the column

22 "Work area", and broadly identify how many areas were

23 either stopped, reduced or paused, just broadly?

24 **A.** Quite a lot.

25 **Q.** In your statement at paragraph 416, could we have,

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1 with what happened. We stopped a whole load of work

2 which was about enhancing the flu plan and taking

3 forward chunks of the flu plan, and we -- and that's

4 clearly a negative, I'm not trying to imply that that is

5 not a negative -- and we added a whole series of generic

6 capabilities that we then used in the Covid response,

7 and my reflection on that is that the capabilities that

8 we built up as a byproduct of our no-deal Brexit work

9 were extremely valuable to us in the pandemic.

10 So, as I say, and just to be very clear, I am not

11 trying to suggest that reducing the work that you showed

12 earlier in some way enhanced us, it clearly didn't, it

13 was -- clearly in an ideal world, if you had all the

14 resources you want, you would do both, I am simply

15 saying, in the balance of weighing up, those

16 capabilities that I quote in my witness statement turned

17 out to be, in my judgment, more valuable than more work

18 on the influenza plan.

19 **Q.** Do you agree that the Exercise Cygnus report concluded

20 that the United Kingdom's preparedness and response in

21 terms of its plans, policies and capability were not

22 sufficient to cope with the extreme demands of a severe

23 pandemic?

24 **A.** Yes, that is what it found and, as I said earlier, there

25 was then a programme of work that followed Cygnus.

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

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

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

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1 compliant with that core recommendation from
2 Exercise Cygnus were not being completed or had been
3 stopped and that our country's system for preparedness
4 and response was imperilled?
5 A. I'm sorry, I'm not quite sure I understood the question.
6 Q. Did you express in a way that mattered your continuing
7 concern that the outcome of Exercise Cygnus was not
8 being addressed because the workstreams designed to
9 address it were being interrupted or had been stopped
10 altogether?
11 A. Well, they were decisions that were not taken lightly at
12 all, and our intention all along was, once we had come
13 out of the period when we had to plan for EU exit, that
14 those things would continue. I couldn't point you to
15 a thing I wrote on that subject, but that was our
16 expectation.
17 Q. Exercise Cygnus was a multi-phase exercise, a Tier 1
18 exercise, was it not?
19 A. Yes.
20 Q. It took place over two days, it was preceded by another
21 exercise, Exercise Cygnet, it involved more than
22 950 people, it was a serious test of the
23 United Kingdom's response capacity, and it largely
24 failed, did it not?
25 A. No, I don't think that's --

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

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

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

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

15 **A.** Yes, that's correct.

16 **Q.** 14 of 22?

17 **A.** Not been completed. A large number of those were
18 ongoing.

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

21 **A.** That's correct.

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

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

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

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

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

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

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

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

6 **Q.** Sorry?

7 **A.** That was not completed, no.

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

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

13 **Q.** Some meetings were held, were they not?

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

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

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

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

6 Were surgical gowns stockpiled?

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

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

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

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

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1 faces but the ones which were better off for black staff
 2 were purchased in much smaller quantity and there had
 3 been no provision for that in the post Exercise Cygnus
 4 pre-pandemic planning?
 5 **A.** Yeah, that is a finding that the department found during
 6 the pandemic and acted on during the pandemic, that is
 7 correct.
 8 **LADY HALLETT:** Mr Keith, sorry to interrupt, but I was asked
 9 to break at about half past or 25 to.
 10 **MR KEITH:** That's a convenient moment.
 11 **LADY HALLETT:** Thank you very much. I shall return at 3.55.
 12 (3.40 pm)
 13 (A short break)
 14 (3.55 pm)
 15 **MR KEITH:** Sir Christopher, it appears to be common ground
 16 that, insofar as your department considered, when
 17 planning for a pandemic, the potential impact on
 18 protected groups, ethnic minorities, vulnerable sectors
 19 of society, the marginalised, the position was that
 20 plainly a pandemic would have different impacts but that
 21 those impacts would be of a clinical nature, so
 22 a pandemic would affect those who have heart disease or
 23 diabetes or some other comorbidity in a different way to
 24 a healthier member of the population; is that correct?
 25 **A.** Yes. So when we've looked at what we did on equalities
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1 for or tested on vulnerable people, ethnic minorities or
 2 any sector of the population other than insofar as they
 3 may be affected clinically; is that correct?
 4 **A.** In the exercise programme, yes, I think that is correct.
 5 **Q.** So it's not right to say there was a lot of thinking
 6 about these issues then. There was no thinking about
 7 these issues then?
 8 **A.** Oh, sorry, I'm not explaining myself correctly. In
 9 wider health policy, there is a lot of thinking --
 10 **Q.** Of course.
 11 **A.** -- about health disparities, was my point. As I said,
 12 what there wasn't was that specifically in pandemic
 13 preparation.
 14 **Q.** My Lady's Inquiry is not into healthcare, it is into the
 15 planning for pandemics?
 16 **A.** Yeah, sorry, I --
 17 **Q.** Yes.
 18 **A.** As I say, I chose my words badly. I apologise.
 19 **Q.** It follows also, doesn't it, that at no time did the
 20 department ever obtain specialist advice on health
 21 inequalities and the implications of health inequalities
 22 on pandemic planning impacts and mitigation strategies?
 23 **A.** No, I don't think we ever commissioned advice on that,
 24 until actually during the pandemic, when of course we
 25 did a lot.
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1 beyond what we did for legal compliance, the focus was
 2 exactly as you say, it was on the clinical elements of
 3 inequality and how those would be impacted by a disease,
 4 that is correct.
 5 **Q.** It follows, does it not, that neither your department,
 6 nor, in fact, any pre-Covid exercise, considered the
 7 issue of how a pandemic in reality, or as part of
 8 a test, would impact vulnerable people or those with
 9 health inequalities or related factors, other than
 10 insofar as they may be impacted clinically?
 11 **A.** Yes, there is obviously a very large overlap between the
 12 two, as you heard from other witnesses.
 13 **Q.** Yes.
 14 **A.** There was a lot of thinking in the department, and still
 15 is, about the issues that you point to. They were, as
 16 you say, not thought of directly in the context of
 17 pandemic preparation. So there was lots of work on
 18 those areas, but I couldn't point you to specific parts
 19 of pandemic preparation.
 20 **Q.** Well, you say, "There was a lot of thinking in the
 21 department, and still is, about the issues that you
 22 point to". There was no thinking, was there, in the
 23 department, or as part of any single exercise between
 24 2007 and 2018, Exercise Pica, about the impact of plans
 25 or the pandemic or the response to the pandemic, planned
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1 **Q.** A bit late, Sir Christopher?
 2 **A.** Sorry, I'm not -- I am merely setting out -- I'm sorry,
 3 I'm merely setting out what happened.
 4 **MR KEITH:** I've no further questions, thank you.
 5 Would my Lady give me one moment?
 6 (Pause)
 7 My Lady, in relation to the Rule 10 process,
 8 I believe that whilst a number of questions were posed
 9 by one core participant, you have not provisionally
 10 indicated that any of them should be posed, and
 11 therefore, in light of that provisional indication, now
 12 that we've actually heard Sir Christopher, are you
 13 minded to confirm your provisional indication and not
 14 allow any further questions to be asked?
 15 **LADY HALLETT:** Unless there are any further submissions,
 16 yes, I am.
 17 **MR KEITH:** Thank you very much.
 18 Questions from THE CHAIR
 19 **LADY HALLETT:** May I ask a couple questions, please,
 20 Sir Christopher?
 21 **A.** Yes.
 22 **LADY HALLETT:** Roughly how many staff did you have to
 23 allocate to Operation Yellowhammer and the Brexit
 24 no-deal?
 25 **A.** I believe in total we allocated, in the process we were
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1 talking about earlier, approximately 70. I will have to
 2 go and confirm that, but I think it was about 70.

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

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

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

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

23 **LADY HALLETT:** Thank you.
 24 You said that, as a result of the pandemic, there
 25 are things that you would have done differently, with
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1 testing capacity that some of our European or other
 2 counterparts had.

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

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

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

16 **MR KEITH:** Thank you, my Lady.

17 **LADY HALLETT:** Thank you very much indeed, Sir Christopher.
 18 Sorry you have been so long in the witness box.
 19 **(The witness withdrew)**

20 **LADY HALLETT:** Yes, Ms Blackwell.

21 **MS BLACKWELL:** My Lady, the next witness is Clara Swinson,
 22 who I understand is in the process of being brought into
 23 the witness box.
 24 **(Pause)**
 25 **MS BLACKWELL:** Thank you, Ms Swinson, would you like to take
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1 the benefit of hindsight and whatever other element of
 2 judgement you may want to use. Can you give some
 3 practical examples of what you would have done
 4 differently if you had known what you know now?

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

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

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

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

23 Fifth, as I think has been widely reported, and
 24 I think Government Office for Science also made this
 25 point, we were short of testing, we did not have the
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1 the oath, please.

2 **MS CLARA SWINSON (affirmed)**

3 **Questions from COUNSEL TO THE INQUIRY**

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

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

8 **A.** Yes, Clara Jane Swinson.

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

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

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

18 **A.** Correct, it is.

19 **Q.** And it's true to the best of your knowledge and belief?
 20 **A.** It is.

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

23 **LADY HALLETT:** Yes.

24 **MS BLACKWELL:** Secondly, INQ000212314. Thank you.
 25 Is that your second witness statement?
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1 A. It is.
 2 Q. Again, is it true to the best of your knowledge and
 3 belief?
 4 A. It is, yes.
 5 Q. Thank you. We can take that down.
 6 I'm going to begin by setting out briefly
 7 an overview of your career history as it's relevant to
 8 the Inquiry.
 9 A. Okay.
 10 Q. You have been a senior civil servant since 2006, you are
 11 Director General within the Department of Health and
 12 Social Care, covering international health and domestic
 13 public health issues, and you have held that role since
 14 November 2016?
 15 A. Yes.
 16 Q. Since this appointment, you have reported to the
 17 Permanent Secretary, Sir Christopher Wormald, who has
 18 just given evidence?
 19 A. Yes.
 20 Q. You are a member of the DHSC executive committee and
 21 a senior sponsor for UKHSA, formerly PHE?
 22 A. That's right.
 23 Q. Thank you.
 24 You are responsible for three directorates,
 25 including the directorate on emergency preparation and

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

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1 health protection, to which we'll turn in a moment.
 2 A. Yes.
 3 Q. You're chair of the PIPP board, now newly renamed the
 4 Pandemic Preparedness Portfolio board, and you've
 5 been --
 6 LADY HALLETT: Why?
 7 MS BLACKWELL: Perhaps we'll come to that, my Lady.
 8 And you have been chair of the PIPP board since
 9 2017, until it was re-formed under its new name in 2022.
 10 You were also responsible for preparations for the
 11 EU exit?
 12 A. That's right, and if I could just add, I'm responsible
 13 for more than three directorates that you said at the
 14 start. My responsibilities have changed a little bit
 15 since 2016, for exactly -- but that is set out in my
 16 witness statement.
 17 Q. All right, thank you. You're responsible for
 18 international policy, bilateral relationships and health
 19 work on a multilateral basis?
 20 A. Correct.
 21 Q. For example, at the World Health Organisation, G7
 22 summit, et cetera?
 23 A. Yes.
 24 Q. Finally you are a UK senior official on the Global
 25 Health Security Action Group?

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

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1 Q. Does the directorate and does the organisation have
2 within it the capacity to upscale in the event of
3 a large emergency?

4 A. Yes. That would require resources across the
5 department, as happened in the Covid-19 pandemic.

6 Q. Right.

7 In terms of the pandemic preparedness programme,
8 I want to ask you some questions about the UK influenza
9 pandemic strategy of 2011, brought into force following
10 the Hine review and the recommendations within
11 Dame Deirdre Hine's report, and largely untouched until
12 the coronavirus pandemic hit. Because isn't it right,
13 Ms Swinson, that the coronavirus action plan published
14 in March 2020 drew very heavily on the 2011 strategy?

15 A. It is correct, yes.

16 Q. Right.

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

23 Do you agree with that?

24 A. The only plan in place, did you say?

25 Q. Yes, the only plan in place, the only strategy to be

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1 have reflected, and the new pandemic portfolio that you
2 referred to in the opening is a recognition that now we
3 are doing -- we would like the strategy to be along all
4 of the different routes of transmission, not just
5 a respiratory pandemic.

6 Q. So was that a mistake for it only to be limited to that?
7 Do you think in hindsight, and knowing what happened in
8 the intervening period, especially with other
9 coronaviruses across the world, that perhaps that should
10 have been drafted more widely?

11 A. I think it was a reasonable decision at the time.

12 I think it was in line with expert advice, and there was
13 not a response to it saying it should have been
14 extended. But clearly, knowing what we do now, as set
15 out, we are changing our approach to cover all the
16 routes of transmission.

17 Q. All right.

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

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

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1 followed and the only plan that was in place --

2 A. Yes. UK-wide. Obviously some other organisations had
3 their own plans but, yes, UK-wide it was -- the 2011
4 strategy was still existing.

5 Q. Right. Do you think, knowing what you do now, that
6 there was good reason for that plan to have been updated
7 between 2011 and when the pandemic hit?

8 A. So there were reasons to update it, for example, it was
9 before the 2012 Act, to be clear about roles and
10 responsibilities, and so on.

11 Q. Yes.

12 A. In terms of its overall approach in terms of the
13 principles, the main areas, there would have been some
14 things that were worth updating and refreshing --

15 Q. Such as what?

16 A. So, for example, you know, technology had changed
17 since 2011, vaccine manufacturing and so on, but the
18 basic premise of the plan, there was not a different
19 strategy that was in place that we needed to publish.
20 The basic premise of the principles is as set out in the
21 2011 plan.

22 Q. What about the fact that it only dealt with pandemic
23 influenza, what do you say about that?

24 A. Yes, I mean, that is, it flows from the National Risk
25 Register that you have been talking about today. We

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

15 Which he goes on to deal with.

16 It's right, isn't it, Ms Swinson, that the 2011
17 strategy did not include any plans for mitigation
18 measures such as lockdown, closing borders, stopping
19 mass gatherings or controls on public transport?

20 A. It's true what it says here and elsewhere in the
21 document, it says it's the working assumption that there
22 wouldn't be restrictions on some of the things you've
23 mentioned. It does say that there might be restrictions
24 on some mass events and some school closures, but the
25 working assumption is as set out, yes.

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1 Q. Other than mentioning those matters which you have just
 2 set out, there are no plans to mitigate, there is no
 3 discussion about the potential outcome of, for instance,
 4 controlling mass gatherings or closing schools, is
 5 there?
 6 A. There are a range of things to mitigate when one doesn't
 7 have medicines or treatments, so there is advice to
 8 people if they're unwell, for example, to stay at home,
 9 through to some of the more extreme measures that you've
 10 just mentioned. But yes, that is what is set out in the
 11 strategy.
 12 Q. All right. But there is no discussion of the impact of
 13 the imposition of those sorts of restrictions?
 14 A. There is no discussion of legally enforced stay at home,
 15 no.
 16 Q. What Professor Mark Woolhouse goes on to say is the lack
 17 of such measures is a striking deficiencies in the UK's
 18 pandemic preparedness. Do you agree with him?
 19 A. I'm not aware of any country that had a lockdown plan.
 20 Obviously it's what happened in the pandemic, and we,
 21 both in the department and across society, need to
 22 reflect on that. But it was not something that was in
 23 the UK plan or any other country that I'm aware of.
 24 Q. No, nor discussion of any of the other measures which
 25 we've set out. Other than mass gatherings and school

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1 said:
 2 "... I believe with the benefit of hindsight that
 3 our preparations ... were affected by an element of
 4 'groupthink'. By that I mean that the spread of many
 5 distinct types of virus could create a pandemic, yet our
 6 shared belief was that the most likely scenario was
 7 a pandemic flu."
 8 What do you say about that?
 9 A. So it's true that our expert advice was that pandemic
 10 flu was and actually continues to be the biggest risk.
 11 You've talked at some detail today about the range of
 12 other pandemics --
 13 Q. Yes.
 14 A. -- and I've explained how learning what -- from what
 15 happened that we wish to take -- setting out a different
 16 approach.
 17 I think a number of witnesses, experts have also set
 18 out in their statements for you that they think flu was
 19 a reasonable scenario, but clearly there was not
 20 different expert advice before the pandemic. Expert
 21 advice and our experience would now show that we should
 22 plan for a wider group of viruses.
 23 Q. Do you think there is a need for more robust challenge
 24 and diverse expertise or perspectives in terms of what
 25 may happen?

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1 closures, there is no discussion about any of the other
 2 mitigating impositions?
 3 A. In terms of social distancing?
 4 Q. Yes, in terms of closing borders, in terms of controls
 5 of public transport, that sort of thing; and what
 6 Mark Woolhouse is saying is the lack of that sort of
 7 information in the strategy is a striking deficiency.
 8 The question to you is: do you agree with that?
 9 A. The strategy did not have those things in it. I think
 10 that was reasonable at the time. It was not
 11 something -- there was a consultation on this document,
 12 for example. Clearly, as the pandemic occurred, actions
 13 that were taken in other countries, and then in the UK,
 14 did lead to legal restrictions on daily life.
 15 Q. Do you agree that the 2011 strategy also didn't plan for
 16 a whole-system effect, with wide-ranging impacts on
 17 society, the economy, public services, that sort of
 18 thing?
 19 A. Well, I believe it has a section on the whole-system
 20 effect, the fact that it would effect the whole of
 21 society, it would have societal and economic impacts, as
 22 set out in the strategy.
 23 Q. All right.
 24 Thank you, we can take that down.
 25 Jeremy Hunt in his statement to the Inquiry has

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1 A. So in terms of expert advice and groupthink, yes, there
 2 are, you know, a whole range of advisory groups which
 3 we've set out in our witness statements.
 4 Q. Yes.
 5 A. You've got evidence from the chairs of some of those.
 6 Both in terms of expertise in the UK, our Chief
 7 Scientific Advisers, and in terms of learning from other
 8 countries, you know, I don't think it was groupthink in
 9 a very small number of people, I think that is the case
 10 across the UK and for most of our European and American
 11 colleagues, or counterparts. Clearly, as Jeremy Hunt
 12 set out, learnings particularly from South East Asia and
 13 maybe expanding the expert input from what we've learnt
 14 now showed that there were some other ways of thinking
 15 about containment of a new novel disease and how to
 16 respond to it.
 17 Q. On that point alone, that could have been done, couldn't
 18 it, at some point past 2016, when it was recommended
 19 from the fallout of Exercise Alice that South Korea, for
 20 instance, should have been contacted and the way in
 21 which they responded to MERS could be analysed and
 22 the UK could take from that indications of how best for
 23 them to react in a similar position, but that wasn't
 24 done?
 25 A. I don't know whether -- I would be surprised if there

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

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

9 **A.** I'm not, no.

10 **Q.** No.

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

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

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

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

22 **MS BLACKWELL:** That needed to be removed?

23 **A.** Yeah.

24 **Q.** Right.

25 In any event, PIPP was the central DHSC led
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1 Exercise Cygnus?

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

6 **Q.** Yes.

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

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

10 **A.** Correct.

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

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

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

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

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

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

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

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

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

14 **A.** Since 2011, yes.

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

22 Can you confirm that the first four workstreams were
23 as follows: surge and triage, community care, excess
24 deaths, and sector resilience, and that those four
25 workstreams were themselves derived from the findings of
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1 "There should be a regular programme of tier 1
2 exercises to coincide with each new parliament and
3 ensure continuity in preparedness;

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

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

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

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

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

17 **A.** Yes, in terms of the exercise programme.

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

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

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

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

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

19 **Q.** Thank you.

20 Now, at some point during the life of PIPP, it began
 21 to create what are known as PIPP risk registers. You
 22 have been kind enough to provide to us the registers for
 23 2016, 2017, 2018, 2020 and 2021.

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

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1 whether there was a risk register tabled or not.

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

5 **A.** Possibly.

6 **Q.** Yes. All right.

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

9 **A.** They are detailed.

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

(Alarm)

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

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

(Alarm)

23 I'm going to continue.

24 **A.** Okay.

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

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

3 **Q.** Right.

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

8 **Q.** All right.

9 **A.** So I think they would have existed --

10 **Q.** In some shape or form.

11 **A.** -- from at least 2011, yes.

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

14 **A.** A gap of what, sorry?

15 **Q.** Well, we haven't been provided with the risk register
 16 for 2019. There is a two-year gap between 2018 and
 17 2020. Is there a reason for that?

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

22 **Q.** That was the EU exit?

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

24 **Q.** Yes.

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

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

3 **A.** Of course.

4 **Q.** Thank you.

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

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

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

18 **Q.** All right, thank you.

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

23 **A.** Yes.

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

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1 try and mitigate that risk?

2 **A.** Not from memory, no. There was work obviously arising

3 from Cygnus in terms of NHS surge. The risk registers

4 would also cover relative lower-level detail from teams

5 in terms of funding, resourcing, business cases and so

6 on.

7 **Q.** All right. So once that risk had been identified and

8 the rating had been given to it and an action had been

9 raised --

10 **A.** Yes.

11 **Q.** -- what would you expect to have taken place between the

12 time that that risk register had been drafted and the

13 following year when the next risk register was drafted?

14 In other words, would any action that had been taken be

15 carried forward to the next risk register in the

16 following year?

17 **A.** There should be, yes. It would depend obviously on

18 resourcing and priorities across the department. I also

19 note that the risk you pick up is a very large one that

20 has been identified, you know, over many years and it's

21 not that two or three actions would be able to be taken

22 forward in a six-month period that would completely

23 resolve it. It would be completely normal that the risk

24 registers were highlighting major issues that were red,

25 or marked red, and would be very difficult things to

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1 mitigating that risk?

2 **A.** The risk being NHS surge?

3 **Q.** Yes, health and social care capacity.

4 **A.** Sure.

5 So it would be made up of, you know, a whole range

6 of things. There were some things that we did -- for

7 surge capacity, you both want to -- or the options are

8 both to decrease demand and they're to increase

9 capacity. So for example in their draft Pandemic Flu

10 Bill, we prepared powers to have regulatory easements on

11 the demand side, for example from CQC, the regular --

12 the Care Quality Commission, sorry -- and to increase

13 capacity, so in order to bring -- be able to bring back

14 workforce who might have been recently retired or hadn't

15 kept up their registration.

16 **Q.** Yes.

17 **A.** So that those are two examples. You would need

18 obviously, both on scale and number, to have, you know,

19 a whole range of things, but that's one example of the

20 work that we did take forward on the draft legislation.

21 **Q.** In terms of surge capacity of staff, apart from

22 acknowledging that that was something which would need

23 to happen in order to mitigate the risk --

24 **A.** Yes.

25 **Q.** -- were there any practical arrangements made, as far as

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1 change.

2 **Q.** All right. Well, I think you know where I'm going: the

3 same risk is present in 2017 and 2018, and in 2018 in

4 relation to this it confirms that the plans have not

5 been fully tested and that is still an issue.

6 Now, I'm going to skip over 2019 because, as we've

7 established, we don't have the risk register for that

8 year. But in 2020, December 2020, that risk is still

9 present: that the health and social care system may be

10 unable to cope in the event of a pandemic.

11 What, if at all, is the interconnection between that

12 being raised as one of the issues in the risk register

13 and the recommendations that we see in Exercise Cygnus

14 that there may be concerns about surge capacity

15 particularly in health and social care? Is there

16 a connection between the two? Did one formulate the

17 other, or what?

18 **A.** Yes, I -- I think there's a link between the two.

19 **Q.** Yes.

20 **A.** I mean, I think that risk, that probably existed before

21 the recommendations of Cygnus. It's a risk that

22 I think, as I say, would never be completely mitigated

23 with full confidence.

24 **Q.** Are you able to say over the period of time between 2016

25 and 2020 what actions were completed in terms of

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1 you are aware, that were in place by the time that Covid

2 hit, relating to that surge capacity of staff?

3 **A.** So I would say surge is a spectrum, there are things

4 that the NHS does every year to surge; in winter to open

5 new wards, for example, for parts of the year. Of

6 course in terms of the overall funding and capacity of

7 the NHS, that was something that was looked at in

8 exactly the time period you're talking about, in terms

9 of the spending review, the funding, both for workforce

10 and for beds and capacities. So there would have been

11 things both on the large scale --

12 **Q.** Yes.

13 **A.** -- in terms of overall capacity and, as I say,

14 preparations, for example, on legislation.

15 **Q.** Right.

16 Well, in relation to the progress of implementing

17 the Cygnus recommendations relating to social care,

18 could we look at, please, INQ000057522. Can we go to

19 page 14, please. Thank you. If we look at the entry

20 just below the mid-line, it's LI18:

21 "A methodology for assessing social care capacity

22 and surge capacity during a pandemic should be

23 developed. This work should be conducted by DCLG, DH

24 and Directors of Adult Social Services ... and with

25 colleagues in the devolved administrations."

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

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

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

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

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

20 **A.** That's fair, yes.

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

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

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

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

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

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

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

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

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

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1 **A.** Yes.

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

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

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

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

23 **Q.** Thank you.

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

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1 **Q.** Yes.

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

5 **Q.** Which is to be commended, yes.

6 **A.** -- it completely reflects that feedback.

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

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

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

25 **Q.** Yes.

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

4 Q. Thank you.

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

12 A. Okay.

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

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

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

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1 now being considered?

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

4 Q. Yes.

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

13 Q. Yes.

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

16 Q. Thank you.

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

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

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1 diseases.

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

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

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

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

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

4 A. Yes, I do.

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

6 A. In terms of the assumptions about PPE, before the
7 pandemic there were a number of assumptions that turned
8 out not to be the case. It was never the case that the
9 assumption was that it would be above business as usual
10 volumes, so it would be an additional stockpile for
11 people to draw on, but that business as usual stocks
12 would continue.

13 Clearly, because of the global demand and in fact
14 the pandemic starting in China and there being lockdowns
15 there, and that's where a lot of the manufacturing was,
16 that the overall supply chain collapsed.

17 So that was one assumption.

18 The behavioural use and the fact that the other --
19 a second assumption is that PPE would be used just for
20 symptomatic patients.

21 Q. Yes.

22 A. Actually very much more was needed in Covid-19, as we've
23 set out I think in Chris Wormald's statement number 6 or
24 7, as it is now -- it was used in the pandemic for
25 asymptomatic -- for all health and care, and so the volumes

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1 were very, very much greater than we had ever assumed.
 2 **Q.** Was one of the problems in planning in this way a lack
 3 of data? The reason that I ask you that is, returning
 4 to the ORC lessons learned review which we have already
 5 touched upon, there is a statement in there as follows:

6 "There was insufficient data available to consider
 7 equality issues around PPE provision. A retrospective
 8 equality impact assessment is now being undertaken and
 9 will help address these concerns."

10 **A.** Yes, and my apologies, because you asked about the
 11 different types of face masks --

12 **Q.** Yes, yes.

13 **A.** -- that is something that definitely came out in wave 1.
 14 Kevin Fenton from Public Health England --

15 **Q.** Yes.

16 **A.** -- carried out a review. It was evident in the first
 17 few months that that is something where there were not
 18 enough different types of face mask, and that is
 19 something both in business as usual and in our
 20 stockpiles of course we need to make sure are covered in
 21 future, now and in the future.

22 **MS BLACKWELL:** Right. Thank you very much.

23 Those are all the questions which I have for
 24 Ms Swinson. Would you excuse my back, my Lady.

25 (Pause)
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1 cross-cutting research and development which would help
 2 to address a range of different pathogens or diseases at
 3 the same time.

4 Finally, Professor Sir Peter Horby of NERVTAG and
 5 Dr Miles Carroll of the PHE were members of these
 6 prioritisation committees.

7 Now, at the time of their publications, would you
 8 have read those reports?

9 **A.** I had not read those reports, no.

10 **Q.** You've not read them.

11 **A.** I have, they were in -- the 2017 I think was in my
 12 witness bundle, I'm aware of what it is and aware of
 13 some of the work flowing from it, but I don't think that
 14 I had read that at the time.

15 **Q.** Would any of the information in those reports have been
 16 brought to your attention at the time?

17 **A.** So, in terms of the research that the UK would do, that
 18 isn't just my job, but in terms of the department, and
 19 in fact the Foreign and Commonwealth Office, where we
 20 would prioritise research funding, that would definitely
 21 be brought to the government's attention, and indeed the
 22 government took some actions that I think do link back
 23 exactly to the research and development blueprint.

24 **Q.** Right. But in terms of your role and in the course of
 25 your role as Director General in the DHSC, how important

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1 In the usual way, I think my Lady has provided
 2 a provisional consent for certain questions to be asked,
 3 and I will turn to Ms Munroe King's Counsel to ask those
 4 questions if, my Lady, that is appropriate.

5 **LADY HALLETT:** Yes.

6 **MS BLACKWELL:** Thank you very much.

7 **LADY HALLETT:** Ms Munroe, thank you.

8 Questions from MS MUNROE KC

9 **MS MUNROE:** Thank you.

10 Good afternoon, Ms Swinson. My name's
 11 Allison Monroe and I represent Covid Bereaved
 12 Families UK. Just a few questions.

13 In relation to the World Health Organisation
 14 research and development blueprint reports, we don't
 15 need to have these brought up, but for reference,
 16 my Lady, they are found -- the 2017 report is at
 17 INQ000149108.

18 Just to contextualise those reports for you,
 19 Ms Swinson, the 2017 and the 2018 reports, the WHO
 20 Research and Development Blueprints, as they're called,
 21 determined that there was an urgent need for research
 22 and development into MERS and SARS and other highly
 23 pathogenic coronaviral diseases.

24 The 2018 Blueprint report also prioritised
 25 Disease X, and both reports noted the importance of
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1 would those documents, those reports -- because they
 2 talk about prioritising --

3 **A.** Absolutely.

4 **Q.** -- in particular MERS and SARS.

5 **A.** Yes. So the Chief Scientific Adviser in the department
 6 is the DG level responsible for our research and
 7 development. I think these are very important documents
 8 for all countries, because they list the diseases where
 9 there could be a major public health international event
 10 and where there is not a pipeline or incentives on
 11 industry currently to have -- to develop vaccines,
 12 therapeutics or diagnostics. So that would have been,
 13 I'm sure, within our Chief Scientific Adviser and our
 14 Foreign Office, Chris Whitty, through the chair of the
 15 UK Vaccine Network, for example, had prioritised
 16 a list -- which was not identical to the WHO one but had
 17 similarities -- for where to invest research into
 18 vaccines.

19 **Q.** From those answers, am I to gather, then, that in terms
 20 of the work and strategies of your own department,
 21 a prioritisation in terms of research and development of
 22 MERS and SARS and Disease X would not be something that
 23 you would have done or prioritised?

24 **A.** No, I don't think that's correct. The UK Vaccine
 25 Network prioritised a vaccine into MERS that became the

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1 Oxford/AZ platform. I think most of the research would
2 be funded by overseas development assistance money, ODA
3 money, and that is -- there is some in the Department of
4 Health and also in the Foreign and Commonwealth
5 Development Office.

6 **Q.** I'm more thinking at the time of their publication,
7 though, 2017 --

8 **A.** Yeah.

9 **Q.** -- and 2018 in terms of research and development and
10 particularly this question of prioritising those
11 diseases. Was that part of the strategy of your
12 department at all?

13 **A.** It was, in terms of prioritising research and
14 development, where there are very substantial budgets
15 across government, both in the Department of Health and
16 in the Foreign and Commonwealth Office and DfID, yes,
17 that would have been taken into account.

18 **Q.** Right.

19 These reports also agreed on the value, where
20 possible, of developing countermeasures for multiple
21 diseases or for families of pathogens.

22 What, if any, action did your department take in
23 relation to this and how was that monitored?

24 **A.** So I've given one example, which is the research and
25 development funding that went to Oxford on the MERS

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1 **A.** Yes. So for the high-consequence infectious diseases,
2 the risk that you were discussing earlier on an emerging
3 infectious disease, obviously was based -- or the
4 scenario was a SARS or MERS type of coronavirus. But in
5 terms of other threats listed there, there would be some
6 that would be very relevant for the UK; there would be
7 others on that list that would be much more likely to
8 have -- to occur in other bits of the world, and I think
9 Sir Chris Whitty's statement sets out those diseases in
10 part of his statement.

11 **Q.** But the question was: how were they reflected in the
12 national risk assessment?

13 **A.** So they would have -- so the type of diseases which had
14 a potential for international spread, a public health
15 event of emergency concern, as the WHO calls it, would
16 be reflected in the emerging infectious disease risk
17 that went on a Covid/SARS/MERS scenario.

18 **Q.** Finally, was NERVTAG asked to comment on the blueprint
19 at any point, either the 2017 or the 2018 WHO blueprint
20 reports?

21 **A.** So those reports were, and the process was run by the
22 World Health Organisation, they brought together
23 an expert group to do so. I think it was from
24 individuals rather than groups, so I don't think NERVTAG
25 themselves would have been asked, but that would have

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1 vaccine. We would have to look further for others. As
2 I say, that would be through our Chief Scientific
3 Adviser, both in the department and the network across
4 government.

5 **Q.** Can you assist on this, please: what, if any, action was
6 there taken to update the UK's list of high-consequence
7 infectious diseases to include Disease X or highly
8 pathogenic coronaviral diseases following those reports
9 in 2017 and 2018?

10 **A.** So the high-consequence infectious disease list is kept
11 under review by groups or the Chief Medical Officer, the
12 Medical Director of the NHS, and the Advisory Committee
13 on Dangerous Pathogens. It's not a static list, it does
14 change. It is pathogens that actually exist, and
15 there's quite a long list.

16 Disease X, as you have put in your question, is the
17 idea of a novel pathogen that would arise. Clearly you
18 need to do research into a whole -- have flexible
19 research in order to be able to respond to a pathogen
20 that doesn't yet exist.

21 **Q.** In terms of the findings from those two reports from
22 2017 and 2018, to what extent were they considered or
23 reflected in the national risk assessment, in
24 particular, again, going back to this point about the
25 prioritisation of SARS and MERS?

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1 been up to the World Health Organisation.

2 **Q.** But from your perspective within your department,
3 obviously there are individuals such as we mentioned at
4 the beginning Professor Horby, who was a member of
5 NERVTAG, who is also part of that prioritisation
6 committee for the research and development blueprint.

7 So following from that, he is a member of that
8 committee, he is a member of NERVTAG; would NERVTAG, as
9 a group themselves, be discussing the findings and the
10 observations of the report?

11 **A.** You would have to check with NERVTAG themselves.

12 **MS MUNROE:** All right. Thank you very much, Ms Swinson.

13 Thank you, my Lady.

14 **LADY HALLETT:** Thank you, Ms Munroe.

15 **MS BLACKWELL:** That concludes the questioning for
16 Ms Swinson, and indeed today's business.

17 **LADY HALLETT:** Thank you very much indeed.

18 Thank you very much for your help, Ms Swinson, sorry
19 again for the delay.

20 **(The witness withdrew)**

21 We will start again tomorrow at 10 o'clock.

22 **MS BLACKWELL:** Thank you, my Lady.

23 **(5.05 pm)**

24 **(The hearing adjourned until 10 am**

25 **on Tuesday, 20 June 2023)**

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