

Tuesday, 27 February 2024

(10.00 am)

(Proceedings delayed)

(10.10 am)

Opening remarks by THE CHAIR

LADY HALLETT: Good morning. Do we still have a problem?

MR POOLE: No, my Lady, it's been resolved.

LADY HALLETT: Thank you very much.

Good morning, everyone here with us at the hearing centre in Cardiff and to those who are following online.

We are holding the hearings on the outskirts of Cardiff, which I know is not ideal for everyone, but our priority was to get these hearings on, and we have provided transport for those who need it to and from the city centre, and I'm sure that we shall be well looked after here at the hotel, and the team, the Inquiry team and the staff here, will do their utmost to ensure that every possible need is catered -- well, maybe not every possible need, but most needs are catered for.

Today we begin the substantive hearings into Module 2B, core decision-making in Wales. I know that some had hoped for an independent Welsh Inquiry, but that, as everyone knows, is not a decision for me. I can promise, however, that the UK Inquiry will do its utmost to investigate and analyse fully and fairly the

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to make oral submissions today. Tomorrow we shall begin with the evidence. We start with the evidence of some of those who were most impacted by the pandemic.

So I shall now pause, if anybody present in the hearing room wishes to leave, and those online can press pause.

(Pause)

Thank you. Could we now play the impact film, please.

(Video played)

LADY HALLETT: Thank you. We shall now resume the hearing, streaming of the hearing. As I said, extremely moving.

Mr Poole.

**Opening statement by LEAD COUNSEL TO THE INQUIRY for
MODULE 2B**

MR POOLE: The Inquiry turns today to its examination of the Welsh Government's core political and administrative decision-making in relation to the pandemic in the period between January 2020 and May 2022.

The purpose of this opening statement is to first explain the scope of this module, Module 2B, how it picks up where Module 1 left off, and how it links to and intersects with Module 2.

Second, to provide some context to the evidence that your Ladyship will hear regarding the stark reality of

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most significant issues that concern the people of Wales.

It's probably appropriate that we begin these hearings in Wales in a week that includes St David's Day, but also includes the National Day of Reflection, on Sunday, when we remember those who lost their lives during the pandemic. And it is because we have to remember those who died and those who suffered that the Inquiry has impact films at the beginning of each module, and we shall begin this module in the same way, with an impact film where people describe their suffering.

It is extremely moving, as its predecessors were, and it reminds us all why we are here. It lasts for about 20 minutes or just over, so if you do not want to watch the impact film, and you're following online, please press pause. If you're here with us in the hearing room, please leave, and we'll make sure you have proper notice, when the film is concluded, to come back into the room.

After the impact film has been played, Mr Tom Poole King's Counsel, Leading Counsel to the Inquiry for this module, will explain the issues that we shall be examining during the course of the next three weeks, and he will be followed by those core participants who wish

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the pandemic in Wales.

Third, summarise but not repeat the evidence that the Inquiry has already heard in Modules 1 and 2, both the context and also substance, and also for the benefit of those who might be turning to the Inquiry for the first time today.

Fourth, to give a narrative chronology of key events and decisions that impacted on Wales during the pandemic.

And finally, to highlight some of the key issues that will be explored in evidence over the next three weeks here in Cardiff.

So the scope of this module.

In these hearings, the Inquiry will analyse the core decisions which were taken in the discharge of the Welsh Government's duty of protecting the lives of the people of Wales. In so doing, we will enquire into, probe and challenge these core decisions to see if they were made on the best information, after proper consultation, as part of a well ordered process, and without undue delay or unnecessary prevarication.

As part of this Inquiry, we will be looking at the threat posed to the people of Wales, not just the threats of harm and actual harm caused by the virus, but also of the countermeasures adopted by the

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1 Welsh Government designed to protect against them.
 2 We will question key decision-makers, including the
 3 First Minister, and other members of the Welsh Cabinet,
 4 and the advice received from political and scientific
 5 advisers that informed Wales' strategic response to the
 6 crisis that wrought devastation across the country.
 7 In Module 1, the Inquiry considered the state of the
 8 UK's emergency preparedness, response and resilience
 9 structures at the time just before Covid arrived in
 10 the UK, in January 2020. Module 1 covered the role that
 11 both the UK Government and the Welsh Government had in
 12 planning for a civil emergency such as the pandemic.
 13 The question posed in Module 1, namely whether the right
 14 groundwork had been laid and the extent to which civil
 15 contingencies framework anticipated a pandemic of this
 16 nature, was not only a necessary prior question but one
 17 that provides important context for the decisions which
 18 the Welsh Government had to make as the pandemic took
 19 hold.
 20 In Module 2, the Inquiry examined the effectiveness
 21 of the UK Government's strategic response to the
 22 pandemic. In so doing, the Inquiry received detailed
 23 evidence from government ministers, senior civil
 24 servants and other advisers relating to key
 25 UK Government decisions which had both direct and

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1 Module 2, but will draw upon that evidence and seek to
 2 look at key aspects of the interrelationship between
 3 the UK and Welsh Governments insofar as relevant to the
 4 Welsh Government's strategic response to the pandemic.
 5 The more detailed scrutiny of the Welsh NHS
 6 response, the care sector, children and education,
 7 shielding, vaccines, PPE, procurement, test and trace,
 8 financial and business support, and many other matters,
 9 is for later modules. However, the general
 10 epidemiological flow of the pandemic, the spread of
 11 infection, death and morbidity caused in its wake and
 12 the core high level political decisions which were taken
 13 by the Welsh Government to try to combat the virus will
 14 be examined in detail in this module.
 15 Of course, there will be exploration of the broad
 16 reasons why core decisions were taken or not taken in
 17 such fields as health, social care and education, but
 18 the detailed examination of the merits of that process
 19 and of the operational impact of such decisions is
 20 outside the scope of this module.
 21 How is the Inquiry to measure how well the
 22 Welsh Government discharged its duty of safeguarding the
 23 life and health of its citizens? The virus left in its
 24 wake of course not just death but injury, incalculable
 25 hardship and misery, as those heartfelt and horrendous

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1 indirect effects on the management of the pandemic in
 2 Wales.
 3 This module, Module 2B, is focused on the
 4 decision-making of the Welsh Government, which was the
 5 predominant means by which the pandemic was managed here
 6 in Wales. It would be artificial, however, for the
 7 evidence of Welsh ministers and their advisers to be
 8 heard in complete isolation. The reality of the
 9 devolution settlement, coupled with the sweeping nature
 10 of the pandemic which affected all aspects of society,
 11 resulted in both the UK and Welsh Governments having
 12 control over the management of the pandemic in Wales.
 13 Though this module's predominant focus will be on
 14 the evidence of Welsh ministers and their political and
 15 scientific advisers, an examination of the management of
 16 the pandemic in Wales will entail an examination of the
 17 Welsh Government's perspective on key decisions and
 18 structures within the UK Government, as well as
 19 an analysis of intergovernmental structures and
 20 relations between the four governments of the UK.
 21 To an extent, this has already been examined with
 22 the UK Government ministers and experts in Module 2, but
 23 this module will also examine specific aspects of
 24 intergovernmental relations. My Lady, this will not be
 25 a re-run of the evidence heard by you already in

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1 recollections of a few moments ago remind us.
 2 However, if the protection of life is the
 3 pre-eminent duty which every government owes to its
 4 people, then the numbers of those who died is the marker
 5 against which the Welsh Government's response must be
 6 judged. This is the simple metric which matters most.
 7 Death was the inevitable consequence of a runaway
 8 high-consequence infectious disease and prevention of
 9 death should arguably have been the Welsh Government's
 10 primary obligation.
 11 The number of deaths across Wales, calculated by
 12 whether Covid-19 is mentioned on the death certificate,
 13 is now over 12,300. That is by any measure a shocking
 14 figure and a terrible loss of life. The testimonies
 15 which we have just heard remind us that each represents
 16 the loss of an individual, often in circumstances that
 17 made their death even harder to bear for their families
 18 and friends, and which multiplied their grief many times
 19 over.
 20 Such loss of life demands the question: did it have
 21 to be that way? That question must be enquired into and
 22 answered by this Inquiry. Those who suffered infection,
 23 hardship and bereavement in Wales, of whom there are
 24 very many in number, are absolutely entitled to nothing
 25 less.

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1 The consequences of the lockdowns were of course
2 grievous too. In societal terms there was an explosion
3 of mental health disorders, an entire generation of
4 educational prospects were harmed, and pre-existing
5 societal inequalities were seriously exacerbated.
6 Non-Covid health conditions went untreated and
7 undiagnosed. In economic terms, there was a 10% fall in
8 GDP in 2020, public finances were severely damaged and
9 massive debts were incurred. Were these dreadful
10 consequences avoidable?

11 A related vital issue in this module is the position
12 of the vulnerable and at-risk groups and the extent to
13 which the Welsh Government assessed the likely impacts
14 upon them of its contemplated non-pharmaceutical
15 interventions. Given the importance of this issue and
16 because it lies at the core of this module, I introduce
17 it now and will return to it later.

18 How was the danger to health posed by the virus
19 weighed up against the risk of societal and economic
20 damage to vulnerable and at-risk groups? To what extent
21 was the possibility of serious long-term health
22 consequences arising from the imposition of NPIs
23 foreseen and addressed?

24 My Lady, tomorrow you will hear from representative
25 witnesses of Covid Bereaved Families for Justice Cymru,

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1 Dr Robert Orford, Wales' Chief Scientific Adviser for
2 Health, and Dr Andrew Goodall, former permanent
3 secretary of the Welsh Civil Service and NHS Wales'
4 chief executive.

5 As I will come to deal with in more detail later,
6 Wales formed its own scientific and technical advisory
7 group in late February 2020, the Technical Advisory
8 Group, known as TAG, supported by the Technical Advisory
9 Cell, known as TAC. TAG comprised a number of
10 scientific and technical experts who provided scientific
11 advice and guidance to the Welsh Government in response
12 to the pandemic. The Inquiry has obtained statements
13 from a number of them, some of whom also sat on UK
14 advisory groups such as SAGE, SPI-M, and SPI-B, about
15 which your Ladyship has already heard evidence in
16 Module 2.

17 Later this week your Ladyship will hear oral
18 evidence from a number of TAG members, including experts
19 in the fields of epidemiology, modelling, behavioural
20 science and public health.

21 With that introduction, may I now say something
22 about the stark reality of the pandemic in Wales?

23 Could we please have INQ000412042 on the screen,
24 please.

25 These first charts from the official Covid dashboard

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1 you will hear evidence relating to the impact of the
2 pandemic from organisations and individuals such as the
3 Disability Rights Taskforce, Race Council Wales, the
4 Children's Commissioner for Wales and the Older People's
5 Commissioner for Wales. Their evidence will address
6 pre-existing structural inequalities that vulnerable and
7 at-risk groups faced before January 2020 and the
8 exacerbation of those inequalities caused by the
9 pandemic and the measures taken to combat it, in
10 particular the lockdowns.

11 I've referred to the Welsh Government's core
12 decision-making, and I must emphasise that the focus of
13 Module 2B is on the important strategic decisions that
14 were made, in essence the Cardiff Bay decision-making
15 that had the potential for the widest effect, had the
16 greatest impact, and which caused the greatest public
17 concern.

18 To this end your Ladyship will be hearing from key
19 decision-makers, such as the First Minister,
20 Mark Drakeford, the former health and social services
21 minister, Vaughan Gething, and a range of scientific
22 advisers. These will include senior figures from Public
23 Health Wales, a key body in Wales' public health
24 response to the virus. You will also hear from
25 Sir Frank Atherton, Wales' Chief Medical Officer,

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1 show deaths where Covid-19 was mentioned as one of the
2 causes of death on the death certificate for Wales and
3 the whole of the UK. As the top chart shows, in Wales
4 the peak of the first wave was 12 April 2020, with
5 73 deaths occurring on that day, the peak of the second
6 wave was 11 January 2021, with 83 deaths, smaller waves
7 occurred from late 2021 onwards, the highest peaking on
8 15 September 2021, with 21 deaths.

9 We can have the following chart, please.

10 Based on ONS data, this shows all the deaths that
11 occurred in Wales, not just caused by Covid. The grey
12 area shows those deaths not involving Covid. The blue
13 area shows the number of deaths involving Covid, and
14 then the combined areas show the total deaths at that
15 time in Wales. The black dashboard line is the
16 five-year average for that period. So the areas of the
17 graph, both colours, above that black dashed line
18 indicate excess deaths, in other words the increased
19 number of weekly deaths that could have reasonably been
20 expected had the pandemic not happened.

21 As this chart shows, the peak of deaths in the first
22 wave was considerably higher, reaching almost 1,150
23 a week, nearly 73% more than the five-year average.

24 Having said that, the peak was only slightly lower
25 in the second wave, but it lasted for a longer period,

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1 leading to over 900 more excess deaths in the second
2 wave than the first wave.

3 We can have the next chart, please.

4 These charts show the daily count of how many Covid
5 patients were in hospital across Wales in the UK from
6 1 April 2020.

7 In Wales, the peak of the first wave was the week
8 commencing 15 April 2020, with 884 patients in hospital,
9 150 of them in mechanical ventilation beds.

10 The peak of the second wave in Wales was the week of
11 13 January 2021, with 1,949 patients in hospital.

12 In the same week, Wales hit the peak of mechanical
13 ventilation beds, with 145 people intubated and
14 ventilated due to severe Covid.

15 Now, it's important to note that these graphs do not
16 show the number of staff per bed or how many empty beds
17 were available to take all of these patients, but, as we
18 can see on the charts, the Omicron variant led to
19 further large peaks in hospitalised patients as high as
20 1,059 on 13 April 2022, although far fewer of these
21 patients needed admission to ICU or died of Covid than
22 in the initial waves.

23 Up to September 2022 there were 41,839 Covid-related
24 admissions across Wales. That figure is now well in
25 excess of 43,000.

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1 It also identifies people with no symptoms, who account
2 for more than a third of those infected. It did not
3 start reporting data until after the first wave was
4 over, and antibody surveillance has shown that
5 approximately 6% of the UK population had been infected
6 by July 2020, ten-fold higher than the reported positive
7 tests.

8 Results were available for England in May 2020, for
9 Wales in early August, and for Northern Ireland in
10 September and Scotland in October. These were all shown
11 by the coloured arrows.

12 Despite what we saw on the previous chart, at the
13 peak of the second wave, there were probably over 44,000
14 people infected in Wales, and at the peak of the Omicron
15 wave, namely 29 December 2021, it was around 160,000
16 people.

17 The ONS have also published an estimate that
18 1.7 million people in total across Wales were infected
19 from the time they started the survey until
20 February 2022. This equated to 56% of the Welsh
21 population, and many more have been infected since.

22 My Lady, you will hear evidence later this week from
23 Professor Ian Diamond, the UK's National Statistician
24 and Stephanie Howarth, Chief Statistician at the Welsh
25 Government, who will present evidence relating to the

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1 We can have the next chart, please, which shows the
2 reported number of new infections per day across Wales
3 and the whole of the UK.

4 As can be seen, the peak of the first wave in Wales
5 was 9 April 20, with 391 newly confirmed cases.
6 However, under-reporting of cases was particularly
7 severe in the first wave and, as with excess deaths,
8 we'll explore the limitations of this data in evidence
9 later this week.

10 The Alpha variant first emerged in Kent around
11 September 2020 and by the time of the peak of the second
12 wave in Wales it was responsible for the vast majority
13 of infections nationally. The next wave, primarily of
14 the Delta variant, peaked on 14 July 2021 in Wales with
15 1,206 confirmed cases.

16 That was followed by the huge Omicron wave which in
17 Wales peaked on 29 December 2021 with 16,252 confirmed
18 cases. It is worth noting that by this time around 7.5%
19 of confirmed cases were thought to be reinfections.

20 We can have the next chart, please.

21 This shows the results of the ONS Infection Survey
22 for England, Wales, Scotland and Northern Ireland. It
23 gives a much more accurate estimate of the true
24 proportion of the population who are infected with the
25 virus at that time by taking a representative sample.

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1 way the pandemic affected Wales, the number of
2 infections and deaths, the way that infection and death
3 rates ebbed and flowed over time and the way that the
4 pandemic affected different sectors of Welsh society
5 differently.

6 Their evidence will expand on the summary I've
7 sought to give and provide a more detailed analysis of
8 the data and what it tells us about the devastating
9 impact of the pandemic on the people of Wales.

10 I will in due course present a summary of the
11 evidence which the Inquiry has gathered so far
12 concerning the key events and decisions taken in the
13 management of the pandemic in Wales, but before doing so
14 I propose to summarise some of the key evidence already
15 heard by the Inquiry which forms the backdrop to the
16 evidence which we will hear in this module.

17 Whilst doing my best to avoid unnecessary
18 repetition, I'm also sensitive to the fact that some
19 core participants and members of the wider public
20 audience here in Wales might well be tuning into the
21 Inquiry for the first time and therefore not have had
22 the context of other evidence which did not have a Welsh
23 focus.

24 Module 1, preparedness evidence.

25 As already mentioned, in Module 1 the Inquiry

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1 considered the state of the UK's emergency preparedness,
2 response and resilience structures prior to the arrival
3 of the virus in January 2020. Module 1 considered the
4 whole of the UK, looking both at UK-wide systems for
5 handling an emergency, which also applied to Wales, but
6 also the systems which existed within Wales.

7 Module 1 heard detailed Welsh-specific evidence,
8 including from the First Minister, the former Minister
9 for Health and Social Services, the director for local
10 government in Wales, and the Chief Medical Officer for
11 Wales.

12 As evidence in Module 1 showed, there was prior to
13 the pandemic no Welsh National Risk Register to take
14 into account the specific circumstances in Wales.

15 Although the risk of pandemic influenza was included in
16 the risk register of the Welsh Government's Health and
17 Social Services Group, it was not identified as
18 an important cross-government issue.

19 The evidence appears to be that the Welsh Government
20 had not assessed how a pandemic had the potential to
21 impact the individual profile of Wales and its
22 population based, for example, on grounds of resources,
23 age, socioeconomic status or underlying health.

24 It is of course a matter for my Lady how Welsh
25 preparedness affected the Welsh Government's strategic

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1 cultural well-being of Wales. However, it was concluded
2 by Professors Bambra and Marmot that, with some
3 exceptions, the specialist structures concerned with
4 risk management and civil emergency planning did not
5 properly consider societal, economic and health impacts
6 in light of pre-existing inequalities. In their
7 opinion:

8 "The UK Government and the devolved administrations
9 and relevant public health bodies did not systematically
10 or comprehensively assess pre-existing social and
11 economic inequalities and the vulnerabilities of
12 different groups during a pandemic in their planning or
13 risk assessment processes."

14 Turning next to some of the relevant evidence
15 adduced in Module 2.

16 As indicated in previous preliminary hearings for
17 this module, a number of experts were jointly instructed
18 by Modules 2, 2A, 2B and 2C to report on pre-existing
19 structural discrimination against groups with protected
20 characteristics in UK society. In October last year the
21 experts gave oral evidence during the Module 2 public
22 hearings to supplement their written reports. The
23 experts are not being called again in this module, but
24 given the relevance of their evidence to matters which
25 will be canvassed with witnesses that will be called in

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1 response to the pandemic.

2 In Module 1 your Ladyship heard evidence from
3 Professor Clare Bambra and Sir Michael Marmot on health
4 inequalities. This evidence provides an important
5 backdrop to the evidence that you will hear about the
6 reaction to the emergency health crisis in Wales from
7 January 2020. Their evidence was to the effect that
8 there is a clear socio-spatial gradient in health in
9 the UK: the more deprived local authorities have worse
10 health than the less deprived. For example, ONS data
11 shows that for 2017 to 2019 male life expectancy was
12 highest in Monmouthshire, at 81.5 years, and lowest in
13 Blaenau Gwent, at 76.5 years. That is a difference in
14 life expectancy of 4.9 years.

15 These health inequalities are also evident at
16 a smaller neighbourhood scale. In Wales the gap in life
17 expectancy between the most and least deprived areas was
18 nine years for men and seven and a half years for women.

19 You also heard evidence, my Lady, about the
20 Well-being of Future Generations (Wales) Act, which was
21 passed in 2015, and focused on "improving the social,
22 economic, environmental and cultural wellbeing of
23 Wales". The Act puts a well-being duty on public
24 bodies, which means the bodies covered by the Act must
25 work to improve the economic, social, environmental and

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1 this module, I propose to briefly summarise their expert
2 evidence insofar as relevant to Wales and the scope of
3 Module 2B.

4 Professor James Nazroo and Professor Laia Bécades
5 gave evidence on pre-pandemic inequalities by race and
6 ageing, including the role of structural racism.

7 Professors Nazroo and Bécades expressed the view that
8 while ethnic minority populations are smaller and more
9 geographically concentrated in Wales compared to
10 England, and data was generally limited in relation to
11 Wales alone, the data which they accessed indicated that
12 processes of racialisation and racism are equally
13 relevant across all four nations of the UK. There is no
14 evidence to suggest that they operate differently in the
15 different nations.

16 They expressed the view that ethnic inequalities in
17 health in the UK are longstanding and persistent, they
18 have been researched and documented for several decades,
19 and that ethnic inequalities in health are most
20 pronounced at older ages in the UK.

21 Professor Nazroo also provided expert evidence on
22 pre-pandemic structural discrimination against elderly
23 people. He was of the view that the evidence produced
24 in his report about later life and ageism and the
25 conclusions drawn are relevant, again, to each nation of

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1 the UK.

2 Professor Nazroo identified that people living in
3 care homes were a population who were at particular risk
4 of complications or death if they experienced
5 a respiratory viral infection. This is particularly the
6 case for those living in nursing homes because of their
7 higher level for medical need. He opined that residents
8 in care homes were also at much greater risk of
9 infection compared to those living in private
10 accommodation, because of close quarter living
11 arrangements and other factors.

12 As had been the case in his report on racism,
13 Professor Nazroo identified a number of missed
14 opportunities in the UK-wide response to the pandemic as
15 regards the particular needs of older groups. He
16 expressed the view that an investigation of which groups
17 of older people were at particular risk of infection,
18 complications and mortality, and that greater risk of
19 adverse consequences of NPI control measures would have
20 allowed targeted protections to be put in place.

21 Professor Thomas Shakespeare and Professor Nick
22 Watson gave evidence on pre-pandemic inequalities
23 associated with disabilities. Professors Shakespeare
24 and Watson reported that in 2020, 22% of the UK's
25 population reported a disability. Of the four nations,

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1 the UK. She expressed the view that, due to increased
2 prevalence of pre-existing physical and mental health
3 conditions, LGBTQ+ people, particularly disabled people,
4 minoritised ethnic people, young and older people,
5 should have been identified as a vulnerable group and
6 measures should have been adopted to reduce their risk
7 of infection.

8 Dr Clare Wenham gave evidence on pre-pandemic gender
9 inequalities. Dr Wenham opined that the
10 disproportionate of epidemics and pandemics on women was
11 established prior to Covid-19. This included the
12 effects of changes to health services, in particular
13 sexual and reproductive health, and increases in
14 domestic violence.

15 Women were also known to suffer worse economic
16 impacts as they disproportionately held roles involving
17 face-to-face contact, which also involved being exposed
18 to an increased risk of contracting the virus, and
19 tended to bear the economic impacts of sickness as they
20 tended to bear childcare responsibilities. She
21 presented an evidence-based analysis that gender
22 inequality and discrimination was pervasive across UK
23 society prior to the onset of the Covid-19 pandemic.

24 Professor David Taylor-Robinson gave evidence on
25 pre-pandemic childhood inequalities.

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1 the figure was highest in Wales, at 28%. In oral
2 evidence Professor Shakespeare commented that:

3 "I think that, generally speaking, people in
4 Scotland and Wales tend to have a higher rate of
5 disability than people in England, because disability is
6 related to deprivation, there's a strong poverty
7 gradient, and therefore you can see that Wales has got
8 the highest figure."

9 Professors Shakespeare and Watson opined that
10 evidence supported the proposition that disabled people
11 tended to be more likely to be unemployed or paid less
12 in employment, live in worse socioeconomic conditions
13 and poorer housing, which in turn increased the
14 likelihood of respiratory illness.

15 Their analysis showed that the increased
16 vulnerabilities to Covid faced by disabled people led to
17 disproportionate impact, particularly on people with
18 intellectual disabilities.

19 Professor Bécares also provided expertise on
20 pre-pandemic inequalities for members of the LGBTQ+
21 community. Professor Bécares reported that it was known
22 prior to the pandemic that LGBTQ+ people reported worse
23 general health than their heterosexual peers. Like
24 others, Professor Bécares reported significant missed
25 opportunities in the management of the pandemic across

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1 Professor Taylor-Robinson reported that in the
2 five years pre-pandemic there was concern regarding
3 deteriorating child health in the UK which had been
4 preceded by a period of improvement. This was linked in
5 large part to socioeconomic inequalities that have been
6 exacerbated by the pandemic.

7 As regards missed opportunities and impacts of the
8 pandemic, Professor Taylor-Robinson provided a detailed
9 view of the shortcomings. Although children were not
10 considered a vulnerable group in terms of susceptibility
11 to the virus itself, children were susceptible to the
12 wider impact of disruption to the broader determinants
13 of health, and so children's health and well-being
14 should have been considered in strategies to contain or
15 delay the spread of the virus.

16 Also amongst those who suffered and indeed continue
17 to suffer from Covid are the victims of the syndrome
18 known as Long Covid. By March 2023, the ONS estimated
19 that 1.9 million people were suffering from
20 self-reported Long Covid. As such, further expert
21 evidence was heard in Module 2 from Professor Chris
22 Brightling and Dr Rachael Evans in relation to
23 Long Covid. In their report the experts concluded that
24 Long Covid was foreseeable, that it remains a major
25 health problem, and there was and is minimal focus on

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1 preparedness for long-term consequences of viral
2 outbreaks such as the pandemic and insufficient
3 surveillance for Long Covid planned at the outset of the
4 pandemic.

5 Expert evidence was also heard in Module 2 in the
6 form of written reports and subsequent oral testimony
7 from Professor Ailsa Henderson and Professor
8 Thomas Hale. Both experts were instructed to provide
9 evidence on behalf of Module 2B, as well as Modules 2,
10 2A and 2C.

11 Professor Henderson provided a detailed history of
12 devolution in Wales, Scotland and Northern Ireland,
13 which I do not intend to rehearse here. In this regard,
14 my Lady, you will hear evidence later this week from
15 Professor Daniel Wincott, professor of law and society
16 in the School of Law and Politics at Cardiff University.
17 Professor Wincott will give evidence on political
18 decision-making in the management of the pandemic in
19 Wales. His evidence will supplement and expand on that
20 already given by Professor Henderson.

21 Professor Hale reported on international data
22 relating to the Covid-19 pandemic, in particular in
23 analysing the effectiveness of the decision-making of
24 the UK Government and the governments of the devolved
25 administrations in comparison to other countries.

25

1 experiences.

2 As mentioned earlier, the impact of the pandemic
3 will not be examined in detail in this module. The
4 detail of the varied and considerable impacts on Welsh
5 society deserve close attention, and they will be given
6 this at a later stage of the Inquiry, not least by
7 the Inquiry's Every Story Matters listening project.
8 Impact, however, does have a part to play in this
9 module. The evidence heard by the Inquiry to this point
10 shows that those in more vulnerable positions in society
11 did worse. My Lady will hear evidence tomorrow about
12 attempts made by certain groups to draw to the attention
13 of the Welsh Government the significant harms which were
14 experienced by different sectors of Welsh society. The
15 extent to which the information about the significant
16 impacts was properly taken into account by the Welsh
17 Government when managing the pandemic is very much part
18 of what we are here to consider in this module.

19 As was the case in Module 2, the extent to which the
20 Welsh Government identified and assessed the likely
21 impacts on these groups is a key part of this module's
22 scope. We intend to consider both those who were at
23 risk because of previous health conditions, as set out
24 in the evidence given by Professors Bambra and Marmot to
25 which I've referred, and also those who were vulnerable

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1 Professor Hale opined that as far as the stringency,
2 speed and effect of the UK response to Covid was
3 concerned, the UK was slower than the average country to
4 adopt distributor measures across nearly every domain of
5 response. Tragically, Professor Hale reported that
6 Wales had the 30th highest death rate per capita
7 globally and it was 57th in the world for stringency of
8 its restrictions, with the highest number of days with
9 a stringency index of above 70 out of all four nations
10 of the UK.

11 Turning to the factual witness evidence in Module 2,
12 the bulk of hearing time was taken up hearing evidence
13 from UK Government ministers, senior civil servants and
14 political advisers and scientific and medical advisers
15 relating to key UK Government decisions. Time of course
16 does not permit me to summarise that evidence here. We
17 will, however, endeavour to put key themes arising out
18 of that evidence to witnesses giving evidence in this
19 module, as time allows, in order to see their responses
20 to matters which involved them and had an effect on the
21 management of the pandemic in Wales.

22 Before turning to the chronology of key events and
23 core decisions, I propose to say something about the
24 evidence available to this module as to the impact of
25 the pandemic on the people of Wales and their

26

1 due to protected characteristics such as age, sex,
2 disability, ethnicity and sexual orientation, as well as
3 those who needed particular consideration due to both.

4 In addition to the moving accounts given in the
5 impact film and the evidence that will be heard over the
6 next three weeks, the Inquiry has received 53 Rule 9
7 responses from UK-wide and Wales-specific impact
8 organisations evidencing the real impact of the pandemic
9 on older groups, those in receipt of care, children and
10 young people, ethnic minorities, women and disabled
11 people.

12 Having summarised some of the key themes arising
13 from the evidence heard in Modules 1 and 2 and some of
14 the evidence, I propose to move next to the chronology
15 of key events and decisions.

16 As already stated, this module picks up where
17 Module 1 left off, namely January 2020. At this stage,
18 as Module 1 evidence shows, the Welsh Government's
19 ability to react to the early emerging signs of danger
20 was largely bound to the emergency structures at
21 UK Government level. The evidence, however, shows that
22 as the pandemic progressed the Welsh Government pursued
23 its own strategies to fight the virus, its own
24 regulations and restrictions, and its own mechanisms for
25 communicating with the public about them.

28

1 The Inquiry has already looked at the key questions
2 in Module 2 of whether the UK Government reacted with
3 sufficient speed in the early months of 2020 on learning
4 of the emergence of the virus in China and whether it
5 was provided with the right information to enable it to
6 do so.

7 These questions apply equally in this module when
8 looking at the Welsh Government response.

9 Given the Welsh Government's later adoption of
10 an autonomous approach, ought it to have taken heed
11 earlier of advice and information received directly from
12 experts or via the UK Government systems to which it had
13 access, such as COBR and SAGE?

14 Given the demographic characteristics of the Welsh
15 population, specifically the differences in health and
16 age profiles in Wales, and its pre-existing autonomous
17 structures to deal with public health emergencies, ought
18 the Welsh Government to have done more to make plans to
19 deal with the virus earlier?

20 Ought it to have done more to seek to influence
21 decision-makers in key positions within UK Government in
22 the best interests of the people of Wales?

23 Had the Welsh Government taken a different approach,
24 might it have been able in the critical early months of
25 January and February to alter the course of the pandemic

29

1 again.

2 Mr Poole.

3 **MR POOLE:** Thank you, my Lady.

4 So we move to January 2020. Evidence heard by
5 your Ladyship in Module 2 indicates that from the very
6 early days of January 2020, UK Government scientists and
7 medical officers were already communicating with each
8 other, public health bodies in the devolved
9 administrations and a handful of external scientists and
10 academics about a new viral pneumonia outbreak.

11 On 8 January 2020 Public Health Wales issued
12 a briefing concerning a cluster of pneumonia cases of
13 unknown aetiology in Wuhan City, China. It recommended
14 that any patients presenting with pneumonia who had
15 travelled to China in the 14 days prior to the onset of
16 symptoms should have a detailed travel and exposure
17 history taken. This briefing went to the Welsh
18 Government.

19 On 9 January the World Health Organisation issued
20 a statement. It did not recommend any specific measures
21 for travellers and advised against application of any
22 travel or trade restrictions on China.

23 On 11 January Chinese media reported the first death
24 from the novel coronavirus.

25 On 13 January the UK scientific body NERVTAG met for

31

1 significantly? This is of central importance, because
2 some argue that had it reacted with greater urgency and
3 to greater effect in January and February, it might not
4 have been forced into making the extraordinarily
5 far-reaching decisions that it later felt itself obliged
6 to take in lockstep with the UK Government and the
7 governments of Scotland and Northern Ireland.

8 My Lady, is that an appropriate point?

9 **LADY HALLETT:** I was just wondering, as we started later,
10 but I suspect it is probably the best moment to pause.

11 For those haven't followed our proceedings before,
12 we take a break, usually every hour and a quarter or so,
13 for the sake of the stenographer, but we also have
14 translators, or interpreters, and so we need to break
15 for them as well.

16 Very well, I shall return at -- I can't see what the
17 time is -- 11.25.

18 **(11.11 am)**

(A short break)

20 **(11.28 am)**

21 **LADY HALLETT:** Sorry if I'm slightly late, I was warming up.

22 I hope everybody is slightly warmer now. I'm afraid in
23 Scotland we did end up freezing people for a while,
24 so ... as long as you don't get too warm. Please tell
25 me if it now gets too hot and we can try to change it

30

1 the first time. It noted that the last official report
2 from China had noted 41 cases of illness due to the
3 novel coronavirus. Of the hospitalised patients, two
4 had been discharged, seven were severely ill and one had
5 died. It also noted that it had been stated that there
6 had been no "significant" human-to-human transmission,
7 which implied there may be some evidence of limited
8 human-to-human transmission.

9 On 16 January the novel coronavirus was classified
10 as a high-consequence infectious disease, requiring
11 barrier care and the use of limited specialist units.
12 Professor Neil Ferguson and his colleagues at
13 Imperial College calculated that Wuhan was likely to
14 have been harbouring more than 1,100 cases by 6 January,
15 more than ten times the official figure, and they sent
16 their report to the UK Chief Scientific Adviser, the UK
17 Chief Medical Officer and others.

18 On 21 January the WHO published its first Novel
19 Coronavirus 2019 report and tweeted that it was now very
20 clear that there was at least some human-to-human
21 transmission. The reported number of confirmed global
22 cases had risen to 283 and there were six reported
23 deaths worldwide.

24 NERVTAG met again, noting that there was clear
25 evidence of person-to-person transmission, but that the

32

1 degree of transmissibility was not clear. The case
2 fatality rate was also not clear, as most of the cases
3 had not yet reached conclusion in either death or
4 recovery, not all cases were being tested or reported,
5 and there was a delay in the external reporting.

6 On the same day, 21 January, a meeting of the
7 NHS Wales executive board took place, at which
8 Dr Andrew Goodall reflected on the pressure that the NHS
9 in Wales had been under at the turn of the year. He
10 noted that many would have felt the system was at
11 a difficult tipping point, requiring system-wide
12 actions. Dr Atherton provided an update on the Wuhan
13 coronavirus in China and advised that plans for
14 isolation and ambulances would be sent shortly in the
15 event that the virus came to the UK. Dr Atherton noted
16 that this area would become of increasing importance.

17 On 22 January the first Scientific Advisory Group
18 for Emergencies (SAGE) was activated on a precautionary
19 basis, ie without formal activation by COBR.

20 If we can, please, have the SAGE minutes on screen.

21 They are INQ000309706. At point 7 the minutes record:

22 "There is evidence of person-to-person transmission.
23 It is unknown whether transmission is sustainable."

24 Then at point 12:

25 "There is no evidence yet on whether individuals are

33

1 director in Public Health Wales for Covid-19, invoked
2 the Public Health Wales Emergency Response Plan at
3 enhanced level.

4 On 23 January, public transport, including outbound
5 trains and flights, were suspended in Wuhan. The WHO
6 issued a statement announced that its emergency
7 committee had been unable to agree that the event
8 constituted a public health emergency of international
9 concern.

10 In London, the Secretary of State for Health and
11 Social Care, Matt Hancock, was told by the UK CMO that
12 there was a 50/50 chance that the Wuhan quarantine would
13 not work. In other words, there was a 50/50 chance that
14 there was no practical means by which the further escape
15 of the virus could be prevented, a 50/50 chance of
16 a global outbreak.

17 Imperial College's third report, which was shared
18 with the UK Government, estimated that the basic
19 reproduction number, the R number, was above 1,
20 indicating self-sustaining human-to-human transmission,
21 and most likely in the range of 2 to 3. This implied
22 that control measures needed to block well over 60% of
23 transmission to be effective in controlling the
24 outbreak.

25 On 24 January, COBR met for the first time, chaired

35

1 infectious prior to showing symptoms."

2 Point 13:

3 "There is no evidence that individuals are more
4 infectious when symptoms are more severe, but that is
5 likely."

6 On the same day, 22 January, Public Health England
7 raised the current threat level from very low to low,
8 stating that:

9 "The risk to the UK population has been assessed as
10 low, based on the emerging evidence regarding case
11 numbers, potential sources and human to human
12 transmission."

13 The second report from Imperial College estimated
14 that there were 4,000 cases in Wuhan and advised that
15 self-sustaining human-to-human transmission should not
16 be ruled out.

17 Although there was no Welsh representative present
18 at the precautionary SAGE meeting of 22 January, the
19 minutes of that meeting were shared with the Welsh
20 scientific adviser for health, Dr Rob Orford, on
21 24 January, and passed on to the Chief Medical Officer
22 for Wales, Sir Frank Atherton and Andrew Goodall, among
23 others.

24 Also on 22 January, Dr Quentin Sandifer, who between
25 January and November 2020 was the lead strategic

34

1 by Mr Hancock as the Secretary of State for the lead
2 government department. The Welsh Government was
3 represented at this meeting by Vaughan Gething as
4 Minister for Health and Social Services.

5 COBR agreed a series of actions to be put in place
6 for when certain trigger points were reached, and that
7 these trigger points would be shared quickly with the
8 chief medical officers of all four nations.

9 Also on 24 January, France reported the first
10 confirmed Covid-19 cases in the WHO European region and
11 *The Lancet* published an article entitled "A novel
12 coronavirus outbreak of global health concern", which
13 reported that the detection of infection in at least one
14 household cluster in China and infections in healthcare
15 workers caring for patients with Covid-19 indicated
16 human-to-human transmission and thus the risk of much
17 wider spread of the disease.

18 The article stated:

19 "... we need to be wary of the current outbreak
20 turning into a sustained epidemic or even a pandemic.
21 ... Every effort should be given to understand and
22 control the disease, and the time to act is now."

23 It was also on this date, 24 January, that
24 Dr Atherton advised the First Minister that there was
25 a significant risk that the virus would arrive in Wales,

36

1 and Mr Gething issued a statement saying that the Welsh
2 Government was closely monitoring the emergence of
3 a novel coronavirus.

4 On 25 January the WHO regional director for Europe
5 issued a public statement outlining the importance of
6 being ready at local and at national levels for
7 detecting cases, testing samples and clinical
8 management. Officials in the UK starting putting
9 preparations in place for the repatriation of UK
10 nationals from Wuhan and surrounding areas.

11 On 27 January the WHO Novel Coronavirus Situation
12 Report reported 80 deaths in China, but none outside.
13 An extraordinary meeting of the UK SPI-M-O committee
14 took place. No Welsh scientists were in attendance at
15 this meeting. Current epidemiological work was
16 discussed and the need for further data and the
17 commencement of modelling work agreed.

18 On 28 January, SAGE, having now been formally
19 convened, met again. There was no Welsh representative
20 present at this meeting. SAGE was informed that 50% of
21 new cases in China were now occurring outside Wuhan, and
22 that a specific test should be ready by the end of the
23 week, with capacity to run 400 to 500 tests per day.

24 SAGE debated the epidemiological characteristics of
25 the virus, including the reproduction rate, which was

37

1 the reasonable worst-case scenario, and that the real
2 risk to the UK comes from China losing control of the
3 situation rather than flights.

4 On 30 January the WHO declared a public health
5 emergency of international concern. On this day too the
6 first case of infection with the virus in the UK was
7 confirmed: two members of the same family, one a 23-year
8 old Chinese student who had travelled back to York from
9 the family home in Hubei.

10 On 31 January the novel coronavirus was discussed by
11 the UK Government Cabinet for the first time. The
12 evidence suggests that Covid was not discussed by the
13 Welsh Cabinet until nearly a whole month later, on
14 25 February.

15 On 31 January the UK CMO publicly confirmed that two
16 patients in the UK, members of the same family, had
17 tested positive for Covid. By the end of January it
18 appears -- it is of course a matter for you, my Lady --
19 that it was clear that a fatal respiratory disease was
20 spreading across the world and, to quote the advice
21 given by Dr Atherton to the First Minister on
22 24 January, there was a significant risk the virus would
23 arrive in Wales.

24 A number of questions arise. Was the fact that the
25 virus would most likely spread to Wales properly

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1 estimated to be between 2 and 3, that the doubling rate
2 was estimated to be between three to four days, and that
3 there was limited evidence of asymptomatic transmission.

4 The reasonable worst-case scenario was assessed by
5 SAGE to be similar to that for pandemic influenza, where
6 no vaccine or specific treatment was available.

7 SAGE agreed that a rapid change in the
8 UK Government's approach would be required in the event
9 of sustained human-to-human transmission outside China
10 or a severe case in the UK.

11 On 29 January, *New England Journal of Medicine*
12 published an article by the Chinese Covid-19 Outbreak
13 Joint Field Epidemiology Investigation Team. The
14 article estimated, based on research of the first
15 425 cases, that the basic reproduction number was 2.2.
16 That is to say, one person will infect, on average, 2.2
17 other non-immune people. And they stated that there was
18 evidence of human-to-human transmission that had
19 occurred among close contacts since the middle of
20 December 2019.

21 The same day COBR met again and an update was
22 provided on the UK's reasonable worst-case scenario
23 planning. The Welsh Government was represented at this
24 meeting by Mr Gething, along with Dr Atherton. The
25 minutes record in part that the UK should prepare for

38

1 appreciated by the Welsh Government? Were the
2 consequences of the lack of any control measures
3 adequately understood? Does the fact that Covid was not
4 discussed by the Welsh Cabinet throughout January
5 indicate that the threat posed by the virus was not
6 taken as seriously as it ought to have been, or that the
7 Welsh Government thought the UK Government had things
8 under control and there was no need to take independent
9 action? Was there a lack of national strategic
10 leadership and co-ordination from the Welsh Government
11 in this crucial early period? Should consideration have
12 been given, even at this relatively early stage, not
13 just to gearing up NHS preparedness but to declaring
14 a major incident for health in Wales and standing up the
15 Emergency Coordination Centre?

16 During February, the evidence suggests that the
17 virus was still not a priority of the Welsh Government.

18 On 2 February the WHO gave a technical briefing. In
19 the UK, a public information campaign was launched by
20 the UK DHSC, advising the population to adopt
21 respiratory and hand hygiene behaviours. The Welsh
22 Government announced that it was working with Public
23 Health Wales to support the campaign. A group of UK
24 senior ministers, the ministerial quad, met for the
25 first time.

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1 At the SAGE meeting of 4 February the UK CMO,
2 Deputy CMO and CSA and certain other scientists,
3 including representatives of the Imperial and London
4 School of Hygiene and Tropical Medicine teams agreed
5 that UK-only China-focused measures would likely only
6 achieve minor delays in slowing UK transmission, but
7 that impacts would be greater if multiple countries took
8 concerted action. There was no Welsh representative at
9 this SAGE meeting.

10 If we can, please, have INQ000074895 on the screen,
11 please.

12 We can see there a consensus statement from SPI-M-O
13 dated 3 February. At paragraph 1, it reads:

14 "The number of confirmed cases of 2019-nCoV in China
15 is estimated to be at least 10 times higher than the
16 number currently [estimated]."

17 Then at paragraph 7, please:

18 "It is unclear whether outbreaks can be contained by
19 isolation and contact tracing. If a high proportion of
20 asymptomatic cases are infectious, then containment is
21 unlikely via these policies. Countries with less
22 effective healthcare systems are less likely to be able
23 to contain sustained outbreaks."

24 On 6 February it was announced that the first UK
25 national had caught Covid-19 in Asia and had travelled

41

1 established in the coming weeks."

2 The sixth meeting of SAGE, on 11 February, which was
3 attended by Dr Orford, noted that it was not possible
4 for the UK to accelerate diagnostic capability to
5 include Covid-19 alongside regular flu testing in time
6 for the onset of winter flu season 2020/2021.

7 On 12 February a ministerial tabletop exercise was
8 held in London. Mr Gething and Dr Atherton took part on
9 behalf of the Welsh Government. The evidence suggests
10 that this exercise focused on the likely impact on the
11 NHS and there was no discussion about infection control
12 measures.

13 Also on 12 February, the first meeting of the Welsh
14 Government countermeasures group took place, the purpose
15 of this group was to monitor and advise on pandemic
16 stocks and ensure that they are deployed according to
17 ministerial agreement.

18 On 13 February the seventh meeting of SAGE took
19 place, again attended by Dr Orford. It debated, in the
20 context of a discussion of how to delay the peak of the
21 epidemic (as opposed to seeking to suppress the spread
22 of the virus), the impact of mass school closures,
23 restricting mass gatherings and mask wearing. It
24 advised that travel restrictions within the UK and
25 prevention of mass gatherings would not be effective in

43

1 back to the UK via the Alps. SAGE was advised of
2 a third UK case of a positive test. Public Health
3 England announced the development of novel coronavirus
4 diagnostic test.

5 On 10 February the team of epidemiologists at
6 Imperial College provided a first estimate of the
7 severity of the virus giving an overall case fatality
8 rate in all infections, so symptomatic or asymptomatic,
9 of around 1%. That is to say, 1 in 100 of every
10 confirmed case, as opposed to those who are infected,
11 will die.

12 SPI-M-O estimated that the number of confirmed
13 Covid-19 cases in China was ten times higher than the
14 number currently confirmed.

15 If we can, please, have INQ000237386 on the screen.

16 The minutes of this meeting also state -- if we look
17 at paragraph 7:

18 "It is a realistic probability that outbreaks
19 outside China cannot be contained by isolation and
20 contact tracing. If a high proportion of asymptomatic
21 cases are infectious, then containment is unlikely via
22 these policies."

23 Then if we go down to paragraph 13, please:

24 "It is a realistic probability that there is already
25 sustained transmission in the UK, or that it will become

42

1 limiting transmission.

2 The SAGE planning assumptions, which advised that
3 Covid-19 would likely infect 80% of the population, in
4 contrast to pandemic influenza that would infect 50% of
5 the population, was shared with the Welsh Government.

6 If we can, please, have INQ000320721 on the screen.

7 We can see in that bottom email that the SAGE
8 planning assumptions prompted Reg Kilpatrick to email
9 Dr Atherton, stating, among other things:

10 "This material needs to be shared internally and
11 rapidly. The DGs need to be aware and so does the Perm
12 [the Permanent Secretary, Shan Morgan] both for
13 information and to underline the potential seriousness
14 of the issue ...

15 "One key lesson from the last two years of dealing
16 with Brexit is that without the free flow of information
17 to trusted individuals within Welsh Government, we will
18 always find ourselves unable to match the UK government
19 in our preparedness; or to have a reasonable and
20 informed discussion about what our next steps should be.
21 And of course we will put our Ministers in a weak -- or
22 negligible -- negotiating position if we are unable to
23 brief quickly and comprehensively."

24 SPI-M-O on 17 February noted that the current
25 estimates of the average case fatality rate seen to date

44

1 were in the range of 0.25% to 4%. The minutes state.

2 "There were differing views within the group about
3 the likelihood of sustained transmission in the UK both
4 currently and in the near future. Some believe it [will
5 be] a realistic possibility that sustained transmission
6 in the UK will become established in the coming weeks
7 while others believe this likelihood is higher and there
8 may already be sustained transmission."

9 The fourth meeting of COBR was held on 18 February.
10 This meeting was attended by the First Minister, as well
11 as Dr Atherton. The UK CMO noted that escalation to
12 a global pandemic and isolation of the majority of cases
13 to China both remained realistic possibilities. Nine
14 positive cases had been confirmed at this point in the
15 UK.

16 SPI-M-O noted on 19 February that the magnitude of
17 the impact certain school closures would have on the UK
18 epidemic of Covid-19 was very uncertain and that
19 detailed forecast of the likely impact would only be
20 possible once there had been several weeks of sustained
21 transmission within the UK.

22 On 21 February news emerged of a cluster of locally
23 transmitted cases in Lombardy, Italy. A lockdown began
24 in Italy covering ten municipalities of the province of
25 Lodi in Lombardy and one in the province of Padua.

45

1 a flattening the peak strategy, namely a mitigation of
2 the viral outbreak, as opposed to a suppression
3 strategy.

4 Also on 25 February the Welsh Cabinet convened and
5 discussed the virus for the first time. Mr Gething
6 updated the Cabinet that the worldwide response was
7 still in the containment stage.

8 At the COBR meeting on 26 February attended by
9 Mr Gething and Dr Atherton, the UK Deputy CMO reported
10 that official data from China showed that case numbers
11 were continuing to increase. Internationally, case
12 numbers in South Korea, Iran and Italy highlighted clear
13 person-to-person transmission and sustained
14 human-to-human transmission in Italy, which received
15 a high number of travellers to and from the UK. The
16 conclusion was that it is still difficult to predict
17 when or if case numbers would increase in the UK.

18 On 27 February SAGE endorsed planning assumptions of
19 an overall 1% case fatality rate and that 80% of the UK
20 population may become infected.

21 Also on 27 February TAC was set up, which -- along
22 with TAG, led by Fliss Bennee and Dr Orford. As
23 mentioned earlier, the purpose of TAG and TAC was to
24 provide scientific and technical information interpreted
25 for Wales in adherence to the advice provided by SAGE.

47

1 On 22 February UK passengers from the cruise ship
2 the Diamond Princess arrived back in the UK. The
3 Diamond Princess had been quarantined on 3 February by
4 the Japanese Government after a passenger from Hong Kong
5 tested positive for Covid-19 after having earlier left
6 the ship on 25 January. Of the 2,600 passengers and
7 1,000 crew, over 500 people became infected. Early
8 reports showed, however, that around 18% of the people
9 infected had showed no symptoms.

10 On 23 February the UK DHSC confirmed a total of
11 13 Covid-19 cases in UK. The tenth meeting of SAGE, on
12 25 February, discussed a report from Imperial College
13 which addressed measures for closing schools and
14 universities, home isolation of cases for seven days,
15 home isolation of other members of the household of
16 index cases for 14 days, and mass social distancing, to
17 try to achieve a reduction of 75% of all interpersonal
18 contacts other than in the home, school, university or
19 workplace, and a 25% reduction in the workplace.

20 The report noted that aggressive NPIs may have
21 a substantial impact on Covid-19 transmission,
22 potentially dramatically slowing epidemic growth, but
23 that when lifted transmission would resume giving rise
24 to another full peak in the winter months. SAGE
25 therefore focused thereafter on modelling and examining

46

1 We intend in this module to examine the reasons why this
2 new advisory group was set up, why it was thought
3 necessary, how it worked alongside SAGE, why it was
4 constituted as it was, how it operated as an advisory
5 body, and how effective it was in guiding the Welsh
6 Government's pandemic response.

7 We will also examine the role of TAG and TAC in the
8 overall divergence of Welsh Government policy from the
9 priorities and strategy of the UK Government, the
10 reasons for that, and the reasonableness of such
11 divergence in the context of a global viral pandemic.

12 I will return to the theme of divergence in due
13 course.

14 Returning then to the chronology. On 28 February,
15 four years ago tomorrow, the first case of Covid-19 in
16 Wales was reported. An adult returning from northern
17 Italy with links to Swansea's Bishop Gore School.

18 On 29 February the total number of confirmed cases
19 in the UK rose to 23. Dr Orford also emailed colleagues
20 at Public Health Wales stating that he had not received
21 a read-out from the latest SAGE meeting, which concerned
22 him.

23 By the end of February the evidence suggests that
24 there was a growing awareness of the threat the new
25 virus posed to Wales. As such, a number of questions

48

1 arise. Given this increasing appreciation of the
2 imminent threat of the new virus, what powers did the
3 Welsh Government have to impose its own suppression
4 strategies before the national lockdown on 23 March?
5 Why did Welsh ministers not seek to persuade the
6 UK Government of the need to take swifter decisive
7 action? What more ought the Welsh Government have done
8 in February 2020 to seek to mitigate the effect of the
9 new virus spreading across Wales?

10 On Monday 2 March the Prime Minister chaired a COBR
11 meeting for the first time. The First Minister and
12 Mr Gething attended. The WHO raised its alert to "very
13 high". In Wales the First Minister established the
14 Covid-19 core group, and at the First Minister's regular
15 Monday press briefing the First Minister mentioned
16 coronavirus for the first time and reported the first
17 confirmed case in Wales.

18 The First Minister said that the Welsh Government
19 had been working hard to prepare for the arrival of the
20 novel virus in Wales for many weeks, and that Wales and
21 the UK were well prepared for these types of incidents,
22 with robust infection control measures in place to
23 protect the public.

24 On 3 March a multi-agency tabletop exercise was held
25 in Wales. The aim of the exercise was to explore the

49

1 around 160,000 people in Wales requiring some form of
2 hospitalisation. Of those, 133,000 would require
3 oxygen, and 14,000 ventilator support. The same
4 modelling suggested somewhere in the region of 25,000
5 deaths.

6 On 5 March the Health Protection (Notification)
7 (Wales) (Amendment) Regulations 2020 were made, which
8 made Covid-19 a notifiable disease in Wales. The first
9 death of a patient with Covid-19 in England was also
10 announced. SAGE recommended implementation of
11 individual home isolation and whole family isolation,
12 followed by social isolation of over 65s and those with
13 underlying medical conditions. The issue of mass
14 gatherings was also debated again, and SAGE concluded
15 that there was no evidence that banning very large
16 gatherings would reduce transmission.

17 On 6 March the Welsh Government Coronavirus Planning
18 and Response Group met. Public Health Wales provided
19 an operations update and reported that the current
20 modelling predicted that the epidemic will peak around
21 10-12 weeks after it has begun. The reasonable
22 worst-case scenario model predicted an infection rate of
23 80% across Wales, with a hospitalisation rate of 30% and
24 a fatality rate of 1%. In a worst-case scenario
25 situation it was estimated that 50,000 beds would be

51

1 multi-agency response to a request to put an urban
2 setting in lockdown in response to Covid-19.

3 Also on 3 March, TAC provided an update note for
4 Dr Atherton which advised that a reasonable worst-case
5 scenario for Wales would see 1.25 million people
6 symptomatic and 162,500 people hospitalised, and
7 infections during the peak week of 250,000.

8 TAC advised that if Covid followed the same patterns
9 as seasonal flu then Wales would see a one to two-week
10 lag in epidemic peak compared to areas of England.

11 On the same day, 3 March, the UK Government's
12 coronavirus action plan was published. This plan set
13 out the UK Government's broad strategic approach, namely
14 contain, delay, research, mitigate. However, by the
15 beginning of March, it appears that containment had
16 failed. In this regard, this module will look at what
17 input the Welsh Government had into this action plan and
18 what consideration was given to Welsh considerations,
19 risks and requirements.

20 On 4 March Mr Gething chaired a Welsh Cabinet
21 meeting which discussed a SAGE report from the previous
22 day summarising the current understanding of the virus,
23 namely that 80% of the population would be infected, 80%
24 would have mild symptoms and the remaining 20% would
25 likely require hospitalisation. That would equate to

50

1 needed to satisfy demand at peak times, which would see
2 over 6,000 hospitalisations per day.

3 It should be noted that in Wales the average daily
4 available hospital beds is around 10,000. Peak demand
5 would therefore exceed this capacity by approximately
6 five-fold. The demand for ventilation would be
7 considerably higher than capacity, approximately
8 50-fold, a point which was noted by Dr Orford in
9 an email to Public Health Wales on 7 March.

10 Also on 7 March the England versus Wales Men's
11 Six Nations rugby match took place at Twickenham Stadium
12 in London, attended by 81,000 people, including the then
13 Prime Minister, Mr Johnson.

14 On 9 March the eighth meeting of COBR took place,
15 chaired by the Prime Minister and attended by the
16 First Minister, Mr Gething and the Welsh CMO. The
17 merits of seeking to delay the peak of the Covid-19
18 outbreak until the summer were debated. The same day
19 a national lockdown was announced in Italy and the Welsh
20 CMO issued a statement confirming two more people in
21 Wales had tested positive for coronavirus.

22 The following day, 10 March, the Welsh Cabinet met.
23 The First Minister provided an update on Covid and said,
24 with six cases in Wales, now was not the time to
25 introduce more restrictive measures on movement. If

52

1 they were used prematurely, it would likely lead to the
2 population being less receptive to messages at a time
3 when the spread of the virus was more virulent.

4 On 11 March the WHO declared Covid-19 a pandemic.
5 Wales had its first case of community transmission when
6 a patient at Caerphilly with no travel history tested
7 positive for Covid-19. Dr Atherton provided an update
8 to a meeting of the Welsh Government Covid-19 core
9 group. Dr Atherton confirmed that there were 15 known
10 cases in Wales with some community transmission. Wales
11 remained in its containment phase of its management
12 strategy, and it would be up to COBR to decide whether
13 to move to the delay phase. Dr Atherton advised that
14 given the events in Italy there was a need to prepare
15 for the reasonable worst-case scenario.

16 Also on 11 March, Dr Atherton provided the
17 First Minister with a technical briefing on mass
18 gatherings and behavioural and social interventions.

19 Could we, please, have INQ000271613 on the screen.

20 We can see there, in the first paragraph:

21 "In the event of a severe epidemic, the NHS will be
22 unable to meet all demands placed on it. In the
23 reasonable worst-case scenario, demand on beds is likely
24 to overtake supply well before the peak is reached.
25 Currently the [reasonable worst-case] is also considered

53

1 tested positive for Covid-19. This was the first case
2 in North Wales.

3 COBR met again on 12 March, attended by the
4 First Minister. The UK CSA provided a situation update.
5 The number of cases in the UK was increasing. It was
6 estimated that there were 5,000 to 10,000 cases within
7 the UK. Numbers would increase quickly. SAGE advice
8 was that the UK was approximately four weeks behind
9 Italy and expected the UK to follow a similar trajectory
10 in terms of the number of cases. COBR minutes note that
11 the UK Government's strategy was to seek to change the
12 shape of the curve as opposed to completely suppress the
13 spread, as that wasn't going to be possible and could
14 lead to a larger second peak.

15 Accordingly, the UK moved from "contain" to "delay",
16 meaning that rather than trying to stop the virus
17 altogether, the government's strategy switched to trying
18 to manage its spread through the population. Contact
19 tracing was no longer a priority, and testing resources
20 were directed towards hospitalised patients instead of
21 being used to identify new cases in the community.

22 The UK CMOs also raised the risk to the UK from
23 "moderate" to "high", and new advice was also issued
24 advising self-isolation for seven days if someone
25 developed a high temperature or a new continuous cough.

55

1 within the bounds of a likely scenario."

2 If we can move to paragraph 3, please:

3 "Applying behavioural interventions could be helpful
4 in containing an epidemic ... or changing the shape of
5 the epidemiological curve, potentially making the
6 response of the NHS and other sectors more sustainable."

7 Then, at paragraph 4, the first objective is to
8 "contain":

9 "... (note -- this is unlikely to be
10 achievable) ..."

11 This briefing also discussed behavioural control
12 measures and noted that restrictions of mass gatherings
13 would likely reduce infection-related deaths by 2%,
14 whereas self-isolation of those with symptoms would have
15 a greater impact, likely reducing deaths by 11%.

16 Also on 11 March, Public Health Wales produced
17 an evidential summary of the key considerations to guide
18 any decision on the declaration of a major incident for
19 health in Wales. Public Health Wales concluded that
20 objectively the demographic characteristics of the Welsh
21 population and specifically the age profile of the
22 population over 65, health and economic status, and
23 dependency responsibilities, are such that Wales may
24 experience disproportionate levels of impact from Covid.

25 On 12 March a patient at Wrexham Maelor Hospital
54

1 On 12 March COBR also debated the cancellation of
2 mass gatherings. COBR minutes note that the Scottish
3 Government was minded to advise against gatherings of
4 more than 500 people, to ensure frontline emergency
5 workers were able to prioritise the response to the
6 pandemic. The UK Government took the decision not to
7 prohibit mass gatherings at this stage.

8 Following COBR, the First Minister announced that
9 the annual Welsh Labour conference, due to be held in
10 Llandudno at the end of March, was postponed. This
11 prompted Lee Waters, the Welsh Government Deputy
12 Minister for Economy and Transport, to send a WhatsApp
13 stating:

14 "I do think it's an odd signal to send that we're
15 cancelling conference but allowing 70,000 to gather in
16 Cardiff on Saturday."

17 70,000 people gathering in Cardiff was a reference
18 to the Six Nations Men's rugby match between Wales and
19 Scotland due to take place on Saturday, 14 March 2020,
20 at the Principality Stadium in Cardiff. In fact, the
21 match was called off by the Welsh Rugby Union at
22 lunchtime on Friday, 13 March (the day before kick-off),
23 but not before 20,000 Scottish rugby fans had travelled
24 from Scotland to Cardiff.

25 An issue for the Inquiry is whether mass gatherings
56

1 should have been banned earlier, and a specific issue
2 for this module is whether the Welsh Government ought to
3 have advised against the Wales and Scotland rugby match
4 and other mass gatherings in Wales, such as two
5 Stereophonics concerts held at the Motorpoint Arena in
6 Cardiff on 14 and 15 March going ahead.

7 It is right to say that the scientific advice in
8 early March had indicated that the benefits of such
9 a ban were not particularly significant. But gatherings
10 were not without some risk and a ban would have
11 reinforced other social distancing good practice, as
12 well as ensuring frontline emergency workers were able
13 to prioritise the response to the pandemic.

14 On Friday 13 March the Welsh Coronavirus Planning
15 and Response Group met. Dr Orford advised that the
16 reasonable worst-case scenario had been reassessed and
17 estimated a mortality figure of around 36,000.

18 Also on 13 March, Mr Gething made a public statement
19 announcing a framework of actions aimed at allowing
20 health and social care providers in Wales to make
21 decisions to assist with timely preparations for the
22 expected number of confirmed cases of Covid. This
23 framework included measures such as the suspension of
24 non-urgent outpatients and surgical care in Wales, the
25 expedition of vulnerable patients from acute and

57

1 care home infections.

2 Was there clinical or scientific advice that testing
3 would not work? Was there a lack of capacity? Did
4 a greater number of infections come from staff and were
5 they contributed to by PPE shortages? Was isolation the
6 proper route?

7 Final resolution of these issues is a matter for the
8 later care module. However, evidence will be called in
9 this module to explore the broad reasons why core
10 decisions were taken in this regard and why it was not
11 until 29 April 2020 that the Welsh Government policy
12 changed to testing all patients discharged from hospital
13 to a care home, regardless of whether they were showing
14 symptoms. This was nearly two weeks later than the
15 change in policy in England.

16 Returning to the chronology and Saturday 14 March,
17 a national lockdown was announced in Spain and an open
18 letter from scientists was published expressing concern
19 over further delay in the imposition of social
20 distancing measures.

21 If we can, please, have INQ000309816 on the screen.

22 This is an email sent from the Welsh HSSG on
23 15 March recording the actions from a meeting of TAC
24 earlier that day.

25 We can look at item 3, please.

59

1 community hospitals, and the suspension of the current
2 protocol which gave patients the right to choice of
3 a care home.

4 The care sector is for a later module, but it is
5 convenient to examine in part one of the major decisions
6 affecting the care sector in this module, given the
7 debate over the extent to which core decision-makers
8 were aware of it and of its catastrophic consequences.
9 It is this decision to discharge hospital patients into
10 social care.

11 There is evidence that more than 1,000 Welsh
12 patients were discharged from hospital to care homes
13 without a test during March and April 2020. As of
14 5 June, ONS figures suggest that nearly a third of Wales
15 Covid-19 deaths had been within care homes. There is no
16 doubt that there was a massive failure of infection
17 control, contributed at least in part to the influx of
18 infected but untested patients. The Welsh Government's
19 position is that it was advised that testing would not
20 be effective for those who were asymptomatic, and there
21 was in any event a lack of testing capacity. It is
22 an issue for the Inquiry whether this belief could have
23 been genuinely or sensibly held. There is clear
24 evidence that by early April 2020 it was known that only
25 testing those with symptoms missed up to half of

58

1 This notes that the initial ballpark estimate is
2 that Wales is two to three weeks on the curve,
3 approximately eight to nine weeks from the peak, and
4 three weeks from outstripping intensive care capacity in
5 Wales.

6 If we could go over the page to page 2 and the first
7 item on page 2. There is a general concern that further
8 delay in implementing household quarantine and
9 protection of vulnerable could affect Wales more than
10 England.

11 Then Dr Orford agrees to include a recommendation in
12 the COBR briefing that the introduction of these
13 interventions in Wales should be with immediate effect.

14 COBR met on 16 March, attended by the
15 First Minister. The UK CMO advised that the UK was on
16 the cusp of the fast upward swing of infections. There
17 had been 35 confirmed deaths in the UK, including the
18 first Covid-19-related death recorded in Wales that day,
19 in Wrexham Maelor Hospital.

20 COBR agreed that a stricter package of measures
21 should be implemented, including self-isolation,
22 household quarantining and shielding older groups and
23 over 70s. The Stay Home, Protect the NHS, Save Lives
24 campaign was launched.

25 TAC advice to the Welsh Government was that with

60

1 these social interventions in place there would be a 66%
2 reduction in the reasonable worst-case scenario.

3 Following this COBR meeting, four ministerial
4 implementation groups, or MIGs, were established to aid
5 collective government decision-making.

6 On Tuesday 17 March France and the Netherlands
7 announced national lockdowns. In the UK, the
8 Coronavirus Bill 2020 was published. The UK Government
9 advised against all international travel and the
10 National Assembly for Wales was closed to the public.

11 On Wednesday 18 March the Covid-19 core group met.
12 Dr Atherton advised that the virus was probably
13 circulating in the community. There were 136 reported
14 cases in Wales and two recorded deaths.

15 Scientific advice had strengthened in its
16 predictions that, despite the low numbers, a far more
17 significant surge in patients suffering from the virus
18 would have become apparent in the weeks ahead.

19 Levels of infection in the south east of England
20 were already elevated and advice suggested that the same
21 pattern would become apparent in Wales with a time lag
22 of at least seven days between Wales and England.
23 Dr Orford advised that modelling suggested the UK was
24 four weeks into the curve and it was expected to be
25 another 11 weeks before the spread of the virus peaked,

61

1 given to the possibility of this very major step? Were
2 the serious consequences of closing schools properly
3 considered and debated at Cabinet? The Inquiry will
4 also want to consider not just whether schools should
5 have been closed but for how long and whether it was
6 right to allow non-essential shops to re-open in
7 June 2020 so that children were allowed to go shopping
8 but not go to school.

9 Returning to the chronology, as of Friday 20 March
10 Wales had 345 confirmed cases of Covid-19 and 12 deaths
11 had been reported. TAC noted an increase of 30-50
12 confirmed cases per day. It was on this day that COBR
13 agreed that hospitality ought to close that evening
14 across the UK.

15 COBR minutes note that the UK Government recommended
16 that public health powers would be used as the legal
17 basis for government action responding to the pandemic,
18 rather than the Civil Contingencies Act.

19 The evidence suggests that the decision led to
20 powers being exercised differently in different parts of
21 the UK. An issue for this module will be the extent to
22 which this was foreseen and the impact, if any, it had
23 on the Welsh Government's strategic response to the
24 pandemic.

25 Also on 20 March, the First Minister announced the

63

1 whereas the NHS in Wales was four to five weeks away
2 from maximum capacity.

3 The decision was taken to close schools in Wales
4 early for Easter. Kirsty Williams, Minister for
5 Education, made this announcement the same day.

6 The issue of school closures and its obvious impact
7 will be addressed in detail in a later module. However,
8 it is necessary to examine in this module how the
9 decisions on schools came to be considered and decided
10 by the Welsh Government and what its general approach
11 was.

12 From a relatively early stage, the possibility of
13 closing schools was being discussed by SAGE. It was
14 discussed repeatedly at SAGE and SPI-M-O meetings in
15 February, and the possibility was referred to in the
16 "contain" plan of 3 March. The evidence suggests that
17 the Welsh Government's assumption was that schools would
18 not close and that the focus was on how to keep them
19 open. Only very late in the day, on 18 March, was the
20 decision taken to close schools in Wales. This was
21 two days after it had been agreed at COBR that keeping
22 schools open was very important, particularly as
23 frontline workers would have school-aged children.

24 These are matters for you, my Lady. What changed
25 between 16 and 18 March? Why wasn't advance thought

62

1 closure of hospitality, entertainment and leisure
2 businesses across Wales.

3 On 23 March, with the death toll across the whole of
4 the UK reaching 335 deaths and 35 deaths in Wales, the
5 then Prime Minister announced the nationwide
6 stay-at-home order would come into effect as of midnight
7 and would be reviewed every three weeks thereafter.

8 The Welsh Government also announced a full national
9 lockdown, closure of hospitality and non-essential
10 retail, a requirement to stay at home, work from home
11 where possible, and restrictions on indoor and outdoor
12 gatherings.

13 The First Minister's press conference on 24 March
14 advised the people of Wales to "stay at home to protect
15 yourself and to protect the NHS".

16 On the same day Mr Gething sent himself an email
17 recording the stark observations of a Welsh hospital
18 consultant.

19 If we could, please, have INQ000299062.

20 The email reads:

21 "Complete chaos at our hospital. No protection for
22 nurses -- very low moral as being asked to care for
23 patient admitted to Orthopaedic wards by medics with
24 respiratory symptoms. Mask not being released."

25 We will examine in this module the powers and the

64

1 strategy of the Welsh Government with regard to the
2 management of the pandemic over this period, the reasons
3 why it acted as it did, how it perceived its role as
4 against that of the UK Government, its access to advice
5 and the limitations on that. We will also ask what
6 more, if anything, could the Welsh Government have done
7 over this initial period January to March 2020 to
8 protect the people of Wales from the virus. What
9 consideration was given to alternative strategies?

10 April saw the introduction of daily ministerial
11 calls instigated by the First Minister. The first of
12 these calls took place on 6 April.

13 On 16 April the Welsh Government agreed that the
14 full package of lockdown restrictions should remain in
15 place.

16 On 24 April the conditional plan for lifting
17 lockdown in Wales was announced, with the Welsh
18 Government publishing *Leading Wales out of the*
19 *Coronavirus pandemic: A Framework for Recovery*. The
20 First Minister's foreword explained that the Welsh plan
21 was based on three pillars: measures and evidence;
22 principles to evaluate changes to the restrictions; and
23 public health response.

24 On the same day, the Secretary of State for Wales,
25 Simon Hart, wrote to the First Minister noting that the

65

1 administrations? Were key decisions taken by the
2 UK Government after a proper process of advice and/or
3 consultation with the devolved administrations?

4 The starting point is that the UK Government could
5 not readily exercise direct control over pandemic
6 management throughout Wales. Health is a devolved
7 matter and the UK Government's decision to use public
8 health legislation and the Coronavirus Act to respond to
9 the pandemic rather than the Civil Contingencies Act
10 confirmed that the response would remain devolved.

11 As the pandemic progressed, the devolved
12 administrations started to go their own way in terms of
13 imposition of NPIs, a clear example of this being the
14 Welsh firebreak, which we shall look at a little later.

15 The Welsh Government also took a different approach
16 to local lockdowns. Now, as your Ladyship heard in
17 Module 2, a number of UK Government witnesses, including
18 the former Prime Minister, suggested that this
19 divergence represented a regrettable failure to ensure
20 consistency of approach across the UK. Welsh ministers,
21 on the other hand, insist that divergence was
22 an inevitable consequence of the different way in which
23 the virus spread across Wales and that in implementing
24 policies that diverged from those of the Westminster
25 government, they were simply properly exercising their

67

1 Welsh framework for recovery did not mention
2 the UK Government once and stating that unless the
3 evidence being relied on by the Welsh Government to
4 diverge from a UK-wide plan is explained, then the Welsh
5 Government will be guilty of adding confusion to
6 an already challenging period of recovery.

7 On 28 April the First Minister wrote to the former
8 Prime Minister attaching the framework of recovery,
9 stating:

10 "Our view is that steps taken at the end of the
11 current three-week period should necessarily be modest
12 and cautious."

13 Notwithstanding this letter, two days later the
14 Prime Minister announced that the UK Government would
15 set out a comprehensive plan the following week for
16 re-opening the economy, schools and travel. This
17 announcement appears to have been made without any
18 consultation with the Welsh Government.

19 The list of issues for this module pose a number of
20 questions in relation to how the governments of
21 Westminster and Cardiff Bay engaged with each other:
22 what was the extent of co-ordination and communication
23 between the UK Government and the Welsh Government, to
24 what extent did the Welsh Government seek and receive
25 advice from the UK Government and the other devolved

66

1 devolved powers.

2 These are issues which were explored in Module 2 and
3 also Module 2A in respect of Scotland. They will be
4 further explored in this module from a Welsh
5 perspective.

6 The evidence suggests that the devolved
7 administrations were not updated on some important
8 UK Government decisions before they were announced
9 publicly. For example, the change in public health
10 messaging from "Stay at Home" to "Stay Alert" in
11 May 2020, which we will come on to in the chronology in
12 a minute. There was also a lack of clarity over which
13 UK Government announcements applied only to people in
14 England, prompting the First Minister to make multiple
15 requests for the UK Government to make this clear in
16 public communications.

17 The Welsh Government was represented at COBR as
18 a general rule, but, my Lady, as you heard in Module 2,
19 concerns about the former First Minister of Scotland
20 briefing the media afterwards led, apparently, to
21 a general disinclination to want to thrash issues out in
22 that forum and meetings became more scripted and
23 formulaic. Some UK ministers were concerned that the
24 devolved administrations were diverging from
25 UK Government policy for the sake of being different,

68

1 a point that is strongly denied by Welsh ministers.

2 In any event, COBR quickly lost its importance and
3 was replaced by the MIGs and then, later, Covid-O and
4 Covid-S. It did not meet between 10 May and 22
5 September 2020. The devolved administrations were not
6 invited to Covid-S, although they were invited to
7 Covid-O meetings, initially only when UK-wide issues
8 were to be discussed but latterly, from October 2020, on
9 a weekly basis.

10 Representatives of the devolved administrations were
11 not invited to the 9.15 am Prime Ministerial meetings,
12 which became the dominant UK Government decision-making
13 body and where much of the strategy was mapped out.

14 The primary historical forum for meetings between UK
15 ministers and First Ministers of the devolved
16 administrations, the JMC, was not used throughout the
17 pandemic. Mr Johnson said in his witness statement in
18 Module 2 that he chose not to meet with the
19 First Ministers of the devolved administrations because
20 in his view this would have been "optically wrong" for
21 fear that this would give a false impression that the UK
22 was a "kind of mini EU of four nations and we were
23 meeting as a 'council' in a federal structure". There
24 is also evidence from within Whitehall that regular
25 meetings with the devolved administrations could be

69

1 representatives on SAGE were from England and more than
2 half of the subcommittees had no representatives from
3 a devolved administration at all. The expert evidence
4 from Professor Henderson is to the effect that there was
5 a predominantly English frame of reference, and a focus
6 on English-only data. The evidence may be that SAGE
7 advice tended, as a result, to consider only the
8 implications on England of the various options that were
9 considered. As a result, SAGE advice tended, according
10 to one attendee, to be translated into different
11 policies by different nations.

12 The evidence suggests, however, that there was ample
13 communication between the UK Government and the Welsh
14 Government at the health minister and CMO level, and
15 of course in the Covid-O meetings.

16 As for local government, the written evidence
17 appears to suggest that the Welsh Government actively
18 engaged with local leaders on decision-making. My Lady
19 will, however, wish to consider whether there was any
20 delay on the part of the Welsh Government in engaging
21 with local government, and explore whether there was
22 a missed opportunity for local authorities to have
23 meaningful input into the decisions taken by the Welsh
24 Government that ultimately were the responsibility of
25 local authorities to implement, deliver and enforce.

71

1 a "potential federalist trojan horse" .

2 Instead, four nation meetings were held, chaired in
3 the main by Michael Gove, the Chancellor of the Duchy of
4 Lancaster, who also chaired Covid-O. It does not appear
5 that, whilst he did chair some of the meetings,
6 Mr Johnson was prepared to lead this group.

7 The view of the First Minister and other Welsh
8 ministers is that some of the meetings held between
9 the UK Government and the Welsh Government were little
10 more than opportunities for the Welsh Government to be
11 provided with information about decisions that had
12 already been taken. There was, it seemed to the Welsh
13 Government, insufficient meaningful input into
14 UK Government decision-making.

15 The UK Government also made unilateral decisions to
16 relax requirements governing international travel,
17 an area of devolved competence, which had the practical
18 effect of obliging the Welsh Government to adopt the
19 same position against its better judgement. The
20 evidence suggests that realistically the Welsh
21 Government could not adopt a position which best
22 addressed the situation in Wales because most
23 international travel into Wales came from England.

24 As for SAGE, Dr Orford did not attend SAGE until its
25 sixth meeting, on 11 February. Most of the academic

70

1 Returning to the chronology and, as already
2 mentioned, on 10 May 2020 the UK Government updated its
3 coronavirus message from "Stay at Home, Protect the NHS,
4 Save Lives" to "Stay Alert, Control the Virus, Save
5 Lives". The leaders of the devolved governments in
6 Wales, Scotland and Northern Ireland decided to keep the
7 original slogan. This new messaging represented
8 a significant divergence in strategy on the part of the
9 UK and Welsh Governments, the former signalling a move
10 towards easing the lockdown and the latter sticking with
11 the existing restrictions.

12 Having decided to keep the "Stay at Home" message,
13 and given that there was very little in
14 the UK Government's announcements to suggest that the
15 new measures only applied in England, there was a lot of
16 public confusion, particularly for those living in and
17 around the border of England and Wales.

18 By way of explanation for the Welsh Government's
19 position, on 11 May the First Minister made a public
20 address to the nation.

21 If we can please have INQ000090562 on the screen.
22 If we can look at the sixth bullet point, the First
23 Minister said:

24 "There has been a lot of focus over the weekend
25 about the differences between the way the regulations

72

1 are being updated in Wales and in other parts of the UK.

2 "The fundamental direction of travel is the same
3 here as in other parts of the UK -- the stay-at-home
4 regulations remain in place ...

5 "However, there are differences in the messaging
6 between Wales and England and I am concerned this may
7 confuse people."

8 If we can go to page 2, please, at the top of the
9 page, the First Minister said:

10 "I want to be clear -- in Wales, Welsh rules will
11 apply ...

12 "We will continue to make decisions, which are right
13 for Wales, using information and expert advice about how
14 coronavirus is circulating here to keep us safe.

15 "The health of the public is paramount. It will
16 inform our decisions and we will continue to inform you
17 as we plan for our future in the weeks ahead."

18 Restrictions across the UK were eased over the late
19 spring and early summer of 2020. Some differences
20 between the four nations were simply a matter of timing.
21 For example, garden centres, the first non-essential
22 retail outlets to be permitted to re-open, were allowed
23 to re-open from 12 May in Wales, 13 May in England,
24 28 May in Northern Ireland and 29 May in Scotland.

25 There were, however, some more substantive

73

1 substantive or merely cosmetic, whether they led to
2 different outcomes, and whether they were to any extent
3 motivated by any factors other than the very best
4 response to the virus for the safety of the people of
5 Wales.

6 On 4 July the UK Government decided to change its
7 advice on social distancing from 2 metres to 1 metre.
8 The Welsh Government decided not to make this change and
9 retained the 2-metre rule. As with the easing of other
10 restrictions, the decision was of course a balance
11 between the transmission risks and the economic
12 consequences of not changing the rule. At the heart of
13 the debate was the recognition that the scientific
14 advice was that the 2-metre rule provided greater
15 protection but that if the 2-metre rule remained it
16 would be economically hugely damaging. It will be
17 an issue for this module whether the economic impacts as
18 well as the public health impacts were properly debated
19 within Welsh Government.

20 On 3 August the UK Government introduced the Eat Out
21 to Help Out scheme. Its policy objectives were obvious:
22 to support economic recovery by stimulating consumption
23 in the hospitality sector. However, the Welsh
24 Government was not consulted and, as you heard in
25 Module 2, it doesn't appear to have been discussed with

75

1 differences in the way lockdown restrictions were eased.

2 Rules on how many people could meet and from how many
3 households varied notably. From 13 May two people from
4 different households were permitted to meet outdoors in
5 England. A week later the Northern Ireland Executive
6 permitted up to six people to meet outdoors. The
7 Scottish and Welsh Governments did not allow meetings
8 between two households until 29 May and 1 June
9 respectively.

10 There was a similar pattern when one looks at the
11 manner and timing of the re-opening of pubs, cafes and
12 restaurants across the UK. Pubs in Northern Ireland
13 were the first to re-open on 3 July, followed by England
14 on 4 July. Scotland and Wales took a more staged
15 approach, opening outdoor areas first on 6 and 13 July
16 respectively, followed by indoor areas on 15 July and
17 3 August respectively.

18 The general pattern was that England and
19 Northern Ireland eased restrictions and re-opened the
20 economy first, followed next by Scotland, and then
21 Wales. We will examine the extent to which divergence
22 was based on proper advice and a reasonable balancing of
23 the competing considerations, whether there truly was
24 separate Welsh evidence which justified a different
25 Welsh approach, whether points of difference were

74

1 the UK CMO or CSA, and it was not the subject of advice
2 from SAGE, SPI-M or SPI-B.

3 The First Minister's evidence is that had he been
4 consulted he would not have supported the scheme and
5 believed that it was designed by Her Majesty's Treasury
6 to play well with elements in the Conservative Party and
7 the right-wing press, who were instinctively opposed to
8 public health measures.

9 Of course this Inquiry is completely politically
10 agnostic in its approach, it has absolutely no personal
11 or political inclination or disinclination towards any
12 of the primary actors in the appalling tale of this
13 pandemic. There has been enough politicisation and
14 polarisation of the public discourse surrounding the
15 government response to the pandemic already.

16 Furthermore, the evidence as to whether the scheme
17 had a noticeable impact on the rates of infection is
18 unclear. There is, however, a wider, more important
19 point, which was explored in Module 2, with the
20 consequence that other ongoing measures were indirectly
21 weakened. Was it a wise policy, is one of the questions
22 to be asked, when restrictions were still in place?

23 Issues for this module will be whether the scheme
24 was something that the Welsh Government should have
25 expected to be consulted on, and why, if the Welsh

76

1 Government did not support the scheme, did it not raise
2 concerns or choose to opt out of the scheme?

3 On 18 August the Welsh Government published its
4 Coronavirus Control Plan. The plan was designed to
5 tackle the steady increase in cases from late summer
6 2020 as people returned from holidays abroad and were
7 socialising more at home and with friends. In late
8 August and early September there was a significant
9 increase in cases in the Caerphilly Borough Council
10 area. Initially this was tackled by the local
11 authority, Public Health Wales and the Aneurin Bevan
12 University Health Board putting in place measures such
13 as additional testing capacity, additional protective
14 measures in care homes, and a targeted public appeal
15 reiterating behaviours that people should take to keep
16 safe.

17 However, those measures were not enough to reduce
18 transmission and on 7 September Mr Gething announced the
19 first local lockdown in Caerphilly.

20 Throughout September and early October, the Welsh
21 Government responded to subsequent outbreaks by imposing
22 further local health protection areas. These were put
23 in place in Rhondda Cynon Taf, Merthyr Tydfil, Newport,
24 Bridgend and Blaenau Gwent, Swansea, Cardiff, Llanelli,
25 Neath Port Talbot, Bangor and the Vale of Glamorgan.

77

1 impact on deaths is often subject to long delays -- so
2 deaths may not decline until after the break."

3 On 16 September SPI-M-O's consensus estimate was
4 that the number of infections in the UK was growing by
5 2% and 7% per day, and that the doubling time could be
6 as fast as seven days nationally. SPI-M-O agreed that
7 a planned circuit-breaker period where strict NPIs are
8 introduced for two weeks around the October half term
9 has the potential to reduce prevalence and subsequent
10 hospitalisations and deaths reaching high levels whilst
11 balancing non-Covid harms.

12 With case numbers increasing, on 18 September TAC
13 advised the Welsh Government that the situation was
14 serious and that a package of NPIs on both a local and
15 national scale may be needed to bring the R rate
16 below 1. TAC's advice was that action would be most
17 effective if implemented early.

18 On 21 September the 58th SAGE meeting considered
19 a paper entitled "*Summary of the effectiveness and harms
20 of different [NPIs]*". Fliss Bennee attend on behalf of
21 TAC. The SAGE minutes provide a shortlist of NPIs that
22 should be considered for immediate introduction,
23 including a circuit-breaker, advice to work from home
24 for all those that can, banning all contact within the
25 home with members of other households, closure of all

79

1 The First Minister in his written evidence describes
2 these local measures as a failed experiment.
3 The Inquiry has also received written evidence from
4 Professor Michael Gravenor that the Swansea modelling
5 team were not commissioned to model the impact of local
6 lockdowns. Professor Gravenor has told the Inquiry:

7 "I think this would be a useful area to explore
8 retrospectively, as it was clear at times that there was
9 considerable variation across Wales due to north/south
10 geography and its links to different urban centres in
11 England) and rural-urban contrasts. I would aim for
12 a Wales model to have these explicitly included in [the]
13 future."

14 Issues for this module will be why the Welsh
15 Government adopted a local lockdown strategy and why
16 this wasn't the subject of modelling.

17 On 14 September the modelling team at the
18 University of Warwick published a paper titled
19 "*Circuit Breakers: Implementing (partial) lockdown for
20 two weeks over half term*". The paper concluded that:

21 "... a well timed and strong lockdown for a two-week
22 period coinciding with half term could have a very
23 notable impact on the number of future cases,
24 hospitalisations and deaths. It provide[d] a useful
25 break if cases are rising too rapidly; however, the

78

1 bars, restaurants, cafes, indoor gyms, and personal
2 services ... and all university and college teaching to
3 be online unless face-to-face teaching is absolutely
4 essential.

5 SAGE noted that Covid-19 incidence was increasing
6 across the country in all age groups and that the effect
7 of the opening of schools, colleges and universities had
8 only just begun to affect this increase. Even so, the
9 latest data suggested that the doubling time for new
10 infections could currently be as short as seven days
11 nationally. Covid-19-related hospitalisations and
12 intensive care bed usage had started to rise. A package
13 of stringent interventions would need to be adopted to
14 reverse the exponential rise in cases.

15 Four days later, on 25 September, the need for early
16 intervention was reiterated by TAC, advising that:

17 "If the current measures do not bring R below 1 then
18 further restrictions will be needed to control the
19 epidemic in Wales. The earlier additional measures are
20 introduced, the more effective they will be."

21 A week later, on 2 October, TAC gave a rather
22 starker warning. TAC's advice to the Welsh Government
23 was that:

24 "Unless measures bring R back below 1, it is
25 possible that infection incidence and hospital

80

1 admissions may exceed scenario planning levels."

2 In other words, unless further steps, such as
3 a circuit-breaker, were implemented, infection incidence
4 and hospital admissions may exceed scenario planning
5 levels. In short, the NHS in Wales would be
6 overwhelmed."

7 Despite this advice, the Welsh Cabinet did not meet
8 to discuss a circuit-breaker until 15 October. The
9 advice from TAC didn't get any better. A week later,
10 9 October, TAC advised that there was still exponential
11 growth, with hospital admissions continuing to rise, and
12 that further control measures were needed. For the
13 first time in this wave of infections, the incidence for
14 Wales was higher than 100 cases per 100,000 people, and
15 the total test positivity for Wales as 7.8%. All local
16 authorities had seen more than 25 cases per 100,000 over
17 the past week and had a 2.5% test positivity.

18 On 12 October Public Health Wales advised
19 Dr Atherton that the reproduction rate in Wales was 1.45
20 and that restrictions needed to be applied within the
21 next two weeks, and for at least three weeks to achieve
22 a reproduction rate below 1.

23 Notes from the daily ministerial call of 13 October
24 record the First Minister updating Welsh ministers on
25 the COBR meeting the previous day, during which meeting

81

1 the decision to implement the firebreak lockdown?

2 The Inquiry will also need to consider whether the
3 funding arrangements between the UK Government and the
4 Welsh Government played any part in the timing and
5 length of the Welsh firebreak. This is because although
6 devolved governments have a direct and immediate
7 responsibility for responding to a pandemic, they do not
8 always have the funding to support decisions if money
9 over and above the Barnett consequential funding is
10 needed.

11 Her Majesty's HM Treasury operates on the basis that
12 when the UK Government wishes to implement a policy in
13 England, consequential funding is made available to the
14 devolved governments. The process does not, however,
15 operate in reverse.

16 Welsh ministers will say that the limitations
17 imposed by these funding arrangements is illustrated by
18 the discussions which led to the Welsh firebreak. The
19 Job Support Scheme, which was to be the successor to the
20 Coronavirus Job Retention Scheme, was due to start on
21 1 November 2020. Further to the Welsh Cabinet's
22 decision in principle to introduce a firebreak in Wales,
23 the First Minister asked the Chancellor of the Exchequer
24 to start the scheme earlier in Wales, a request which
25 was declined.

83

1 the UK CSA and CMO advised the Prime Minister that
2 Tier 3 measures would not be enough to reduce the
3 R number below 1, but that a circuit-breaker would. The
4 First Minister invited Welsh ministers to consider
5 a circuit-breaker. Dr Atherton informed the meeting
6 that the four CMOs of the UK supported
7 a circuit-breaker. Public Health Wales, TAC and SAGE
8 all agreed that that was the right approach.

9 On 15 October, a Welsh circuit-breaker was discussed
10 in Cabinet and an in principle decision was made to
11 introduce a circuit-breaker on 23 October to cover three
12 weekends. This in principle decision was not formally
13 approved until Cabinet met again on Monday 19 October
14 and the First Minister announced that evening that the
15 Welsh firebreak lockdown would take effect from Friday
16 23 October for two weeks.

17 Issues for this module to consider will be whether
18 the need for a firebreak lockdown could have been
19 avoided had different decisions in the easing of
20 restrictions been taken in late summer 2020. Given the
21 advice that had been received by the Welsh Government in
22 mid-September that a circuit-breaker was needed and
23 would be most effective if implemented early and deeply,
24 was the delay in implementing a circuit-breaker
25 justified? Why did it take four days to formally make

82

1 The First Minister described the effect of that
2 decision in his written evidence as one of the most
3 misguided decisions of the whole pandemic, demonstrating
4 in his view that HM Treasury was in effect acting as
5 a Treasury for England, not a Treasury for the UK.

6 This is denied by UK Government ministers, including
7 the Prime Minister, Mr Sunak, who has provided written
8 evidence to this module stating that Wales received
9 £5.2 billion additional upfront spending by
10 8 January 2021, and that there was no temporal gap in
11 financial support as the Coronavirus Job Retention
12 Scheme was extended with effect from 31 October 2020.

13 Returning to the chronology, on 24 November the
14 four nations reached a joint decision on a package of
15 relaxations over the festive period. The core element
16 of this package was a relaxation of mixing in private
17 houses to allow three households to form a bubble from
18 23 to 27 December. Travel restrictions were also to be
19 lifted across the UK for this period to allow families
20 from across the country to form a bubble.

21 In order to allow some mixing over the festive
22 period, the Welsh Cabinet met on 27 November to discuss
23 the imposition of NPIs in the pre-Christmas period. The
24 Cabinet minutes note that if the rise in the number of
25 infections was left unchecked it would overwhelm

84

1 an already stretched NHS, which would lead to a greater
2 spread and higher incidence in older age groups. The
3 Welsh Cabinet agreed that the most appropriate approach
4 was to draw on the Scottish level 3 model, but to create
5 a bespoke solution for Wales.

6 TAC advice was commissioned. Based on modelling,
7 TAC advised that introducing Tier 3 restrictions, so
8 namely the closure of hospitality and entertainment and
9 a reduction in mixing, prior to the relaxation of
10 restrictions before Christmas, would reduce the number
11 of hospital and ICU beds required for Covid-19 patients
12 and also the number of deaths.

13 As such, Tier 3 restrictions were introduced in
14 Wales with effect from 4 December.

15 On 9 December, Dr Atherton updated the Welsh Cabinet
16 on current transmission rates. In summary, the number
17 of cases was continuing to rise, with 2,000 new
18 infections reported the previous day. Infection rates
19 were now greater than prior to the start of the
20 firebreak, whereas in Scotland rates were significantly
21 lower. Cabinet, therefore, agreed in principle that
22 Wales would move to alert level 4 restrictions from
23 28 December if infection rates did not significantly
24 fall by then.

25 On the same day Mr Gething received letters from the
85

1 change to Christmas easing of restrictions.

2 The following day, 16 December, the First Minister
3 announced that Wales would move into alert level 4,
4 a lockdown from Christmas Day, and that a smaller
5 Christmas was a safer Christmas.

6 On Saturday 19 December the First Minister updated
7 Cabinet following an earlier meeting with Mr Gove, the
8 First Ministers of Scotland and Northern Ireland, along
9 with the UK CMO and CSA. As a result of a new strain of
10 the virus, the First Minister informed Cabinet that the
11 UK Government would be announcing significant new
12 measures that would see parts of England, including
13 London, move into Tier 4 restrictions, in effect a full
14 lockdown.

15 In Wales, hospital admissions were running ahead of
16 the reasonable worst-case scenario and there was
17 significant pressure on the social care sector. Rates
18 per 100,000 in some areas of Wales were higher than in
19 some of the English Tier 3 areas that had been moved
20 into Tier 4. In the circumstances, the decision was
21 taken to bring forward alert level 4 restrictions for
22 the whole of Wales from midnight that night. The
23 First Minister describes in his written evidence to this
24 module as this being one of the hardest decisions the
25 Welsh Government faced during the whole pandemic.

87

1 chairs of two local health boards letting him know their
2 concerns that the health system could be overwhelmed.
3 Dr Goodall also emailed Mr Gething stating that there
4 was a visible increase in overall and confirmed cases
5 and that cases were in fact running ahead of the number
6 that he had shared with Cabinet as his personal
7 worst-case scenario.

8 The following day, 10 December, Mr Gething was sent
9 information from Public Health Wales containing worrying
10 information about the R number and doubling time. The
11 advice from Public Health Wales was to introduce a suite
12 of additional restrictions, essentially to impose
13 a firebreak prior to Christmas.

14 At a Cabinet meeting on 10 December, Mr Gething
15 reported that infection rates across Wales now exceeded
16 370 in every 100,000 people. The decision was taken to
17 move secondary schools and colleges to online learning
18 from Monday 14 December.

19 On 14 December Mr Gething was informed that there
20 was a new variant of Covid-19 circulating in the UK and
21 this new variant was more transmissible.

22 On 15 December, Public Health Wales advised that
23 level 4 restrictions should be brought in immediately.
24 During a ministerial call that evening Dr Atherton also
25 advised an immediate move to level 4 restrictions and a

86

1 Whilst the management of the first lockdown was
2 undertaken largely on a UK basis, with Welsh Government
3 decision-makers relying heavily on the advisory systems
4 available to them via the UK Government, these later
5 outbreaks took place at a time when the Welsh
6 Government's strategy for the management of the pandemic
7 had diverged from that of the UK Government. Whilst
8 decision-makers may claim, and have claimed, that the
9 early pandemic involved them being overwhelmed by the
10 new virus, in these later parts of the pandemic the
11 Welsh Government had at least the experience of the
12 first wave to call upon in order to ameliorate its
13 response. Issues for this module will be whether the
14 Welsh Government learned from these previous experiences
15 to prepare for and respond better to subsequent waves of
16 the virus in the interest of preventing infection and
17 ultimately saving lives? Whether a further lockdown in
18 Wales was necessary? Should the decision to lock down
19 have been taken earlier?

20 Moving into 2021, on 6 January, in light of cases
21 remaining very high in most parts of Wales, with rapid
22 increases in North-East Wales, the Welsh Cabinet decided
23 to maintain alert level 4 restrictions across the whole
24 of Wales for another three weeks. Fortunately, as Wales
25 moved into spring 2021, restrictions were able to be

88

1 eased and schools in Wales were able to resume
2 face-to-face teaching in late February 2021.

3 Heading into the winter, Omicron emerged as
4 a variant of concern. Such were the concerns that the
5 First Minister and First Minister of Scotland wrote
6 a joint letter on 29 November to the Prime Minister
7 calling for a COBR meeting to discuss the risks posed by
8 Omicron.

9 On 10 December COBR met for the first time since
10 January. COBR minutes record the UK CMO confirming with
11 high confidence that Omicron was growing rapidly across
12 the UK and infections were likely even for those who had
13 two vaccines. Dr Atherton confirmed that Wales only had
14 a small number of Omicron cases, 13 in total.

15 COBR met again on 19 December. The Covid-19
16 Taskforce reported that there had been a number of
17 Covid-19 cases across the UK over the previous five days
18 and that the two days prior broke the record for the
19 highest number of cases in a single day since the start
20 of the pandemic.

21 Dr Atherton reported that Wales was still
22 experiencing high but stable community transmission of
23 Covid-19 cases and confirmed Omicron were rising, but
24 from a low baseline.

25 On 21 December, given the increased transmissibility
89

1 struck. I've already mentioned the Covid-19 core group,
2 which consisted of the Welsh ministers and key officials
3 most involved in developing the Welsh Government
4 pandemic response.

5 In addition, the First Minister established the
6 Star Chamber in March 2020 to oversee and co-ordinate
7 the Welsh Government's fiscal response to the pandemic.
8 The BAME Covid-19 Advisory Group was also set up under
9 the leadership of Judge Ray Singh, with its two
10 sub-groups chaired by Professor Keshav Singhal and
11 Professor Emmanuel Ogbonna, who your Ladyship will be
12 hearing evidence from tomorrow.

13 The Inquiry also received evidence about the
14 Disability Equality Forum, which met regularly over the
15 course of the pandemic, chaired by Jane Hutt. Following
16 a meeting of the Disability Equality Forum on 23 June
17 2020, work began to produce a report about the
18 devastating impact of the pandemic on disabled people.
19 My Lady will be hearing from the author of that report,
20 Professor Debbie Foster, also tomorrow.

21 As part of the Inquiry's examination of Welsh
22 Government decision-making, we will be examining the
23 extent to which informal communication such as WhatsApp
24 messaging played a role in core decision-making and how
25 effective and appropriate such means of communication
91

1 of Omicron, the Welsh Cabinet decided to move to alert
2 level 2 from Boxing Day in order to slow transmission.

3 Fortunately, by the time of the 21-day review on
4 13 January 2022 there had been a rapid change in the
5 trajectory of the data, and infection rates in Wales
6 were falling. Gradually, restrictions were eased
7 throughout the spring of 2022, with the last
8 restrictions in Wales lifted in May 2022.

9 Having given that whistle-stop tour of the key
10 decisions and events of January 2020 through to
11 May 2022, I propose to next explain some of the other
12 key areas that will be explored in evidence in this
13 module.

14 The Inquiry has already heard evidence in Module 1
15 about structures which existed at UK Government level
16 and within the Welsh Government to deal with emergencies
17 such as the Covid-19 pandemic. The evidence which has
18 been heard included national entities like COBR, in
19 which it was envisaged that the Welsh Government would
20 play a part, but also local entities, like the Shadow
21 Social Partnership Council, which was set up to bring
22 together employers, employees and the voluntary sector
23 and which met regularly during the pandemic.

24 As well as existing structures, new entities were
25 created to deal with and respond to the pandemic when it
90

1 were. To this end, the Inquiry has disclosed hundreds
2 of WhatsApp and text messages from numerous messaging
3 groups, including messages from prominent Welsh
4 Government ministers, including the First Minister, and
5 others in key advisory roles within the Welsh
6 Government. Although it does not appear that text or
7 WhatsApp exchanges were used as an alternative to formal
8 decision-making processes, the messages do shed light on
9 and provide relevant context to some of the key
10 decisions which the Inquiry will be examining in this
11 module.

12 There are instances where the Inquiry has received
13 evidence that informal communications have been deleted
14 by the participants. The Inquiry will wish to know why
15 and how such messages are now not available for
16 inspection.

17 The Inquiry has also received copies of Welsh
18 Government policies about the use and retention of
19 informal communications. The Inquiry will wish to know
20 the extent to which these policies have been complied
21 with and compliance with them policed.

22 The importance of the advice provided to the Welsh
23 Government is a matter upon which I've already touched.
24 In this module we will examine the advisory systems
25 which the Welsh ministers had access to in formulating
92

1 their strategy to combat the virus. In particular, we
 2 will look at the extent to which established advisory
 3 systems available to the Welsh Government via UK-wide
 4 structures such as SAGE and NERVTAG provided Wales with
 5 a reasonable opportunity to seek and receive appropriate
 6 advice upon which to base its decisions, the
 7 circumstances in which Wales came, during the course of
 8 a public health emergency, to form its own, new bespoke
 9 advisory systems, in the form of TAG and TAC, the
 10 operation of those systems, the composition of key
 11 advisory bodies, the advice which they provided, the
 12 extent to which it was appropriately communicated,
 13 understood and acted upon.

14 The significance of data, and in particular local
 15 data and modelling, will be examined as well as whether
 16 adequate local data was available to assist in the Welsh
 17 Government's strategic response.

18 The limited testing capacity at the start of the
 19 pandemic meant it was hard to know how the virus was
 20 spreading and where. The extent to which systems for
 21 data collection and assimilation were adequately
 22 improved as the pandemic went on will be considered, as
 23 well as the extent to which data was reasonably
 24 publicised and explained in order to maximise the
 25 public's understanding of the threat and steps being

93

1 coronavirus laws and regulations in Wales proportionate?

2 The Coronavirus Act had its genesis in the draft
 3 Pandemic Influenza Bill, work on which was ongoing for
 4 some time. Some argue that ministers were able as
 5 a result to impose significant restrictions on the
 6 public with less parliamentary scrutiny. Was this the
 7 case? If so, was this appropriate and understood? Did
 8 a lack of clarity in legislation and regulations make it
 9 difficult for the Welsh public to know what was
 10 criminalised and what was not, and also to lead to
 11 uneven enforcement? How was the balance struck between
 12 incentivising people to adhere to social restrictions
 13 such as self-isolation and punishing them for breaches?
 14 Were the rules enforced fairly?

15 Having been through some of the key events and core
 16 decisions, and identified the issues, I now need to make
 17 some points about the way in which the Inquiry will
 18 approach its task.

19 At the outset, the Inquiry recognises that there
 20 were no easy decisions. The Welsh Government, in common
 21 with all other governments, was required to make
 22 extremely serious and far-reaching decisions about how
 23 it would respond. It faced terrible dilemmas in the
 24 knowledge that a wrong or ill-judged step could prove to
 25 be extremely damaging, perhaps in entirely unintended

95

1 taken to combat.

2 The role of cross-border data collection and
 3 analysis exercises will also be considered, including
 4 the extent to which these worked in the best interests
 5 of Wales to make sure that a combination of local data
 6 and data beyond Wales was being used efficiently to
 7 understand the nature of the threat both generally and
 8 specifically to the people of Wales.

9 The Inquiry will seek to ask how effective the Welsh
 10 Government's public health communications were. Were
 11 the rules on meeting outdoors, social distancing and
 12 staying local so complex as to be unwieldy and
 13 counterproductive? Were the public health
 14 communications accessible for vulnerable and minority
 15 groups? What, finally, was the impact of alleged or
 16 proved breaches of rules and standards by ministers,
 17 officials and advisers?

18 Turning, finally, to the issue of enforcement. The
 19 list of issues for this module identifies the following
 20 questions: how and by what means were coronavirus laws
 21 and regulations enforced in Wales? Why did the Welsh
 22 Government decide that criminal sanctions were
 23 necessary? When making this decision, what
 24 consideration was given to vulnerable and at-risk
 25 groups? In general terms, was the enforcement of

94

1 ways. Its decisions were literally matters of life and
 2 death.

3 This module will not be attempting to substitute its
 4 own judgement for that of the Welsh Government
 5 decision-makers. It will be examining instead whether
 6 the key decisions were not just open to the
 7 decision-makers to take, but well reasoned, that is to
 8 say sufficiently well thought out, sufficiently speedy
 9 but taken after suitable consideration and thought, and
 10 justifiable in the context in which they were made and
 11 in light of the knowledge then available.

12 There may not have been a single right answer in the
 13 exercise of the Welsh Government's high level strategic
 14 decision-making, but there could certainly have been bad
 15 answers, decisions that were not properly justified or
 16 answers that were unnecessarily delayed. Whether there
 17 were will have to await the evidence.

18 The point about knowledge is critical. The Inquiry
 19 does not intend to enquire through the distorted lens of
 20 hindsight. For this reason, in the particular context
 21 of lockdown decision-making, counterfactual scenarios
 22 such as how many deaths would have occurred if the
 23 government had done or not done that must be treated
 24 with particular caution.

25 The evidence may show that the odds were always

96

1 stacked against Wales because the demographic
 2 characteristics of the Welsh population, in particular
 3 the differences in health and age profile in Wales,
 4 meant the impact of the virus was always likely to be
 5 more acute. But the evidence may also show -- we will
 6 have to see -- that there was actually a failure of
 7 technical insight. Was the inevitable spread of the
 8 virus after the end of January properly appreciated by
 9 the Welsh Government? Were the consequences of the
 10 likely lack of control measures adequately understood?
 11 Was there a failure to scale up resources? Was there
 12 a failure of process? Was there a failure to obtain and
 13 consider specialist non-scientific advice, such as
 14 societal, economic, education impact and real world
 15 events, alongside the advice from TAG, TAC and SAGE?
 16 Was a proactive strategy adopted and pursued, or did the
 17 Welsh Government simply follow the UK Government's lead?
 18 Was there a failure of leadership and decision-making?
 19 The Inquiry will need to enquire whether there was
 20 a lack of national strategic leadership and
 21 co-ordination from the Welsh Government in January and
 22 February 2020. The Inquiry will enquire into whether
 23 the Welsh Government demonstrated sufficient leadership
 24 when it came to the events of March 2020, the first
 25 lockdown, the re-emergence of the virus in September,

97

1 (2.00 pm)

2 **LADY HALLETT:** Ms Gowman.3 **Submissions on behalf of Covid-19 Bereaved Families for**
 4 **Justice Cymru by MS GOWMAN**5 **MS GOWMAN:** Thank you, my Lady.

6 Prynghawn da a chroeso i Gymru, good afternoon and
 7 welcome to Wales, my Lady. I appear on behalf of
 8 Covid-19 Bereaved Families for Justice Cymru.
 9 12,510, the number of deaths registered in Wales
 10 where Covid-19 is mentioned on the death certificate as
 11 at 2 February 2024. Countless lives lost and so many
 12 more shattered. Against this context, the Welsh
 13 bereaved are still fighting for truth, justice and
 14 accountability.

15 Module 2B will scrutinise the Welsh Government
 16 pandemic response. During the pandemic, the Welsh
 17 Government asserted its right to do things differently
 18 using its devolved powers, it claims to have adopted an
 19 evidence-based approach to pandemic response measures
 20 tailored to Wales. The Cymru group has significant
 21 misgivings and considers that harmful mistakes were
 22 made.

23 Any government would be hard pressed to match the
 24 shocking display of arrogance and central government
 25 toxicity within Westminster at that crucial time,

99

1 the firebreak in October, and the lockdown of
 2 January 2021.

3 Finally, we must pay thanks to the individual
 4 efforts and heroism of civil and public servants and
 5 health and social care workers who put their lives on
 6 the line to battle the pandemic, the scientists, medics
 7 and commercial companies who were able to produce
 8 life-saving treatments and ultimately vaccines, the
 9 local authority workers and volunteers who delivered
 10 food and medicine to elderly and vulnerable people and
 11 who vaccinated the population, and the emergency
 12 services, transport workers, teachers, food and
 13 medicinal industry workers and other key workers who
 14 kept Wales going through the darkest of days.

15 Through this Inquiry we seek not only answers but
 16 also hope. Never again can a virus be allowed to lead
 17 to so many deaths and so much suffering. In the face of
 18 unprecedented challenges we must uncover the truth,
 19 learn from our experiences and chart a path forward that
 20 ensures the safety, well-being and resilience of Wales.

21 **LADY HALLETT:** Thank you very much indeed, Mr Poole.

22 We'll break now, and I shall return at 2 o'clock to
 23 hear from Ms Gowman.

24 (12.58 pm)

(The short adjournment)

98

1 however the Inquiry must guard against unhelpful
 2 comparisons. The Westminster yardstick sets the bar
 3 particularly low. The Welsh Government must be judged
 4 not solely by comparison to what was happening in
 5 Westminster but by its own standards, its own evidence,
 6 by what it knew and when.

7 This module is particularly important for the Cymru
 8 group, as it remains bitterly disappointed that despite
 9 repeated calls from the Welsh bereaved and political
 10 community, the Welsh Government has refused to open
 11 itself to scrutiny by establishing a Wales-specific
 12 inquiry. The Welsh Government has established a special
 13 purpose committee to supplement the work of the
 14 UK Inquiry, however it lacks teeth and has been likened
 15 by one of its own members to using a sticking plaster to
 16 treat a bad wound. The Cymru group considers that the
 17 Welsh Government seeks to thwart a granular inspection
 18 of Welsh decision-making, seeking instead to hide behind
 19 and deflect blame onto the UK Government, and within
 20 this context it is very much welcomed that this Inquiry
 21 will shine a spotlight on the decision-making in Wales
 22 and will do its utmost to investigate and analyse fully
 23 and fairly the most significant issues impacting Wales.

24 The Inquiry's ongoing commitment to facilitating the
 25 participation of the Welsh bereaved is also welcomed.

100

1 The decisions made by Welsh Government must be
 2 understood through the lived experiences of the Welsh
 3 people. The Welsh bereaved saw first-hand consequences
 4 of deficiencies in preparedness and response. They
 5 witnessed individual and systemic failures as Covid-19
 6 spread like wildfire through hospitals and care homes,
 7 fuelled by derisory testing regimes and inadequate PPE.
 8 The voices of the bereaved in Wales must, have and will
 9 continue to be heard in the powerful testimony to come.

10 Some of the most insightful evidence, my Lady, in
 11 Module 2 came from contemporaneous informal
 12 communications such as WhatsApp and text message. The
 13 Welsh Government claims to have disclosed all material
 14 within its possession. However, the disclosed material,
 15 we say, is belated and dubiously limited. Some in Welsh
 16 Government deny the use of informal communication for
 17 government business, but this does not ring true or bear
 18 scrutiny. Others claim that messages were simply
 19 deleted. This is questionable and contrary to the words
 20 of the First Minister's official spokesman who said to
 21 the press on 7 November 2023 that staff were regularly
 22 reminded of the need to maintain and retain robust
 23 records relating to decisions taken throughout the
 24 pandemic.

25 The limited messages that have been disclosed

101

1 SAGE's English-centric focus justifiable? And was the
 2 establishment of TAG and TAC necessary and effective in
 3 achieving its aims?

4 Documents disclosed to the Inquiry point to
 5 deficiencies in respect of TAG and TAC, with concerns
 6 raised in respect of independence, expertise, capacity
 7 and co-ordination. Disclosure from one subgroup
 8 suggests that the engagement with TAG was never really
 9 formalised and the commissioning of work was almost
 10 completely informal and haphazard. Many requests were
 11 verbal and responding to some specific point, with
 12 almost a knee jerk or panic flavour to them.

13 Further, it is suggested that Wales struggled to
 14 have its voice heard at UK scientific fora, a small fish
 15 in a larger pond. And what impact did that have?

16 The Inquiry should also examine the interface
 17 between science advice and policy. Did policymakers ask
 18 the right questions, and were they able to effectively
 19 translate scientific advice into robust policies? The
 20 Cymru group is concerned to read that there has only
 21 been a low level of challenge from policy teams to
 22 scientific advice, which suggests a sign of policy
 23 weakness.

24 Finally on this topic, it is also of real concern
 25 that at the start of the pandemic the disclosure

103

1 clearly show WhatsApp and text messages used to discuss
 2 government business where they shouldn't have been.
 3 They show Welsh Government's senior special advisers
 4 suspiciously and systemically deleting communications.
 5 They show special advisers reminding themselves and
 6 others that they had agreed "to clear out WhatsApp chat
 7 once a week". They show Jane Runeckles, the most senior
 8 special adviser for the First Minister for Wales, and
 9 Vaughan Gething, Minister for Health, turning on
 10 disappearing messages. They show that despite asserting
 11 to the Senedd that he did not use WhatsApp, Mr Drakeford
 12 was regularly using WhatsApp to discuss policy,
 13 announcements and even to seek clarification on the
 14 rules. This beggars belief.

15 The Welsh bereaved look forward to hearing how the
 16 Welsh Government justify the use of informal
 17 communications for government business, and to
 18 understand why full access to all informal communication
 19 has not been made available to allow for full scrutiny
 20 of policy discussions and decision-making via this
 21 forum.

22 On science and modelling, TAG, TAC and its subgroups
 23 were established "not to re-create all the SAGE
 24 mechanisms but to allow us to just simply translate the
 25 implications of that into the Welsh context". Was

102

1 suggests that Wales did not have any modelling
 2 capability, leading to over-reliance on SPI-M models,
 3 notwithstanding the "poor fit" for Wales.

4 Did Welsh Government act quickly to identify
 5 modelling needs and mobilise expertise? If not, what
 6 impact did this have on the Welsh Government's response?
 7 There must be close scrutiny of the Welsh Government's
 8 early response to the threat of the virus, including
 9 whether valuable time was lost in January, February and
 10 March 2020.

11 The Inquiry heard in Module 2 that by late
 12 January 2020, and by 4 February at the very latest,
 13 the UK Government should have been electrified into
 14 action, and the Welsh Government should equally have
 15 been so electrified.

16 On the contrary, the disclosure suggests that the
 17 Welsh Government's initial response was slow, chaotic
 18 and disjointed, notwithstanding clear evidence that the
 19 NHS in Wales was imminently to become overwhelmed. The
 20 CTI has stated that the evidence suggests that during
 21 February 2020 the virus was not a priority for the Welsh
 22 Government, and the Cymru group agrees. The
 23 observations of Public Health Wales' then lead strategic
 24 director are also telling. He states:

25 "What I think was missing in the first few weeks

104

1 from 8 January 2020 when I first became aware to
2 20 February 2020 when the [Health and Social Services
3 Group] Coronavirus Planning and Response Group first
4 met, was national strategic leadership and co-ordination
5 from Welsh government."

6 A view also seemingly echoed by the Chief Scientific
7 Adviser for Health.

8 After the first case in Wales was reported on
9 28 February 2020, the disclosure suggests that the
10 response continued to be slow and the Welsh Government,
11 led by the nose of a clumsy UK Government, failed to act
12 with focus and speed required to anticipate and prepare
13 for the interventions that became necessary. Armed with
14 scientific data, it was open to the Welsh Government as
15 a devolved administration to act sooner. Why didn't it?
16 Why did it blindly follow the UK Government in a case of
17 the blind leading the blind?

18 Why, for example, was the Welsh Government so slow
19 to ban mass gatherings, declining to cancel the Wales
20 versus Scotland rugby match and two Stereophonics
21 concerts in mid-March, despite the increasing rates of
22 community transmission evident at that time?

23 Third, what were the consequences of inadequate
24 early response? The disclosure suggests that by reason
25 of the Welsh Government's deficient response it was

105

1 transmission. The Cymru group wishes to understand the
2 steps which could and should have been taken from that
3 moment on.

4 Mr Drakeford in his witness statement states that
5 there needed to be sufficiency of evidence before
6 operational decisions could be based on it. In the
7 absence of certainty on asymptomatic transmission, but
8 in the context of clear risk evidence, decision-makers
9 could and should have erred on the side of caution. And
10 I note, my Lady, that this was an argument traversed at
11 length in Module 2, and Mr Drakeford's observations in
12 that regard didn't hold up to scrutiny.

13 The failure to heed the risk is unacceptable. One
14 area where the failure to acknowledge risk of
15 asymptomatic transmission had devastating consequences
16 in Wales was in respect of the decision taken to
17 discharge people from hospital into care homes without
18 testing. The accounts of the bereaved are stark. One
19 member of the Cymru group states:

20 "My father, and others, were discharged from
21 hospital to care homes across the borough to make room
22 for anticipated Covid patients. None of these people
23 who were discharged were tested."

24 In respect of discharge to care homes, guidance
25 issued in Wales on 8 April 2020 raised that negative

107

1 deprived of precious time to armour up for battle, to
2 prepare the interventions required. During this lost
3 time, decision-makers in Wales could and should have
4 been liaising with key partners, establishing effective
5 consultative fora, and formulating co-produced plans on
6 a whole range of non-pharmaceutical interventions,
7 including track, trace and isolate and PPE, and
8 bolstering the fragmented health and social care sector
9 against the foreseeable demands to be placed on it.

10 Finally, leading the charge on the pandemic was the
11 First Minister for Wales, his Cabinet and his special
12 advisers. In Wales, we have a saying, [Welsh spoken],
13 which translates to "A man without prudence is a ship
14 without an anchor". The Inquiry will consider whether
15 this First Minister effectively steered the Welsh ship
16 through the pandemic storm, and did the Cabinet and
17 special advisers serve him well as his second mate. The
18 Cymru group is unconvinced, perturbed instead by its
19 perception of chaos.

20 Moving on to transmission, the Cymru group asks the
21 Inquiry to examine the evidence which was available at
22 all stages of the pandemic in relation to asymptomatic
23 and airborne transmission. The disclosure is clear that
24 as early as 28 January 2020, SAGE and in turn the Chief
25 Scientific Adviser for Wales, were aware of asymptomatic

106

1 tests were not required prior to transfers or admissions
2 into the residential setting. Thus essentially
3 endorsing the discharge of potentially infectious
4 asymptomatic and symptomatic patients into care homes.
5 The Welsh Government's eventual decisions on 22 and
6 29 April 2020 to firstly test everybody being discharged
7 to a care home and, later, to provide step-down
8 facilities for those who had tested positive, was
9 a change that came later in Wales than in England.

10 Similarly, the decision to extend testing to all
11 staff and residents in care homes was not taken until
12 16 May 2020, again slower than the other three nations.
13 Why did Welsh Government delay in changing its policies
14 to factor in the risks of asymptomatic transmission?
15 Did the Welsh Government give thought to the likelihood
16 of the rapid spread of the virus amongst the most
17 vulnerable? The perception of the Cymru group is that
18 the delay was akin to a death warrant for the elderly,
19 and a stark message from the Welsh Government that they
20 did not matter.

21 A further area which saw similarly disastrous
22 consequences was in respect of the failure to provide
23 timely testing for healthcare workers. One Cymru member
24 states:

25 "My father caught Covid while in hospital. The

108

1 nursing staff were quite open about the circumstances --
2 the nurses had gone to work thinking they had a cold,
3 when really they had Covid."

4 Next the Cymru group asks the Inquiry to scrutinise
5 the issue of airborne transmission. The evidence from
6 Module 2 established that the possibility of Covid-19
7 being airborne should have been recognised from an early
8 stage. Given what was known, the Cymru group states
9 that stronger measures should have been taken at
10 an early stage to mitigate against the risk of airborne
11 transmission, including public messaging, guidance,
12 targeted NPIs, for example mandating the use of FFP2 and
13 FFP3 masks for healthcare workers. Did Welsh Government
14 decision-making accurately reflect the scientific
15 understanding of transmission as it unfolded and
16 adequately mitigate the risks? If not, why not?

17 Next, the events of autumn 2020. In the face of
18 mounting concerns regarding the increasing prevalence of
19 the virus on 21 September 2020, SAGE recommended
20 a firebreak. What followed was an unacceptable delay by
21 the Welsh Government in the face of failed lockdowns, as
22 it ignored TAC warnings and unjustifiably dragged its
23 feet, with the announcement of a firebreak eventually
24 being made almost one month later on 19 October.

25 Welsh Government had again let cases get too high
109

1 measures such as mask wearing at an earlier stage
2 robustly challenged.

3 There was also significant scope for confusion,
4 disruption, and increased risk to those living in Wales
5 by reason of the divergence in NPIs. Given the need for
6 consistent, clear communication with the public, there
7 should have been good reason for any areas of divergence
8 in policy between the four nations. The Inquiry must
9 examine whether divergences were based on sound reason
10 or whether, for example, they were politically motivated
11 or otherwise misguided. The Inquiry must examine,
12 bearing in mind the risk of confusion, whether the Welsh
13 Government did all it could to seek to prevent repeated
14 and avoidable ambiguity in the UK Government's public
15 messaging and to ensure that its own messaging was
16 crystal clear.

17 Turning to my final topic, my Lady,
18 intergovernmental relations. The way in which the UK
19 and devolved administrations interacted with each other
20 in a time of prolonged crisis is a vitally important
21 area of examination. We know from Module 2 that there
22 wasn't a formal structure for regular meetings between
23 First Ministers of the devolved administrations and the
24 Prime Minister of the UK Government, especially after
25 May 2020, when COBR ceased to meet regularly. Despite

111

1 before imposing a lockdown. Did it learn nothing from
2 wave 1?

3 The Welsh Government appears to blame
4 the UK Government funding decisions for the delay but
5 there is clear evidence to refute this suggestion which
6 we hope will be put to witnesses.

7 Further, the group wishes to understand why the
8 restrictions introduced following the autumn firebreak
9 were, in the words of Wales' Chief Scientific Adviser
10 for Health, "insufficient to control the growth of the
11 epidemic". What controls should have been put in place
12 and why weren't they?

13 There are many areas of divergence in
14 non-pharmaceutical interventions between the Welsh
15 Government and the UK Government, for example on
16 testing, face coverings, circuit-breakers and relaxation
17 of restrictions. The bereaved want to understand the
18 justification for Welsh Government divergent
19 decision-making when the core science was the same.

20 Further, crucial decisions made by the Welsh
21 Government such as on testing and face coverings, as
22 I've already indicated, were made later than the
23 corresponding decisions in the rest of the UK. Why?
24 And in particular, the bereaved want to see the
25 rationale for not mandating low harm precautionary

110

1 this, the evidence in Module 2 suggests that there were
2 plenty of opportunities for regular contact between
3 Welsh Government and UK Government at many levels. Is
4 that correct? If not, if the Welsh Government had
5 concerns about the level of engagement, what did it do
6 about it?

7 The wider question is whether the Welsh Government
8 genuinely sought to forge relations that would enable
9 the best chance of alignment of policy where necessary,
10 or whether there was a tendency towards silos and
11 anti-Tory default position of one-upping and blaming the
12 UK Government. There should have been no place for
13 playing party politics in a pandemic, with lives at
14 stake, and the Cymru group wishes to understand the
15 extent to which party politics and public perception
16 impacted on the Welsh Government's willingness to engage
17 with and approach the UK Government in a spirit of
18 collaboration.

19 My Lady, my conclusion will be delivered in Welsh,
20 followed by English, and I'm told that I must pause to
21 allow anybody who wants to listen via the headset to
22 plug in.

23 **LADY HALLETT:** Unless the English is a translation of the
24 Welsh.

25 **MS GOWMAN:** It is.

112

1 **LADY HALLETT:** Otherwise we can wait for the English.
 2 **MS GOWMAN:** Absolutely.
 3 **(Interpreted):** My Lady, there has been some
 4 acknowledgement by some witnesses that some errors were
 5 made by the Welsh Government in response to the
 6 pandemic, however the Cymru group considers the general
 7 tenor of the Welsh Government's evidence to be a gloss
 8 minimisation or the heavy caveat of hindsight;
 9 unacceptable diversion from accountability. The Cymru
 10 group is concerned that the Welsh Government has failed
 11 to meaningfully reflect on its decision-making during
 12 the pandemic to identify learnings. This concern is
 13 somewhat supported by the Welsh Local Government
 14 Association's evidence, which suggests that lessons
 15 learned exercises completed by Welsh Government have
 16 been carried out without input from its key partners.
 17 The reality is that disclosure shared with this
 18 Inquiry suggests that errors were made. These errors
 19 caused unnecessary pain and suffering to the deceased
 20 and their loved ones. We invite the live witnesses to
 21 be reflective, accountable and to give full and
 22 transparent answers to this Inquiry so that lessons can
 23 be learnt. And there will be lessons to be learnt, and
 24 the Inquiry must make findings to prompt change.
 25 To cite another Welsh proverb, [Welsh spoken],
 113

1 transparent answers to this Inquiry so that lessons can
 2 be learnt, because there will be lessons to be learnt,
 3 and the Inquiry must make findings to prompt change.
 4 To cite another Welsh proverb, [Welsh spoken],
 5 "Adversity brings knowledge, and knowledge, wisdom".
 6 Changes must be made speedily in the light of any
 7 findings so that when the next pandemic strikes, as it
 8 inevitably will, the people of Wales will be better
 9 protected from harm and loss of life.
 10 Diolch am wrando, thank you for listening, my Lady.
 11 **LADY HALLETT:** Thank you very much indeed, Ms Gowman. Very
 12 grateful.
 13 Mr Straw, any Welsh passages from you?
 14 **Submissions on behalf of John's Campaign and Care Rights UK**
 15 **by MR STRAW KC**
 16 **MR STRAW:** My Lady, I represent John's Campaign and Care
 17 Rights UK.
 18 I'd like to start by reading some excerpts from two
 19 letters. The first is from Mrs Jenny Davies about her
 20 husband Meirion Davies to the First Minister of Wales
 21 and Mr Gething on 28 September.
 22 **(Pause)**
 23 Thanks very much.
 24 The first letter is from Mrs Jenny Davies about her
 25 husband Meirion Davies to the First Minister and
 115

1 "Adversity brings knowledge, and knowledge, wisdom".
 2 Changes must be made speedily in the light of any
 3 findings so that when the next pandemic strikes, as it
 4 inevitably will, the people of Wales will be better
 5 protected from harm and loss of life.
 6 **(In English):** My Lady, there has been some
 7 acknowledgement by some witnesses that some errors were
 8 made by the Welsh Government in the response to the
 9 pandemic, however the Cymru group considers that the
 10 general tenor of the Welsh Government's evidence is one
 11 of gloss, minimisation or the heavy caveat of hindsight,
 12 unacceptable divergence from accountability.
 13 The Cymru group is concerned that the Welsh
 14 Government has failed to meaningfully reflect on its
 15 decision-making during the pandemic to identify
 16 learnings. This concern is somewhat supported by the
 17 Welsh Local Government Association's evidence, which
 18 suggests that lessons learned exercises completed by
 19 Welsh Government have been carried out without input
 20 from its key partners.
 21 The reality is that disclosure shared with the
 22 Inquiry suggests that errors were made. These errors
 23 caused unnecessary pain and suffering to the deceased
 24 and their loved ones. We invite the live witnesses to
 25 be reflective, accountable and to give full and
 114

1 Mr Gething on 28 September 2020. She says:
 2 "Do you know when I can see my husband in his
 3 nursing home again? I have achieved one 15-minute
 4 indoor visit in six months. At the moment there are no
 5 visits allowed because of lockdown. How would any human
 6 being like it if they received a phone call which in
 7 effect meant 'Sorry, you can't see your husband any
 8 more, and we're keeping him locked up here'.
 9 Baroness Ros Altmann, member of the House of Lords, had
 10 the courage to say on television recently that
 11 loneliness and starvation would be more likely to cause
 12 death than Covid-19. A great many people agree with
 13 this. The government really needs to listen to
 14 John's Campaign and authorise one family caregiver to
 15 have the right to visit and to be recognised as
 16 a key worker. Care home residents are being kept like
 17 prisoners and being denied their human rights."
 18 That's from Mrs Jenny Davies' letter in 2020.
 19 On 22 May 2022, a coalition of 60 MPs signed
 20 a letter produced by Care Rights UK and John's Campaign
 21 referring to the devastating harm and harrowing
 22 experiences which the restrictions were continuing to
 23 cause for those in care. Still, nearly two years on,
 24 the problem identified by Mrs Davies hadn't been
 25 properly addressed, and the letter maintained the call
 116

1 for a right to a care supporter, in other words a family
2 or friend to provide care.
3 My Lady, I start with those two letters because we
4 respectfully submit that the Inquiry should focus on
5 people, the individuals who were affected by the
6 pandemic. Core decisions are only significant when they
7 impact on people, and it's important that those
8 decisions are seen through that lens. In this context,
9 we warmly welcome the fact that this module has started
10 with a video of the experiences of individuals affected
11 by the pandemic.

12 The two letters also illustrate several themes which
13 I'd like to come back to. For example, for those
14 needing care, the Covid restrictions caused severe and
15 disproportionate indirect harm. There was a failure by
16 core decision-makers to take it into account and, more
17 broadly, to take proper account of input from
18 stakeholders. There was also a failure by core
19 decision-makers to adjust restrictions in light of that
20 indirect harm.

21 My submissions focus on people needing and providing
22 care. Now, that's not just those in care homes, it's
23 also people receiving care at home, in hospitals, in
24 mental health units, or otherwise. It's not just the
25 old, but it's also young people who are in need of care

117

1 core decision-making.

2 So the first example is indirect harm. Core
3 decision-makers failed to pay sufficient attention to
4 indirect harm and to mitigate it. The government
5 obtained detailed evidence about Covid and the extent to
6 which restrictions would tackle it, but comparatively
7 little evidence was obtained about indirect harms.
8 Covid was often the overriding consideration but
9 decisions should have been made by balancing not just
10 the harm caused by Covid but the harm that would be
11 caused by the restrictions that would be imposed in
12 response.

13 That point is well illustrated, we say, by reference
14 to those needing care. Restrictions led to severe
15 indirect harm on those needing care and that's set out
16 in more detail in paragraphs 14 to 21 and 38 of our
17 submissions.

18 Notwithstanding the high proportion of overall
19 deaths from Covid of those needing care, Covid wasn't
20 the biggest problem for them. In fact, it was only
21 a small proportion of the overall deaths of those in
22 care homes. 83.3% of care home deaths were from causes
23 other than Covid during the pandemic. In Welsh
24 care homes, dementia and Alzheimer's remained the
25 highest causes of death throughout the whole period.

119

1 as well. And we focus on care in part because it's
2 a useful context to illustrate the broader problems in
3 core decision-making. But we also focus on care because
4 this group really was at the sharp end of the pandemic.
5 It perhaps suffered more than any other group as a
6 result of Covid and the response to it.

7 That's supported by statistics, for example, those
8 which we set out at paragraphs 5 to 8 of our written
9 submissions. For example, in the first three months of
10 the pandemic, 39% of deaths in the UK were of care home
11 residents. Many more were deaths of those receiving
12 care outside the care home, for example in domiciliary
13 care. There was a far higher rate of death of care home
14 residents than in hospitals. There was also devastating
15 indirect harm.

16 This was an emergency within an emergency, and it
17 should have received central attention by
18 decision-makers, but it didn't. In many ways the
19 care sector was overlooked.

20 I'd like to come to some specific examples now, but
21 to summarise those, they show three core things.
22 Firstly, those needing or providing care weren't given
23 sufficient attention. Secondly, core decisions about
24 those in care were flawed. And thirdly, these examples
25 help understand the broader flaws that there were in

118

1 Similarly, in domiciliary care, there was a 225%
2 increase in excess deaths in the first wave. The great
3 majority of that was from non-Covid causes, 77%. Yet
4 Covid was prioritised over all else.

5 The restrictions that were imposed caused severe
6 interruptions to medical care and treatment. The number
7 awaiting medical treatment, including serious conditions
8 such as cancer, increased nine-fold. Restrictions also
9 prevented contact with essential or family carers, and
10 that meant a loss of critical care and support for those
11 who needed it most.

12 The specifics of this are explained in more detail
13 by the Older People's Commissioner and by
14 John's Campaign in their witness statements. For
15 example, they explain that these carers check for health
16 problems, check for sores, dehydration, for pain, help
17 communicate, help to explain whether the individual was
18 suffering pain or to identify medical problems that they
19 suffered. The carers helped to provide medical care,
20 for example medicine or physiotherapy. The restrictions
21 interrupted that critical care that they could provide.

22 This, together with the isolation itself, had many
23 adverse consequences which were raised from an early
24 stage. For example by Age UK, they explained that the
25 restrictions had a profound impact on physical and

120

1 mental health. Amnesty, in 2020, recorded that every
2 single one of the family members and care home staff
3 interviewed by Amnesty International expressed the
4 concern that the prolonged isolation of care home
5 residents had devastating consequences.

6 Similar concerns were raised by many other
7 stakeholders, Mencap, the Older People's Commissioner,
8 John's Campaign, Care Forum Wales, Care Rights UK, the
9 Patients Association, the Alzheimer's Society and
10 others, and yet those concerns were either not listened
11 to or not properly responded to.

12 It was not only a physical and mental deterioration
13 that the restrictions led to, but in addition there was
14 the emotional point of spending the last months of one's
15 life alone and in pain with no support of one's loved
16 ones. That, for many, was a critical factor which was
17 forgotten.

18 So there are two issues we say really concerning
19 indirect harm. The first is that a number of the core
20 decisions about restrictions were inappropriate in light
21 of the indirect harm. I'll come back to that in more
22 detail in a moment.

23 The second issue is that there was insufficient
24 understanding of indirect harm by core decision-makers
25 and/or a failure to take it into account. That's the

121

1 limited, few people were invited to provide input, it
2 wasn't a focused consultation on specific issues. But
3 perhaps more importantly, it was ignored, it didn't feed
4 into the core decisions. And that's the view of many
5 stakeholders in this area, including Professor Wincott,
6 who said there was an absence of data on social care,
7 and this was a serious gap in the evidence base for
8 policymaking in Wales.

9 A third issue, a third specific example, is the
10 discharge decision in March/April 2020 without prior
11 testing. We agree with Mr Poole King's Counsel that
12 there is no doubt that there was a massive failure of
13 infection control, contributed at least in part to the
14 influx of infected but untested patients into
15 care homes. And we say that was obvious, for three key
16 reasons.

17 Firstly, there were very high rates of Covid-19 in
18 hospitals at the time; secondly, those in care were
19 obviously highly vulnerable to Covid-19; and, thirdly,
20 asymptomatic transmission was well recognised by
21 17 March.

22 That was the date on which it was announced that
23 people would be discharged without prior testing. The
24 policy was maintained from 17 March until the start of
25 May. Large numbers of people as a result were

123

1 view of many stakeholders. It's also the view of
2 a number of those in government. For example, the Chief
3 Information Officer, Mr Nelson, TAG's policy modelling
4 group, Professor John Watkins, Dr Chris Williams from
5 Public Health Wales, Dr Rob Orford, the Chief Scientific
6 Adviser, Professor Michael Gravenor, all expressed the
7 concern that not enough was done to understand indirect
8 harms.

9 Even as late as July 2021 TAG expressed the concerns
10 that indirect harms are less well understood and
11 measured, and that was within its five harms guidance.

12 So the explanation isn't that this information
13 wasn't unobtainable, it was readily available from
14 an early stage. We look forward to exploring in
15 evidence in more detail why it was that this evidence
16 was overlooked.

17 It appears that this is linked to a broader
18 procedural flaw, which is a failure to take into account
19 information from stakeholders or experts. There were,
20 in this context, in the care context, some opportunities
21 at least to provide comments, and that was positive,
22 for example the Care Forum Wales, Older People's
23 Commissioner and the mid-2021 Locked Out report were
24 opportunities for some people in this area to provide
25 feedback. But that wasn't sufficient. Firstly it was

122

1 discharged into care homes.

2 Now, the reason for the May 2020 decision, the
3 reversal, which was to test people who -- even people
4 who were asymptomatic, was because of the recognition of
5 the risk of asymptomatic transmission. But we say that
6 risk was well known well before May 2020, indeed it was
7 well known before 17 March 2020.

8 The evidence of that has been usefully summarised in
9 a decision of the Divisional Court in the case of
10 Gardner. Paragraphs 34 to 125 set out extensive
11 evidence that that was known before.

12 There's other evidence that's before the Inquiry.
13 To give a few examples, Professor Watkins on
14 28 February 2020 in the British Medical Journal wrote
15 an article which was widely cited which recognised the
16 risk of asymptomatic transfer. The Chief Scientific
17 Adviser for Health was told on 1 April 2020 that there
18 are potentially a high proportion of infectious people
19 who are symptomatic. Yet despite that -- we say it's
20 inexplicable that there was a month's further delay in
21 responding to that at a critical time.

22 So we understand that it will be uncontroversial
23 that the government failed to identify or take into
24 account evidence of asymptomatic transmission, and
25 that's because a Welsh Government scientific evidence

124

1 advice report in November 2022 itself accepted that
2 discharge without prior testing overlooked the potential
3 risk for asymptomatic transmission.

4 This again illustrates a broader problem in core
5 decision-making: the failure to properly consult
6 stakeholders and experts and the failure to take that
7 information into account.

8 One specific example of that is that on
9 22 March 2020 Mr Heaney told Mr Gething that isolation
10 facilities in care homes would be put in place to manage
11 these discharges. It appears that was one of
12 Mr Gething's reasons behind the decision. But in fact
13 up to 58% of care homes did not feel able to effectively
14 isolate suspected Covid-19 residents. That's from
15 an Alzheimer's Society survey in May 2020. Again, that
16 information was available, had the government properly
17 consulted people. But it didn't.

18 A fourth example, fourth specific example, concerns
19 restrictions on visits for those needing and providing
20 care. There were stringent restrictions in place,
21 essentially a blanket ban, for much of the time, from
22 March 23, 2020 until May 2021, and onerous restrictions
23 continued thereafter. The adverse effect of those
24 restrictions had been made clear by mid-2020, perhaps
25 earlier. Many stakeholders had told the government or
125

1 on the other hand, the harm that the restriction would
2 cause, the harm that no visits would cause.

3 In addition, the personal wishes, the autonomy of
4 the individual affected ought to have been taken into
5 account. So, for example, the question should have been
6 raised: does the person prefer to spend their last
7 months isolated, in severe decline, with the increasing
8 risk of death from non-Covid or face an increased risk
9 of Covid? We say that ought to have been taken into
10 account.

11 And again these illustrate wider problems with core
12 decision-making: evidence from stakeholders being
13 overlooked, indirect harm being overlooked, and
14 an inflexible blanket approach being taken which led to
15 the wrong results.

16 A fifth example is PPE shortages. Sufficient PPE
17 was not made available to those providing care, among
18 others, during the first few months of the pandemic.
19 The evidence of that is in paragraphs 41 to 42 of our
20 submissions. And that appears to be accepted by the
21 government, Mr Gething in particular. The main question
22 is why. Mr Gething suggests the answers include
23 problems in systems for the distribution to social care,
24 so PPE was sent to local authorities but they did not
25 forward it to care providers. We hope to explore
127

1 made public statements identifying the adverse effects,
2 and I've covered some of those earlier in my
3 submissions. They weren't taken into account, they
4 didn't lead to appropriate changes.

5 The blanket ban continued until 28 August 2020. At
6 that point, there was a relaxation in the sense that
7 local risk assessments took place, but those risk
8 assessments were only about the risk of Covid, there was
9 no recognition of the problems with indirect harm, there
10 was no balance between that indirect harm and the risks
11 of Covid.

12 In October 2020 the blanket ban was imposed again
13 and continued for a very long time, and in our
14 submissions at paragraph 39 we identify a number of
15 changes that ought to have been made to that ban. One
16 of them was the essential caregiver point that the
17 John's Campaign had been calling for, for some time, in
18 other words an individual who can be permitted to visit
19 their relative, with a prior negative test, at any time,
20 who is provided with PPE in the same way as ordinary
21 staff is provided with it.

22 Another measure that ought to have been taken, we
23 say, is that risk assessments in individual cases should
24 have been carried out. There ought to have been
25 a balance on the one hand of the risk of Covid against,
126

1 whether this is a broader flaw in the decentralised
2 nature of social care in Wales and something which ought
3 to be challenged.

4 Other answers were given by Care Forum Wales, one of
5 which was that England took precedence.

6 The sixth example is inadequate guidance. There was
7 a delay at the outset of the pandemic in sufficient
8 guidance being produced for those in the care sector.
9 So there was no helpful guidance until 15 April 2020,
10 and that was despite a number of requests from
11 stakeholders and despite the great vulnerability of
12 people in this sector.

13 Care Forum Wales and the Older People's Commissioner
14 both indicated the government was slower to respond to
15 the concerns of the care sector in producing guidance
16 than it ought to have been. Once guidance did come in,
17 at times it was conflicting and confusing. The Older
18 People's Commissioner drew attention to this early on
19 and to the importance of clarity. Her 21 June 2020
20 report noted that guidance was often confusing and
21 contradictory. Care Forum Wales mirrored this, guidance
22 was impossible to follow, and many others did, and yet
23 the guidance continued to be unclear.

24 We have set out particular examples of this, but to
25 pick on two of them, the first is whether unpaid carers
128

1 should have been given priority for vaccinations, and
2 the guidance really vacillated between whether or not
3 that was the case over a short period.

4 Similarly, John's Campaign called for more specifics
5 on what the "end of life" meant in terms of visits, and
6 that was because that was being interpreted in a very
7 narrow way on the ground, causing real problems, and
8 despite multiple efforts by John's Campaign there was no
9 clarification of the guidance.

10 Again, this indicates concerns of stakeholders were
11 not being listened to by central government or properly
12 responded to.

13 Should there have been a single person within
14 government who was responsible for clarity and
15 consistency of guidance? Should there have been a
16 single person responsible for ensuring guidance was
17 understandable for those who may have difficulty in
18 understanding it? These are questions we hope to
19 explore in evidence.

20 The seventh and final example is a more general lack
21 of support for the care sector. We give various
22 examples of this, but they include: care workers were
23 not key workers until October 2020; they were denied
24 testing that was provided to the NHS; unpaid care was
25 particularly neglected, even though it was the largest

129

1 So we look forward to exploring these questions in
2 evidence and being able to revisit them in closing
3 submissions.

4 **LADY HALLETT:** Thank you very much indeed, Mr Straw.

5 A number of the issues you raise, as I'm sure you
6 appreciate and you've alerted your lay clients, a number
7 of the issues cross over different modules. And it
8 comes with the modular structure, we all know that,
9 there's bound to be overlap, but we'll try hard to make
10 sure that some of the issues you mention may get dealt
11 with in a later module but we'll see how they fit in
12 with the core decision-making. But thank you very much
13 indeed.

14 Right, Mr Friedman.

15 **Submissions on behalf of Disability Wales and Disability
16 Rights UK by MR FRIEDMAN KC**

17 **MR FRIEDMAN:** We act for Disability Wales and Disability
18 Rights UK. They are national disabled people's
19 organisations, DPO, led by and for disabled people.

20 They thank my Lady and your team for creating this
21 stage of the Inquiry in Wales, as they thank the teams
22 who have done the same in England, Scotland and are
23 preparing Northern Ireland. As in Scotland, now in
24 Wales, this Inquiry is concerned with both a crisis of
25 devolution and a crisis for disabled people. Nothing

131

1 source of adult care provision in Wales and the rest of
2 the UK it was largely overlooked by ministers. A series
3 of concerns were raised about that area, for example by
4 Carers UK, but they weren't -- but very little was done
5 to help.

6 If one takes together the numerous examples that
7 I've touched on above of the care sector being
8 overlooked or deprioritised, it raises some important
9 questions which we hope to explore.

10 Firstly, this was such an important group by size,
11 vulnerability and the severity of the adverse impact, it
12 should have been given greater attention.

13 Secondly, were the lives of those in care valued
14 less? Were they considered to be less important due to
15 age or illness?

16 Thirdly, were the duties in the Equalities Act and
17 the Human Rights Act not complied with? The Children's
18 Commissioner's opening submissions indicate that that's
19 the case, at paragraph 6, and we endorse the opening
20 submissions.

21 The disabled people's organisations, similarly, note
22 the -- draw attention to the Welsh Government's laudable
23 commitment to human rights, but know that it wasn't
24 delivered, it wasn't effected on the ground, and we also
25 endorse those.

130

1 indicates those two things more profoundly than the
2 figures for Wales that emerged in the summer of 2020:
3 68% of the people who had died of Covid were disabled
4 people, a terrible ratio of seven out of ten deceased in
5 Wales compared to the still shocking six out of ten
6 across the UK as a whole.

7 Learning disabled people, when age is taken out of
8 the equation, were at least three times more likely to
9 die of Covid in Wales than non-disabled people, but that
10 number, said the statisticians, could be as much as
11 eight times.

12 When age is placed back into the equations, these
13 figures reflect the UK's debt to the elder Welsh people,
14 many of whom suffer from respiratory disease because of
15 coal mining and were part of the 20th century's
16 industrial workforce. Once Covid began, awareness of
17 that health legacy did not escape either the Chief
18 Medical Officer of Wales or the Technical Advisory
19 Group.

20 The statements of the Welsh ministers, as well as
21 their professional backgrounds, show a culture of
22 government in Wales that is very different in tone and
23 working practices to the environment that my Lady looked
24 at in Westminster.

25 From the First Minister, who trained as a social

132

1 worker and is a professor of social science, through to
2 the group of civil servants who assisted the
3 politicians, this is not a governing class that was
4 divorced from the humanities of everyday life, and yet
5 the vaunted social democracy of Wales and the humanist
6 aspirations it has for the role that the state can play
7 in people's lives could not prevent both mass death and
8 real suffering. Why was that so? And what does that
9 tell us about the government of Wales and the Union
10 alike?

11 Starting with the place of disabled people in the
12 overall system of Welsh Government, first, that system
13 has evolved in a piecemeal and incomplete fashion. That
14 was particularly apparent in emergency planning. The
15 Welsh Government had only taken on Civil Contingencies
16 Act responsibilities in 2018. It had no better pandemic
17 plan than its UK counterpart, but never acknowledged as
18 much. What was said in Scotland can be said again here:
19 if Wales knew that it had an older, poorer population,
20 why did it not make itself more ready to protect them?
21 And if it declared its commitment to comply with the
22 United Nations convention on the rights of disabled
23 people, why did it overlook international law
24 obligations contained in the convention concerning
25 planning, data collection and engagement with disabled

133

1 of Future Generations (Wales) Act.

2 These laws use the language of rights without it
3 being sufficiently precise to make any rights described
4 justiciable. Indeed, Professor David Feldman goes so
5 far as to call this legislation which bears no law.

6 Finally, on system, there are features of
7 intergovernmental relations that pulled in disastrously
8 different directions. They range from extraordinary
9 oversights like not inviting Welsh representatives to
10 the first five SAGE meetings, to truly fatal disputes
11 about the timing of furlough funding in
12 mid-October 2020.

13 All core participants will want the Inquiry to look
14 at the rights and wrongs of these matters, but the
15 stance of disabled people's organisations is that
16 humanity is sovereign over state.

17 It is morally imperative to involve
18 intergovernmental relations within the United Kingdom
19 that assure best endeavours to protect people from being
20 killed or harmed irrespective of where or who they are.

21 Like all four nations, when Wales had to start its
22 Covid planning from scratch, it made mistakes. It
23 thought food packages for those shielding would be
24 distributed by the UK Government, only to have to catch
25 up with England when that assumption proved to be wrong.

135

1 people for the purposes of pandemic preparedness?

2 Second, this was a very bad moment for the
3 four nations to unite in jointly governing a pandemic of
4 this unprecedented nature. Wales, especially its
5 population of disabled people, was seriously compromised
6 in its resilience as a result of austerity. Going into
7 2020, Brexit had soured relations and monopolised
8 resources. The different geography of UK inequalities
9 was pronounced. The gulf in politics and economics that
10 was blamed for those inequalities was deep. The power
11 imbalance between the devolved administrations and the
12 UK state was significant.

13 Third, Welsh Government may have political
14 commitment to developing equality and human rights, but
15 it is not straightforward to create those things when so
16 much of Welsh public law and economics remain part of
17 the law and economics of England. That is the case even
18 though the Senedd now has lawmaking powers.

19 In Scotland, my Lady had Professor Cairney saying:
20 who doesn't like human rights? But emphasising that the
21 critical question is: how are they being enforced? In
22 Wales, my Lady has the previous Lord Chief Justice of
23 England and Wales, Lord Thomas, questioning the benefit
24 of aspirational Wales legislation such as the Social
25 Services and Well-being (Wales) Act and the Well-being

134

1 While its experts knew that care homes would be the
2 greatest places of risk, Welsh Government introduced
3 testing later than other nations, although all of them
4 were too late.

5 What Welsh Government did well, and in many ways
6 better than in other nations, was to partner with its
7 people. For disabled people, civil servants reached out
8 to DPOs in mid-March to find out what the government
9 needed to learn. Regular meetings between Jane Hutt,
10 the Deputy First Minister and Chief Whip, and DPOs
11 started in early April 2020. Existing structures such
12 as the Disability Equality Forum were used more
13 frequently and dynamically also from April 2020 onwards,
14 and new structures on inclusive communication and Covid
15 morals and ethics were created based on liaison with
16 DPO.

17 This is fundamentally different from what
18 the UK Government did, and it contrasts with the extent
19 to which Scottish Government disengaged from civil
20 society groups in the first weeks of the crisis. It was
21 Welsh Government that uniquely in the UK commissioned
22 a DPO-led study of the effects of the pandemic response
23 on disabled people, which became the Locked Out report.
24 And on the recommendations of the report it was Welsh
25 Government that set up a disability taskforce, again

136

1 unprecedented in the UK.

2 The outcome of this premium placed by government on
3 social partnering is what the Welsh Government
4 overlooked in crisis planning it was able to somewhat
5 remedy in scaling up its existing relationships, but the
6 DPO join the other parties in submissions today to
7 observe that relying too heavily on good relations was
8 not enough.

9 Like the Scottish machinery of government, the Welsh
10 system does not have departments, it is organised into
11 multidisciplinary groups which in turn each form the
12 several more focused directorates. The turnover or
13 churn of ministers is seemingly not as problematic as in
14 the rest of the UK. Most ministers serve for the
15 duration of the Senedd. Vaughan Gething worked on the
16 health portfolio for six years. Rebecca Evans had led
17 local government and finance since 2018. The size of
18 the government was such that all decisions could be
19 taken through the Cabinet. Jane Hutt, as lead minister
20 on equality issues, was present on the daily calls and
21 was part of the Covid core group, but there was never
22 a dedicated minister for disabled people, which may
23 explain partly why Wales was not prepared prior to the
24 pandemic. Further, without a dedicated minister, what
25 worked was left too much to chance, based on the

137

1 Treasury funding, and on this all the scientists were
2 unsuccessful in persuading the UK Government in
3 September and October 2020 to act more forcefully and
4 earlier to stop the second wave.

5 In terms of recognising the discrete experience and
6 rights of disabled people, Wales was arguably more
7 advanced than the rest of the UK. Since 2002 it has
8 sought to govern in accordance with the social model
9 that holds disability to be a societal construct rather
10 than inherent to the challenges of individual medical
11 condition or impairment. The complaint of disabled
12 people in Wales is that during Covid-19 the so-called
13 "medical model" made a considerable comeback. The
14 reversion can be seen in the linkage of vital services
15 to being on the shielding list, defined as a list of
16 medical conditions. It was Welsh Government that
17 initially acquiesced in the passing of Part 2 of
18 Schedule 12 of the Coronavirus Act, which suspended
19 statutory duties relevant to protecting disabled people
20 at a point when those duties actually needed enhancing.
21 We passed an Act, as Jane Hutt, lamented, which singles
22 out disabled people's most basic rights as something
23 that can be switched off when expedient to do so.

24 Although not the act of government, it was under
25 Welsh Government's watch that the use of Do Not

139

1 accident of Jane Hutt, who was committed to make things
2 happen, which might equally have led to different
3 outcomes if certain core personalities like her were not
4 in place.

5 There was also a lack of proper auditing by the
6 centre of government on what services were being
7 delivered and withdrawn on the ground via local
8 government. Again, this was outcomes based on
9 relationships and personality and, we say, not
10 necessarily enough on process.

11 The Welsh ministers make their case for small state
12 machinery and long-standing collaborative cultures. The
13 question on the one hand posed by Professor Wincott is:
14 was that machinery compromised by cosiness? But the
15 broader question for Wales and the UK is: does
16 government by social partnership scale up in crisis?
17 The DPO want the Inquiry to consider how it can, and why
18 it must.

19 Turning to expertise, like Scotland, Wales set up
20 its own scientific advice mechanism to ensure local
21 focus on local data. The accusations against SAGE,
22 without criticism of its integrity, is that it was too
23 Anglo-centric in terms of its people, its knowledge and
24 actual product. Like SAGE advice, the Welsh Technical
25 Advisory Group could not escape the constraints of UK

138

1 Resuscitate notices proliferated in an unaccountable
2 fashion. The issue was given UK-wide prominence by
3 letters issued by a GP surgery in Maesteg, which
4 suggested to elderly, frail and disabled people that it
5 was better to use resources on the young and fit, who
6 were said to "have a greater chance of survival".

7 While Welsh Government quickly committed itself to
8 engagement and partnership with disabled people, to
9 a considerably greater extent than the rest of the UK,
10 there are still lessons to learn on how best to do that.
11 Mark Drakeford tells you in his statement that the
12 relationship between the state and the citizen in Wales
13 should be one of co-production and that expertise never
14 lies solely on the part of the provider. But in order
15 to get beyond aspiration, co-production and co-design
16 need to be treated as a discipline, skill and law.

17 However more developed that endeavour is in Wales,
18 its practice failed to consistently and timeously feed
19 back on whether recommendations from partners were
20 adopted. Input was still missed at the point of policy
21 formation and planning. Consultation was too often
22 sought about decisions already made. Grassroots DPOs
23 and other third sector also lacked financial capacity to
24 participate.

25 The lesson of all these modules is also that

140

1 co-production and co-design cannot work without capacity
2 and infrastructure, and on this data is critical.
3 Wales, like the rest of the UK, made decisions under too
4 much uncertainty, not just about the virus, but about
5 who was where, in what circumstances, when decisions
6 were made.

7 In Wales, there were startling gaps. No modelling
8 was done for Welsh care homes because the data was not
9 available. The Care Inspectorate for Wales confesses in
10 its statement to the Inquiry that it cannot guarantee
11 that all deaths in care homes were notified to them.
12 Felicity Bennee, an important witness, who co-chaired
13 TAG and TAC, described data sharing in Wales as
14 patchwork that had not finished being sown together.

15 There was a shortage of data analysts, a sense, real
16 or otherwise, that data was not being properly shared
17 from England and a view, at least held by Bennee, that
18 Wales had not yet worked out how to work as
19 collaboratively with the subjects of data as it should.

20 If my Lady then considers protection of disabled
21 people in Wales during the pandemic, despite awareness
22 of the risks the issues already seen elsewhere in
23 the UK, including lack of access to food and essential
24 resources, collapse of health care and independent
25 living services and the suspension of disabled people's

141

1 not radical economics but limited intervention to
2 maintain some aspect of ordinary wage earning with
3 considerable support of businesses. That was valid, but
4 it was never going to protect disabled people and their
5 low paid or unpaid carers.

6 From the Welsh Government perspective, the UK Covid
7 economics also put profit and expedience over care when
8 it resisted for those few crucial weeks the scientific
9 advice from both SAGE and the TAG to introduce an autumn
10 2020 firebreak. In Wales, for Felicity Bennee, who knew
11 the numbers, it was, in her words, overwhelmingly
12 painful that the UK was insufficiently flexible to
13 enable a one-month Welsh firebreak only to go into its
14 own a few days later. Whether this was a Treasury for
15 England rather than a Treasury for the UK, as the
16 First Minister alleges, will be for my Lady to decide,
17 but the hierarchy of power in this relationship is
18 unmistakable, and the tragedy of the delay is not
19 disputed.

20 My Lady, at the beginning of the address we said the
21 DPO were thankful for the work that you and the Inquiry
22 teams in the four nations were doing, but we did not say
23 why. There are two reasons in particular, being
24 gratitude.

25 First, what the evidence is showing, as the Inquiry

143

1 rights, all happened here.

2 That lack of protection in what is otherwise
3 a progressive state committed to the social model
4 creates puzzles for this Inquiry, including for those
5 advocating for a change of values as important in its
6 own right. To be considered in this module are
7 therefore the following:

8 First, as with issues of race and gender, Wales has
9 not reached a default position of inclusivity. The
10 Locked Out report concluded that the root cause of this
11 is "simple thoughtlessness" about the position of
12 disabled people.

13 Second, dynamic and effective engagement with DPO
14 remains essential to correct attitudinal barriers as
15 much as physical barriers that prevail in state and
16 society.

17 Third, missed opportunities to properly use data
18 creates its own dangers at least as much as misuse of
19 data. It has taken Covid-19 to really bring that to
20 light.

21 And fourth, as was pressed upon my Lady in Scotland,
22 human rights are not enough if they do not contain
23 socioeconomic rights.

24 On that point of redistribution, the DPO have now
25 made the case several times that UK Covid economics was

142

1 moves across the United Kingdom, is that in many ways
2 this country of nations has stopped knowing about itself
3 culturally, economically and politically. The
4 possibilities and challenges of what is happening in
5 each of the four nations are largely not comprehended by
6 governors, academics, lawyers and businesses, let alone
7 the wider public. It is this Inquiry, occasioned and
8 focused as it is on the Covid state of emergency, that's
9 putting together for the first time a proper account of
10 what the devolved United Kingdom is and how it is run.

11 Second, in the UK's lost comprehension of itself,
12 disabled people across the four nations have suffered
13 because inequalities have been allowed to grow,
14 aggravated by unequal geographies of income,
15 infrastructure, and co-morbidities. Covid was not the
16 great leveler of inequality and division, it was the
17 great revealer of those things. Disabled people
18 constitute the lived and deceased evidence of that
19 reality. It is this Inquiry that can help people across
20 the UK to understand why different parts of society have
21 been chosen to suffer profoundly different human
22 experience.

23 Thank you, my Lady.

24 **LADY HALLETT:** Thank you very much indeed, Mr Friedman.

25 Mr Gardner, can we fit you in before we take

144

1 a break?

2 **MR GARDNER:** I planned 20 minutes, my Lady.

3 **LADY HALLETT:** Okay.

4 **Submissions on behalf of the Children's Commissioner for**
5 **Wales by MR GARDNER**

6 **MR GARDNER:** My Lady, I appear before you on behalf of the
7 Children's Commissioner for Wales.

8 The office of the Children's Commissioner for Wales
9 was established via the Care Standards Act 2000
10 following the Waterhouse Inquiry. This was a judge-led
11 Inquiry which concluded that the children in Wales
12 needed an independent champion to ensure that their
13 rights are respected and upheld.

14 Wales was the first country of the UK to establish
15 the post of Children's Commissioner. The Children's
16 Commissioner for Wales is a national human rights
17 institution compliant with the Paris principles.
18 Independence from government has always been a key tenet
19 of the office's role. The Inquiry will hear evidence
20 about how the working relationship between
21 the Commissioner's office and the Welsh Government
22 altered during the pandemic, but the Paris principles,
23 particularly around independence, remained an important
24 aspect for the commissioner to maintain in scrutinising
25 and holding the government to account.

145

1 office advises government on draft guidance and
2 legislation through consultation processes and dialogue
3 with officials and ministers. The urgent nature of
4 decision-making in the pandemic necessitated that the
5 office worked closely alongside government to discharge
6 this responsibility and hold the government to account
7 on behalf of children and young people across Wales.

8 In practice, this meant that the Commissioner's
9 office was asked to comment on draft guidance and public
10 messaging at very short notice throughout the pandemic.
11 For the avoidance of doubt, the Commissioner and her
12 office were not a part of the formal decision-making
13 process at any point. But through the document review
14 process, the Commissioner and her team were able to
15 question to what extent and how the potential impact of
16 decisions on children's rights were considered. Where
17 this review process didn't result in greater clarity,
18 the Commissioner would follow this up in writing with
19 officials, ministers or the Chief Medical Officer.

20 The Commissioner had decided at the start of the
21 pandemic that the office had an important role to play
22 in ensuring that children's rights were actively
23 considered in a fast paced decision-making process. At
24 such a crisis point she wanted the government to get
25 things right for children rather than potentially

147

1 This module will hear evidence from

2 Professor Sally Holland, who was the Children's
3 Commissioner for Wales throughout the period with which
4 the Inquiry is concerned.

5 My Lady, the Office of the High Commissioner for
6 Human Rights recognises that in humanitarian crises,
7 including pandemics, human rights issues will often
8 arise. This is both because of the crisis itself and
9 that measures to manage the crisis are likely to have
10 a greater impact upon more vulnerable groups within the
11 population, which includes of course children and young
12 persons.

13 During the response to any humanitarian crisis
14 protecting and upholding human rights should be
15 an overarching and key aim of the state. It is
16 essential after the event that human rights are
17 adequately considered and reflected upon in order to
18 strengthen the nation's resilience against future
19 crises.

20 The Commissioner's legal points include the ability
21 to review how the Welsh Government has exercised its
22 functions. The Commissioner is required to have regard
23 to the United Nations Convention on the Rights of the
24 Child, or CNCRC(sic), in doing so.

25 It is through this power that the Commissioner's

146

1 getting things wrong or miss key considerations and then
2 be critical from the sidelines.

3 I turn then to children's rights in Wales.

4 The Rights of Children and Young Persons (Wales)
5 Measure 2011 requires the Welsh ministers to have due
6 regard to the children's rights under the CNCRC --
7 sorry, I apologise, the UNCRC -- in exercising all of
8 their functions. In this way, the individual articles
9 of the UNCRC are incorporated into Welsh law through the
10 Measure. The Brown principles set out how due regard
11 should be exercised in practice, requiring
12 decision-makers to be actively aware of their duties,
13 and to be actively aware in advance of taking decisions
14 as well as having this in mind when taking the decision.

15 It requires a conscious approach and state of mind.
16 Crucially, a duty bearer cannot satisfy the duty by
17 justifying a decision after it has been taken. Regard
18 to equality generally will not be sufficient to
19 discharge the duty, and it is not a matter of just
20 ticking boxes.

21 It is good practice to keep an accurate and timely
22 record of decision-making and how relevant questions
23 have been considered but the record in itself may not
24 satisfy or demonstrate how the duty has been exercised
25 if the principles have not been complied with.

148

1 The primary way in which due regard under the
2 Measure is demonstrated in Wales is through a children's
3 rights impact assessment, or CRIA. The Welsh
4 Government's children's scheme which accompanies the
5 Measure describes a CRIA as "the tool officials are
6 expected to use to support Welsh ministers in ensuring
7 the due regard duty is fulfilled".

8 The scheme also requires the Welsh Government to
9 undertake and publish CRIAs on the government website in
10 order to promote transparency. Officials are expected
11 to record their reasons if a CRIA has not been
12 undertaken. The duties under the Measure would have
13 applied to all decision-making processes, actions and
14 omissions that fall within the scope of this module.

15 The experience of the Children's Commissioner, as
16 noted in Professor Holland's written evidence, is that
17 CRIA were often completed late, were far removed from
18 the original decisions, and reflected back on the
19 relevant decision. Retrofitting CRIA analysis to fit
20 a decision already taken was not a unique phenomenon to
21 the pandemic, but this was exacerbated by the condensed
22 timeframes for decision-making during the pandemic. For
23 some major decisions, such as school operations, no CRIA
24 was completed at the time.

25 A fully completed template setting out the articles
149

1 affecting children that their rights had been considered
2 during the decision-making processes. Now, this
3 includes decisions such as to fund free school meal
4 equivalents during the school holiday periods and the
5 re-opening of libraries, which many children had said
6 were of great benefit and importance to them.

7 However, where decisions were in respect of the
8 whole population, such as decisions to re-open
9 hospitality settings in summer 2020 prior to re-opening
10 schools, it was less clear how children's rights had
11 been considered. The practice of completing a CRIA as
12 part of a decision-making process that is compliant with
13 and proactively takes account of children's rights is of
14 prime importance to the Commissioner, and it is
15 anticipated and hoped that it will be further explored
16 by this Inquiry.

17 I turn to public health considerations.

18 During the pandemic, public-facing guidance was
19 issued from both the Welsh Government and Public Health
20 Wales. The Commissioner considered it was a difficult
21 process at times to ascertain whether decision-making
22 sat with the government or with Public Health Wales.
23 Queries would be raised by the Commissioner's office
24 with the government, who would say that this was
25 a public health matter. Meetings with public health

151

1 of the UNCRC and available research evidence completed
2 many, many months after the decision had passed would
3 not advance or uphold children's rights in
4 decision-making processes as this did not feed into the
5 decision at the time. This does not satisfy the Brown
6 principles of due regard, nor does it make
7 decision-making compliant with the duties on Welsh
8 ministers under the Measure.

9 The Commissioner's team gave initial advice to the
10 Welsh Government to this effect in both April 2020 and
11 again in May 2020.

12 Decisions around opening or partial opening of
13 schools and the use of face coverings within schools are
14 examples of where it was sometimes difficult to follow
15 the rationale behind governmental decision-making, or
16 even what had actually been decided.

17 The Commissioner did not and does not suggest the
18 scientific evidence should not be used to make decisions
19 of this nature. Nonetheless, the Commissioner expected
20 all decisions to carefully and consistently consider the
21 potential impact on children's rights and to clearly
22 communicate the rationale behind any measure that may
23 impede children's actions to their rights where this was
24 deemed unavoidable.

25 It was more apparent for decisions directly
150

1 officials, however, would say that they needed the
2 government to take decisions and direct them in issuing
3 guidance.

4 When seeking to scrutinise or influence decisions
5 and the resulting guidance at this time, it was
6 difficult for the Commissioner to understand who held
7 responsibility for what and therefore where to take the
8 concerns that children and families across Wales were
9 bringing to the Commissioner and her team.

10 This was particularly the case around children's
11 homes. The Welsh Government would issue general
12 guidance pursuant to the legislation around social
13 distancing and other mitigating measures. However,
14 Public Health Wales issued guidance to professionals
15 around their role in managing coronavirus infections.

16 In practice, this meant that children's care homes
17 were in receipt of guidance from both institutions that
18 was not worded the same, leading to confusion over the
19 rules that they should be applying. This at times led
20 to a more restrictive interpretation being followed to
21 ensure compliance and without necessarily actively
22 considering children's rights and experiences. This is
23 a matter that could usefully be clarified through
24 the Inquiry process to aid communications in future
25 public health crises.

152

1 I turn to the crossover between reserved and
2 devolved matters, because there were increased areas
3 where the jagged edge of devolution caused practical
4 difficulties when implementing new legislation and
5 guidance in Wales.

6 One sector in which this became apparent was youth
7 justice, specifically youth custody settings. In Wales,
8 there is one youth offending institution, HMP Parc in
9 Bridgend, and there is one secure children's home,
10 Hillside in Neath Port Talbot. Guidance for all justice
11 settings was issued by the UK Government in March 2020
12 at the outbreak of the pandemic. It essentially
13 confined inmates, including young offenders, to their
14 cells for 23 hours a day. This failed to take into
15 account children's human rights.

16 The Commissioner was involved in discussions with
17 the Youth Custody Service, who instituted a different
18 regime in HMP Parc, and they did so swiftly, whereby the
19 boys were grouped into family cohorts, to allow them to
20 have exercise, showers and association time in limited
21 and managed groups. This was in March 2020, well before
22 the bubbles concept had arisen for the population at
23 large. It showed what could be done if thought was
24 given to how the health risk profiles might differ in
25 smaller settings of young people, and if primary thought

153

1 for children in Wales, to row back on the devolution
2 settlement in a pandemic.

3 The issues seen in youth justice settings also come
4 back to the decision-making processes and resultant
5 guidance not proactively considering or taking into
6 account the differing health risk profiles for children
7 and young people in small group children's homes as
8 compared to large residential care or nursing homes
9 accommodating the elderly and vulnerable.

10 A one-size-fits-all approach has been shown throughout
11 the Covid pandemic not to be suitable or to meet
12 children's individual needs and rights.

13 I turn to the divergence in governmental approaches.

14 Social partnership is a foundational principle the
15 Welsh Government's approach. It is a common -- it is
16 common for public sector organisations such as the
17 Children's Commissioner to be actively involved and
18 consulted during policy and legislative development.
19 This continued into the pandemic and beyond and is a key
20 feature of the approach here in Wales. The size and
21 scale of the public sector in Wales allows this to be
22 done in a manageable way. This allowed for
23 the Commissioner to be proactively consulted in response
24 to a range of issues affecting children in Wales.

25 Within days, weekly calls had been set up with senior

155

1 was given to how to safely manage the public health
2 risks but with children's rights being factored in.

3 More practical difficulties arose and persisted for
4 Hillside Secure Children's Home, as they provide both
5 youth justice places and secure welfare beds. They
6 straddle the guidelines between justice, under the
7 UK Government, and welfare, under the Welsh Government
8 and local authorities. Practically this impacted upon
9 staff in the setting and also directly upon the welfare
10 of young people placed in their care.

11 The setting should be commended on the efforts they
12 made to manage these constraints as best they could to
13 support the young people during the time, but
14 a confusion between jurisdictions inevitably caused
15 confusion on the ground.

16 Previous modules and witnesses have explored the
17 possibility of reverting control over decision-making in
18 public health events like a pandemic to the
19 UK Government to achieve consistency. In the view of
20 the Commissioner, this risks oversimplifying the
21 existing devolution settlement. The approach to youth
22 justice is just one example that illustrates how the
23 approach in Wales to children's health and care is
24 inherently different. Guided by the UNCRC rights-based
25 approach, it would not be straightforward, or desirable

154

1 government officials and the Commissioner. This evolved
2 into proactive sharing of matters arising whereby
3 the Commissioner's office was feeding in families'
4 experiences and queries in real time to the government,
5 allowing for these to be reflected upon, and this in
6 turn did allow for appropriate changes in Welsh
7 Government's legislation and guidance. The Inquiry may
8 wish to weigh up to what extent this was beneficial and
9 should be preserved, maintained or even extended in the
10 future.

11 Notwithstanding the difference in approach here in
12 Wales, it is apparent that many of the primary decisions
13 were taken by the UK Government, and the Welsh
14 Government were either expected to or chose to fall into
15 line with those decisions. Clear examples in this
16 regard relate to the proposed suspension of social care
17 protections and safeguards and support for children with
18 additional learning needs. The Welsh Government
19 initially proposed to follow the decisions in England
20 relating to fostering and adoption medical assessments
21 and the support for additional learning needs, and
22 sought to inform rather than consult the Commissioner's
23 office on its decision.

24 To its credit, the Welsh Government pulled back on
25 these proposals following constructive challenge but the

156

1 initial decision had only involved local authorities not
2 children and families or those who work on their behalf
3 such as the Commissioner's office. Had a CRIA been
4 undertaken as part of this initial decision-making
5 process, this may have prompted consideration of wider
6 viewpoints and children's rights issues at that initial
7 stage.

8 I turn to the convergence of care settings and risk
9 profile.

10 Now, Module 6 will specifically focus on the
11 care sector, but in relation to decision-making as falls
12 within this module, it is important to reflect on the
13 generic approaches to risk profiles.

14 The Commissioner wishes to highlight that
15 a one-size-fits-all approach to the legislation and
16 guidance fell short of due regard for children's rights.
17 A care or nursing home for the elderly or those with
18 additional vulnerabilities is a clear risk factor when
19 dealing with a public health emergency. However, the
20 majority of children's homes in Wales are small
21 settings, often two to four beds, usually accommodating
22 teenagers. Larger or group providers may have their own
23 education provision, meaning that the young people are
24 only mixing in limited and consistent groups, much like
25 the bubble system or the rule of six. Requiring

157

1 people in sharing messages and listening to their views,
2 such as televised press conferences with the then
3 education minister, Kirsty Williams, two large-scale
4 nationwide surveys of children and young people,
5 organised by the Commissioner's office, and ministerial
6 meetings with children and young people facilitated by
7 the Commissioner's office.

8 None of this would have happened without the direct
9 involvement and support of the Commissioner's office but
10 it is notable that the government was open to working in
11 this way and to listening to children and young people
12 in making their decisions. The Commissioner encourages
13 the Inquiry to consider how this practice can be
14 protected and sustained or even built upon.

15 I turn to my final point on scientific evidence and
16 messaging, because it is clear that both the UK and
17 Welsh Governments had access to scientific data and
18 advice to inform their decision-making processes, but
19 the Commissioner and her team were frequently called
20 upon to comment on or advise on decisions and guidance
21 at very short notice, where scientific evidence on which
22 decisions were made was often not available at that
23 point or at all, which meant that actual decisions
24 themselves could not be adequately scrutinised.

25 The Commissioner was always careful to put out clear

159

1 children in these settings through official guidance to
2 self-isolate for a minimum of 14 days upon every contact
3 with Covid and to have their contact with their families
4 completely stopped for lengthy and repeat periods of up
5 to 28 days following any sort of outbreak was
6 inconsistent with their risk profiles and their human
7 rights.

8 Despite many professionals in Welsh Government,
9 Public Health Wales and other public sector agencies
10 recognising this, the guidance was not changed or
11 amended as matters developed and understanding of
12 transmission and risks evolved. Again, we invite the
13 Inquiry to consider whether or not this blanket approach
14 to all paid due regard to children's specific and unique
15 rights and whether it was proportionate to continue with
16 this approach throughout the pandemic.

17 I turn to the voice of children and young people,
18 because Module 2 heard evidence from the former
19 Children's Commissioner for England, Anne Longfield,
20 reflecting her frustrations or disappointment at the
21 UK Government not listening to the need to hear from and
22 speak to children directly. She described governmental
23 indifference to children and their needs. By contrast,
24 there were a number of ways in which the Welsh
25 Government did actively engage with children and young

158

1 and reassuring messages to children and young people at
2 every available occasion but at times this was hampered
3 by a lack of clarity around the basis of government
4 decisions.

5 Governments will hold all of the information and
6 advice that has led to their decisions and they are
7 therefore best placed to provide clarity and
8 transparency. This Inquiry may wish to consider how
9 that clarity and transparency may assist in clearer
10 public messaging going forward.

11 In conclusion, my Lady, children's lives were
12 affected in every way by the decisions of the pandemic.
13 Whilst efforts to reach out to them, to hear their
14 voices and to listen to their needs were made by Welsh
15 Government, often following encouragement or support of
16 the Commissioner to do so, the Commissioner remains
17 concerned as to whether, when and how their rights were
18 properly considered and fed into the decisions which
19 were made which directly affected them. The Inquiry
20 will weigh up how well this was done and whether this
21 could or should be done differently in the future.

22 I'm grateful, my Lady.

23 **LADY HALLETT:** Thank you very much indeed, Mr Gardner.

24 Right, we'll take a break now. Shall I be generous
25 or not generous? 3.40. I'll be generous.

160

1 (3.22 pm)

2 (A short break)

3 (3.40 pm)

4 **LADY HALLETT:** Mr Jacobs. I'm not going to look over to the
5 right as I would normally do.

6 **Submissions on behalf of the Trades Union Congress and Wales**

7 **Trades Union Congress by MR JACOBS**

8 **MR JACOBS:** Good afternoon, my Lady.

9 This is the opening statement of the Trades Union
10 Congress, the TUC, and the Wales TUC. The Wales TUC is
11 part of the TUC, but is autonomous in matters that are
12 devolved to the Welsh Government.

13 The 48 unions affiliated to the TUC represent over
14 5 million working people across a range of sectors and
15 across the four corners of the UK. The Wales TUC
16 represents around 400,000 workers in Wales through its
17 affiliated unions.

18 The TUC and Wales TUC aim to provide a voice for
19 working people and to shine a light on the consequences
20 of government decision-making upon the experiences of
21 those at work.

22 In Modules 1 and 2, the Inquiry heard evidence from
23 Kate Bell, assistant general secretary of the TUC. In
24 this module, the Inquiry is to hear evidence from
25 Shavanah Taj, general secretary of the Wales TUC.

161

1 As John said in the impact film this morning, "Thank God
2 for the nurses that were there. You should see what the
3 nurses were going through".

4 The social care workforce also suffered. It is
5 a workforce that is generally undervalued and underpaid,
6 yet during the pandemic the burden was monumental. As
7 described by many, there were appalling problems with
8 PPE.

9 Kate Bell's supplementary statement in Module 2 gave
10 an account of a member of GMB who worked in social care
11 and described being given a plastic pinny that appeared
12 to be the same that was used in the catering sector for
13 sandwich making. The worker described how distressing
14 it was trying to support those dying in the care home as
15 the virus ripped through it, how it felt knowing that no
16 doctor or nurse would enter the building to administer
17 anything to ease the pain for a dying resident.

18 As a workforce, many in social care felt forgotten,
19 with little press coverage even at the time regarding
20 district and community nurses, reablement, home care and
21 residential care. The worker said:

22 "Covid has left a lasting impression on care. So
23 many staff have left, as they have been sickened by the
24 way it was dealt with. Many staff have said that if
25 Covid hits us hard again, they will walk out of work and

163

1 This opening submission will highlight the loss and
2 sacrifice of those in the workplace in Wales, and focus
3 on the approach to decision-making within the Welsh
4 Government.

5 From the union perspective, as with the Scottish TUC
6 and the Scottish Government considered a few weeks ago
7 in Module 2A, the process of decision-making in Wales
8 was one which no doubt had its deficiencies but was
9 nonetheless underpinned by a process of meaningful
10 engagement and partnership, which was welcome and
11 valuable.

12 As with our opening submissions in each of the
13 substantive hearings thus far in this Inquiry, we begin
14 by acknowledging the loss and sacrifice during the
15 pandemic in the workplace. We pay tribute and express
16 gratitude to those who conveyed their stories so
17 powerfully in the impact film this morning. It was
18 a difficult but important reminder of the horrors of the
19 pandemic, and the human stories that unfolded across so
20 many parts of our society.

21 Those in workplace across a number of sectors played
22 their part in the pandemic response. Those in
23 healthcare were well and truly on the frontline and
24 endured the dangerous, shocking and exhausting
25 experiences of caring for those who were acutely unwell.

162

1 never go back in. Who can blame them? I think Covid
2 will always affect us in whatever we go on to do in
3 life. I've had flashbacks from writing this, and a few
4 tears remembering."

5 Of course, there were those in other sectors who
6 faced increased occupational exposure to the virus.
7 Data regarding mortality rates across sectors indicates
8 that process plant and machine operative occupations had
9 the highest rate of mortality from Covid. Caring,
10 leisure and other service occupations had the largest
11 number of deaths of all the major occupational groups.

12 The Inquiry has already heard evidence as to the
13 intersection between occupational exposure and
14 socioeconomic inequalities. It was often the poorest in
15 society who had the least ability to comply with
16 measures, the least opportunity to work from home, and
17 were most exposed to the virus in health settings and in
18 service jobs.

19 There is also an ethnicity dimension. Professors
20 Nazroo and Bécares have described that those in ethnic
21 minorities were more likely to be employed in sectors
22 that increased their risk of exposure to an infectious
23 agent, such as in transport and delivery jobs, or
24 working as healthcare assistants, hospital cleaners,
25 social care workers, and in nursing and medical jobs.

164

1 It all points, my Lady, to one of the profound
2 consequences of the pandemic: that those who were
3 generally less well off, with greater disadvantage and
4 vulnerability, paid the greater price. It was the price
5 paid by people who kept parcels being delivered to our
6 door, who transported key workers to work, who processed
7 our food, who stacked our shelves, who cared for our
8 sick and elderly, and many others.

9 My Lady, two further points of context are, first,
10 the lack of resilience of public services going into the
11 pandemic and, second, the lack of advance planning.
12 These issues have been the subject of Module 1 and will
13 be the subject of a report from this Inquiry. Though
14 not the focus of this module, these issues nonetheless
15 loom large.

16 Whatever the deficiencies and virtues of the
17 processes for decision-making in Wales, very little can
18 be done to eliminate a profound lack of preparedness and
19 resilience. As in England, services in Wales have been
20 hollowed out by austerity; the waiting lists for
21 healthcare and the consequences of such terrible waiting
22 lists, which were touched on in the impact film this
23 morning, were worsened by the pandemic but were not
24 caused by it. There is a simple and inalienable truth
25 that healthcare and social care services that are

165

1 striking characteristics of the Welsh response to the
2 pandemic.

3 As the pandemic hit, the structures supportive of
4 social partnership were in fact strengthened and
5 increased. The Shadow Social Partnership Council --
6 chaired by the First Minister and comprising of union,
7 employer and government representatives -- was extended
8 early in the pandemic with third sector partners and the
9 Older People's Commissioners and Children's
10 Commissioners. It was a sensible attempt to expand the
11 breadth of views in forming the far-reaching decisions
12 that the government were called upon to make during the
13 pandemic.

14 The Wales TUC participated in various general and
15 sector or issue-specific fora for decision with the
16 government, which we have described in more detail in
17 our written opening. The result was that the Wales TUC
18 generally felt able to advocate for the rights and
19 safety of workers at the very top levels of
20 decision-making, and felt that their input was taken
21 into account.

22 Like all meaningful relationships, it had its
23 frictions, and that can be seen in the evidence; but
24 that, my Lady, is a symptom of consulting meaningfully
25 and at pace. Placatory and empty consultation is easy.

167

1 creaking in peacetime will struggle to avoid collapse if
2 a pandemic hits.

3 The report from Module 1 is eagerly awaited, but it
4 appears that the pandemic planning in Wales was as poor
5 as it was in England. The essence if it is simple:
6 effective pandemic response requires a quick response,
7 but a quick response will be frustrated if there has not
8 been the necessary planning. Many of the real
9 opportunities to reduce the devastating effect of
10 a pandemic such as Covid-19 lie in better advance
11 preparation and planning for a future pandemic.

12 My Lady, we turn to the issue of government
13 consultation and partnership with the unions and the
14 pandemic response in the workplace.

15 An important feature of the pandemic response in
16 Wales was the culture of social partnership which was
17 well embedded before the pandemic. Boris Johnson's
18 unfortunate words in private meetings were that he could
19 not have "the bollocks of consulting with unions". In
20 contrast, the approach in Wales was a shared sense of
21 purpose common to government, unions and other partners.
22 As Shavanah Taj describes, it is about delivering change
23 by finding shared goals and listening in order to
24 negotiate the best possible outcomes. Mark Drakeford
25 appropriately describes this aspect as one of the most

166

1 Meaningful partnership can come with challenges.

2 The Welsh Government's comparatively open approach
3 to consultation and seeking agreement and common purpose
4 is a story told by a number of stakeholders. The
5 Children's Commissioner for Wales has described being
6 proactively consulted, as has the Welsh Local Government
7 Association, the disabled people's organisations and the
8 John's Campaign, although there have rightly been
9 observations about how the processes need to be
10 improved.

11 In the arena of workplace safety, the approach to
12 social partnership bore some advantages. In Wales, the
13 2-metre social distancing in the workplace was
14 introduced at an early stage as a legal requirement
15 rather than discretionary guidance, as in England. The
16 Wales TUC, working with the Welsh Government, set up
17 a whistleblowing hotline enabling workers to report
18 incidents of breach. The Wales TUC and Welsh Government
19 also collaborated to introduce a risk assessment tool
20 designed for staff in the NHS, but also used more widely
21 to accurately assess the risk posed to NHS and
22 social care staff. That was intended to enhance staff
23 safety and ameliorate some of the disproportionate
24 impacts.

25 One area of intense frustration, however, was the

168

1 lack of enforcement of workplace safety. As the TUC and
 2 Wales TUC has pointed to on numerous occasions, the
 3 Health and Safety Executive is severely underfunded.
 4 During the pandemic, unions in Wales found consistent
 5 evidence that a significant number of employers were
 6 failing to take sufficient precautions against the
 7 disease, and workers repeatedly reported not being
 8 consulted on workplace Covid risk assessments. Despite
 9 clear evidence of the lack of adherence to regulations,
 10 the Welsh Government was unable to improve the
 11 situation.

12 Another important issue was that of financial
 13 support for those required to self-isolate, particularly
 14 those on low incomes in higher risk workplaces with
 15 inadequate provision for sick pay. A study by Public
 16 Health Wales noted the most common challenges for
 17 self-isolation included financial difficulty and the
 18 problem was pronounced for those in precarious work who
 19 were more likely to report financial concerns, more
 20 likely to report mental health difficulties, and more
 21 likely to report having no access to food or medication
 22 during self-isolation.

23 The issue was raised repeatedly by the Wales TUC
 24 with the government, but the response was mixed, and
 25 ultimately no more effective than that of the UK

169

1 including this afternoon by the Welsh bereaved families
 2 group, that the dysfunction in Westminster should not be
 3 taken as some sort of barometer or baseline for
 4 assessing government; that would be to set
 5 an unacceptably low standard for the governments of our
 6 four nations.

7 We do observe, however, that the Welsh Government
 8 appears to have avoided some of the dysfunction seen in
 9 Westminster. As described, it was more open to
 10 partnership with others, but it was also quicker to work
 11 within agreed frameworks for decision-making, and there
 12 appears generally to have been appropriately formal and
 13 reflective discussion within government.

14 Finally, we touch on the issue of collaboration
 15 between the Welsh and Westminster governments.

16 We urge a cautious approach to the narrative
 17 suggested by Mr Johnson and others that differences were
 18 being sought for difference's sake. The differences may
 19 have resulted from a different approach to the balancing
 20 of the imperatives of saving lives and of saving
 21 livelihoods.

22 As the pandemic progressed, the UK Government -- at
 23 least the Prime Minister and Chancellor -- appear to
 24 have seen decisions as a choice between saving lives and
 25 saving the economy. Some within UK Government saw that

171

1 Government.

2 In Wales, the same ineffective Test and Trace
 3 Support Payment Scheme was introduced, albeit even later
 4 than in England. It was not introduced until
 5 November 2020. The reasons for that should be explored,
 6 and it may have been influenced by the financial aspects
 7 of the devolution settlement for Wales.

8 There were some positives. The Welsh Government did
 9 increase the payment from the £500 in England to £750,
 10 and the Wales TUC also welcomed the introduction of
 11 a fund to support creative freelancers affected by
 12 Covid-19.

13 Separately, social partnership contributed to the
 14 attempts to address the inequalities of the pandemic.
 15 On 1 April 2020, the Welsh Government invited union
 16 evidence on equality impact. The Wales TUC response
 17 highlighted the disproportionate impact on a range of
 18 groups, including the particular impacts on BAME
 19 workers, pregnant women, parents and carers, disabled
 20 people, and migrant workers. The Wales TUC also
 21 launched a survey to enable BAME workers to share their
 22 experiences.

23 Next, my Lady, we touch briefly on the differences
 24 in culture between the Welsh Government and Westminster.

25 We agree with the observation made by some,

170

1 as a false dichotomy, and that appears to have been the
 2 view also of the Welsh Government.

3 As Mark Drakeford has said, for the Welsh Government
 4 there was never a tension between these two objectives.
 5 If lives could not be saved, then livelihoods would be
 6 badly undermined because staff would become unavailable
 7 and customers would cease to be customers. For some in
 8 the UK Government, the debate was between either saving
 9 lives or saving livelihoods, as if these were mutually
 10 exclusive objectives.

11 My Lady, the flaws of that approach have been
 12 considered in Module 2.

13 My Lady, we conclude with this observation: to some
 14 witnesses in Module 2, the deeply unattractive side of
 15 the internal dysfunction within the UK Government was
 16 "just Westminster" or an inevitable part of government.

17 As with Module 2A, the evidence in Module 2B
 18 demonstrates that a more mature, professional and open
 19 form of central government is achievable. It is
 20 submitted that the evidence in this module demonstrates
 21 the value of a form of government that is open to and
 22 meaningfully engages with the views of stakeholders,
 23 including trade unions, but also of course many others.

24 In that respect, it is welcome that the Welsh
 25 Government has confirmed this approach for the future by

172

1 establishing the Social Partnership Council in law and
2 placing a social partnership duty on devolved public
3 bodies.

4 Unsurprisingly, there is room for improvement.
5 Earlier this afternoon, John's Campaign highlighted
6 areas where greater consultation was required, and we
7 say that the approach of consultation and engagement is
8 one which should be embraced but also strengthened in
9 a future pandemic.

10 My Lady, that's our opening statement.

11 **LADY HALLETT:** Thank you very much indeed, Mr Jacobs.

12 Mr Allen.

13 **Submissions on behalf of the Welsh Local Government**
14 **Association by MR ALLEN KC**

15 **MR ALLEN:** Good afternoon, my Lady, and thank you.

16 As in Module 1 of this Inquiry, I represent the
17 interests of the Welsh Local Government Association,
18 which welcomes the opportunity to be a core participant
19 and looks forward to assisting you in any way it can.

20 During Module 1, it was widely acknowledged that the
21 UK's preparedness and resilience for a pandemic was ill
22 focused and inadequate. In this module, the WLGA asks
23 you and the Inquiry team to look at how the Welsh
24 Government could have better used the great knowledge
25 and experience that the WLGA and its members, the WLGA

173

1 aspects of the WLGA's position that I wish to state now.

2 First, the WLGA does, of course, recognise that
3 during the pandemic the Welsh Government had to make
4 decisions under great pressure, time and circumstance,
5 and that this process of hindsight does not readily
6 capture the pressure of the moment; and others today
7 have made the same point.

8 Next, it also recognises that the Welsh Government,
9 though it had extensive devolved powers, had to work in
10 partnership with the London-based administration on some
11 issues and, where this was so, it had significant
12 consequences for the effectiveness and efficiency of
13 government in Wales.

14 Thirdly, the WLGA reminds you that whatever policies
15 were announced centrally, they had to be delivered
16 locally. It is this third aspect, a key point, that
17 I must develop in these opening remarks.

18 In short, the WLGA submits that, however apt and
19 well designed central government policies may appear to
20 be, the success of their delivery will always depend on
21 the capacity of those organisations tasked with their
22 operationalisation.

23 If policymaking, whether by the Welsh Government or
24 the London administration, overlooked the need for
25 partnership with local government, its delivery was

175

1 being the representative of all Welsh local authorities,
2 could have provided.

3 Its position, my Lady, on this is nuanced. The WLGA
4 accepts that from the outset there was considerable
5 engagement by the Welsh Government with it, and with
6 local government more generally. There is, though,
7 a qualification to this point: the nature of this
8 engagement changed over time from initially being
9 a process of sharing information to later a more
10 meaningful dialogue, and eventually to a recognition of
11 local government as a trusted delivery partner.

12 In short, the WLGA considers that fuller and earlier
13 engagement could well have been more effective. Its
14 position is, therefore, that in any future similar
15 emergency, such engagement should be early enough for it
16 to inform and influence strategy and decision-making,
17 and be undertaken systematically and consistently at
18 both the political and official levels.

19 You will see most fully how the WLGA develops these
20 points in the first and very extensive witness statement
21 from its chief executive in due course, and also in the
22 shorter second witness statement, the latter prepared
23 after reading witness statements from others, including
24 those working in and for the Welsh Government.

25 But today, in these opening remarks, there are three

174

1 likely to be suboptimal. Put the point the other way
2 around, it was the extent to which the Welsh Government
3 co-designed its policies with local councils having
4 responsibility for their delivery that was a determining
5 factor in their success.

6 This can be encapsulated in two overarching
7 questions for this module, and we note actually that
8 these two questions match closely questions posed by
9 Mr Poole this morning.

10 First, how significant at each stage between early
11 2020 and summer 2022 actually was that engagement?

12 Secondly, could a more extensive engagement have
13 enriched policymaking and delivery?

14 These are questions about the extent to which
15 co-design between those operationalising and those
16 posing(?) policy could have been.

17 The WLGA's submission is that initially engagement
18 was not as extensive as it could have been, and that had
19 greater use been made of local knowledge and expertise,
20 there would have been a better, swifter impact on
21 communities, though it also acknowledges that later in
22 the pandemic there was a significantly increased degree
23 of engagement.

24 I make a few points about these submissions. For
25 instance, my Lady, you will see from the evidence that

176

1 the Welsh Government created work groups that operated
2 in a somewhat insular manner for too long before
3 consulting with others. It could sooner have harnessed
4 the local authority directors of public protection, and
5 there are areas where these bodies could have done more
6 had they known more about the disease and the measures
7 chosen to mitigate its impact, including having more
8 expert resource prepared and available, along with the
9 provision of advice on social gatherings and events.

10 Of course it must be kept in mind that the Welsh
11 Government was never fully autonomous during the
12 pandemic. Nonetheless, it is submitted further that
13 a more open dialogue with the WLGA and its local council
14 members about the issues that arose from these matters
15 would have resulted in better decisions.

16 For instance, local authorities were not engaged
17 early enough as the pandemic developed. Knowledge and
18 preparations were at times based on what was in the
19 media. The Welsh Government did not involve key
20 response partners early enough. Local authorities were
21 aware of conversations and preparations to consider the
22 impact of a pandemic, but were not privy to the detail
23 of potential response needed. The concepts of
24 a lockdown and the component elements of such a response
25 were not relayed effectively by government. And had

177

1 There are six specific issues I need to develop in
2 a little greater detail.

3 The first of these is test, trace and protect, TTP.
4 Now, this initiative was very important, yet the
5 national health protection plan was drafted without any
6 full understanding of how it would be scaled up across
7 the whole of Wales. In fact, by May 2020 it was still
8 envisioned as being solely by Public Health Wales. Only
9 eventually was local government asked to help and
10 subsequently, when this occurred, it led on many of the
11 initiatives associated with TTP. This could have
12 happened earlier, and local authority expertise in
13 managing and operating call centres utilised sooner.

14 Next, there are many issues concerning money and
15 resources and, running through all the relevant issues
16 of this module, this is a key theme. The current dire
17 straits of many local authorities are suddenly more in
18 the news, but it isn't a new story. You will be aware
19 from Module 1 that, prior to the pandemic, all local
20 authorities had suffered austerity, budgets under
21 significant pressure, for too many years.

22 The point is they had of course done their best to
23 cope, and as a result there was a dangerous assumption
24 that local authorities were adequately resourced to
25 deliver the tasks arising from the pandemic controls

179

1 a more involved dialogue existed, they could have
2 reviewed resource arrangements around care homes,
3 reviewed systems for engaging and protecting vulnerable
4 people, and prepared enforcement officers to deal with
5 the restrictions on trade and movement.

6 This planning could have gone on at local level for
7 some weeks before the decisions made on March 23.

8 Moreover, involvement in the creation and content of
9 the regulations, such as the 21-day reviews, as they
10 progressed, would have avoided so many minor amendments
11 to the number 2 regulations during the lifting of the
12 restrictions and the re-opening of the economy.

13 Before making decisions about the need for rainbow
14 hospitals, the Welsh Government could have reduced the
15 extent to which there was a failure to meet demand, used
16 existing resource more effectively, and created extra
17 time for the consideration of the views of others, such
18 as local authorities.

19 Local authorities and colleagues from the police had
20 a vital role in terms of enforcement and enacting
21 decisions, and yet at times they were informed of
22 changes at the very last moment, or even at the same
23 time as the media, leaving enforcement officers to
24 interpret regulations and guidance, often without
25 an understanding of policy intent and direction.

178

1 even whilst maintaining service continuity, and this
2 assumption was never subjected to any detailed forensic
3 analysis.

4 Some points, though, about this are now quite clear:

5 Local authorities are aware that permanent funding
6 was given to Public Health Wales, whereas local
7 authorities only received some temporary funding for the
8 period, now discontinued.

9 Many of the officers deployed to work in health
10 protection supporting care homes, providing expert
11 advice to TTP, enforcing the coronavirus regulations,
12 have left the profession, and the pressures facing
13 public protection services in Wales are set out clearly
14 in the directorate of public protection report of 2021,
15 *Building for the Future*. Their recommendations, we
16 suggest, must inform the basis of resource planning with
17 the Welsh Government for the future.

18 So investment is now required before a future
19 pandemic emerges so as to avoid uncertainties,
20 complexities and variability such as happened in 2020.

21 My Lady, I emphasise that this isn't just a money
22 issue, but one of capacity and of time and process. The
23 WLGA says that legislation should be drafted now, in
24 conjunction with the police, and investment should be
25 made accordingly, and a rolling programme of secondments

180

1 from local authorities and the health boards into
2 a Welsh Government contingency team would build better
3 relationships, develop a pool of expertise and enhance
4 understanding across the public sector.

5 Thirdly, my Lady, I want to say something about data
6 and communications, such as some others have raised
7 today. It's another area requiring significant
8 investment. It was a key issue during the pandemic, and
9 this is why a better regime is now needed to understand
10 fully the risks and transmission issues and how these
11 can be best explained locally in the future.

12 The picture during the pandemic was again nuanced.
13 The information that was collected and shared did
14 improve over time, and this permitted a greater
15 understanding of both the prevalence and spread of the
16 disease. However, when local authorities and other
17 stakeholders submitted evidence and feedback, it was not
18 so clear where it went and how it was used, or whether
19 it had influenced policy direction.

20 So that's why the WLGA argues that investment in
21 a better understanding of the public health and public
22 protection roles of local authorities is also critical,
23 and that this must address data sharing in detail.

24 My Lady, this is a theme you've heard before from
25 me.

181

1 services has been overlooked. Early communication by
2 the Welsh Government could have led to an advanced
3 market surveillance regime being introduced, and to more
4 interventions being made.

5 Fifthly, NPIs.

6 My Lady, before I conclude, I want to stand back
7 from these points for a moment to consider NPIs from
8 a different angle.

9 First, NPIs are more than just an issue for local
10 authority engagement with the Welsh Government or for
11 better investment for the future. They have, as you've
12 heard, an intergovernmental aspect. The Inquiry will
13 surely note the uncertainty on the scope of NPIs,
14 particularly in border areas, though in fact they
15 diverged both across borders and with further
16 differences between urban and rural areas. It is surely
17 obvious that workability about cross-border issues was
18 essential -- there was some note of that, of course, in
19 the film at the beginning this morning -- yet border
20 local authorities received neither advance warning nor
21 time to prepare, nor time to adapt local arrangements.
22 Better engagement with local authorities would have
23 provided more insight into potential consequences around
24 decisions to stay local, the 5-mile guide, and the
25 impact upon the vulnerable, along with the restrictions

183

1 Local authorities acknowledge that the Welsh
2 Government did use partners to send its key
3 communication messages to them, and to specific
4 audiences and communities, though the role that they
5 took in advising the business community should not be
6 overlooked.

7 Finally on this particular point, the WLGA argues
8 that it's a significant consequence of the diverse
9 nature of our communities that regular TV briefings can
10 only have a limited reach to many of those most
11 vulnerable. Public confusion had to be resolved locally
12 during the pandemic, and the same applied to queries
13 from business about the substantive effect of
14 regulations.

15 My Lady, my fourth point concerns the PPE. It's
16 been said that the market was flooded with fraudulent or
17 substandard PPE, and indeed the supply and control of it
18 was inconsistent, failed to meet the required standards
19 on some occasions, and was often described falsely.
20 This of course must not be allowed to recur, and there
21 is much that could be done. Local authorities have
22 a better understanding of the trade sectors and the
23 enforcement responsibility to challenge non-compliant
24 product. For instance, the role of the local directors
25 of public protection through their trading standard

182

1 on the sale of certain goods. Local authorities' input
2 could have avoided failure associated with these
3 policies.

4 The next point about NPIs is that they had of course
5 significant and social and economic impacts. So a more
6 extensive engagement with local authorities would have
7 had a more positive impact on a range of social and
8 economic issues, such as the impact of -- from school
9 closures, the impact on those who were vulnerable, and
10 the consequences for the local economies. More
11 communication with local authorities on the option of
12 lockdown would have enabled them to use that opportunity
13 to look at remote working options earlier.

14 Finally, I finish with some comments about
15 compliance with those NPIs that were in fact imposed.
16 In practice, local partnership with the police provided
17 invaluable insight on local similarities and
18 differences, and the complementary powers of enforcement
19 agencies provided more effective outputs. Local
20 authority engagement with the four Welsh police forces
21 was initially a bottom-up approach with local engagement
22 from the National Police Chiefs' Council or the CPS.
23 However, meetings between the Welsh Government, the WLGA
24 leaders and the Welsh Police and Crime Commissioners
25 became a good example of joined-up and regular

184

1 discussion in relation to pressing enforcement issues.

2 Overall, local authorities in Wales believe they
3 adopted a proportionate and mature approach, providing
4 guidance and advice alongside more robust enforcement
5 when appropriate. Their aim for the future is to do
6 that and to do it better, my Lady.

7 Thank you. We look forward to assisting you during
8 this module.

9 **LADY HALLETT:** Very grateful, Mr Allen, thank you very much.
10 Mr Kinnier, I think you finish today's proceedings.

11 **Submissions on behalf of the Welsh Government by**
12 **MR KINNIER KC**

13 **MR KINNIER:** My Lady, thank you.

14 The Welsh Government welcomes you to Wales, and in
15 particular it welcomes the Inquiry's examination of its
16 decision-making during the pandemic. Scrutiny may
17 sometimes be difficult, even uncomfortable, but it is
18 necessary. That is because fair but unsparing scrutiny
19 is vital to make sure that the four nations of the
20 United Kingdom learn the lessons of the pandemic and do
21 so effectively.

22 This module's importance is obvious, but as its work
23 begins, it is worthwhile to re-state why, and as the
24 First Minister himself said in his statement:

25 "The pandemic touched the lives of everyone: my own,
185

1 Fair scrutiny requires a careful examination of the
2 evidence and analysis that was available to
3 decision-makers and their advisers at the time the
4 decisions were made and advice given.

5 As Mr Poole rightly recognised this morning,
6 scrutiny is not and cannot be an exercise in the
7 application of hindsight, knowing what we now know,
8 four years or so since the pandemic started.

9 In answering the Inquiry's questions, the
10 First Minister and other Welsh ministers will set out
11 the reasons for their decisions, and senior civil
12 servants from the Welsh Government will explain the
13 advice that they gave, and they stand ready to be
14 examined on the evidence they give.

15 In their opening statements, the Bereaved Families
16 for Justice Cymru, John's Campaign and Care Rights UK
17 and others have raised questions that fall to be
18 answered in this and also in later modules. The precise
19 dividing line between the subject matter of this module
20 and Module 3 and Module 6 is for you to decide, but
21 whichever part of this Inquiry you decide the questions
22 are best put, the Welsh Government will continue to
23 answer them in its statements, by its disclosure and in
24 evidence.

25 My Lady, the devolution settlements in Wales,
187

1 my colleagues, our communities, but none more so than
2 the many families who lost loved ones. I want to
3 acknowledge this loss at the outset ... and take this
4 opportunity to express my personal sympathies and
5 sincere condolences, to those affected, and to all who
6 sadly lost loved ones, across the nations. The pain and
7 sadness of their losses will last a lifetime and I will
8 continue to recognise this at every opportunity. Sadly,
9 too many families have lost loved ones. This cruel
10 virus has stolen lives, and it has left their loved ones
11 with questions, which they rightly want answered.
12 I would also like to take an opportunity to recognise
13 the suffering of those who continue to live with the
14 debilitating [side effects and] after-effects of the
15 virus. We continue to learn not only of the impacts on
16 our health but on our society as a whole. I, and the
17 Welsh Government, are committed and will remain
18 committed to this Inquiry and to learn lessons for the
19 future."

20 To that end, my Lady, the First Minister and other
21 Welsh ministers, together with senior officials from the
22 Welsh Government, have given statements, disclosed
23 documents, and they will attend to be examined by
24 Counsel to the Inquiry over the course of the next
25 three weeks.

186

1 Scotland and Northern Ireland have been well established
2 now for more than a quarter century, so Module 2B cannot
3 be a crude exercise in comparing the Welsh Government's
4 decisions against those of the UK Government. England
5 is not the standard against which the decisions of the
6 Welsh Government, and indeed the other devolved
7 governments, should be judged.

8 The Welsh Government was reassured by your statement
9 last year that there is an obvious value in assessing
10 decision-making across the four nations and the
11 interactions between them. The approach you proposed
12 last August had the advantage of reflecting how
13 government in the UK works. In responding to the
14 pandemic, the four governments had, for the most part,
15 their own powers and responsibilities. Using those
16 powers, they made the decisions that they considered to
17 be in the best interests of their nations.

18 The Welsh Government is, however, concerned that the
19 concept of divergence was used in examination of
20 witnesses in Modules 2 and 2A, and indeed in opening
21 this morning, which suggests that the policy of the
22 UK Government is the benchmark against which the
23 decisions which the Welsh Government's decision-making
24 will and indeed should be considered.

25 For that reason, the Welsh Government should be
188

1 grateful for the assurance that the substance of
2 examination will reflect the constitutional, legal and
3 political realities of the Welsh devolution settlement.

4 The size of Wales, the stability of its political
5 structures, and particularly the stability of
6 relationships between individuals and public bodies,
7 especially in the NHS in Wales, became a significant
8 feature of decision-making in the pandemic. In making
9 the decisions that affected Wales, Welsh ministers knew
10 daily how decisions were impacting the people they
11 serve. Well established relationships between the Welsh
12 Government and those on the frontline of the response
13 not only enabled a productive conversation, but also
14 robust challenge.

15 The Welsh TUC vigorously advocated for the rights
16 and safety of all workers, and importantly considered
17 that they were listened to by ministers. That view is
18 also reflected in the evidence of other parties from
19 whom you will hear evidence, including the British
20 Medical Association, the Welsh LGA and others.

21 Cross-party co-operation is commonplace in the
22 Senedd, and working with local authorities with
23 different political leaderships to the Welsh Government
24 is the norm rather than the exception. For that reason,
25 leaders of the Senedd opposition parties, together with

189

1 of the pandemic and the response on health and other
2 inequalities. Since the start of devolution, the Welsh
3 Government has focused on addressing entrenched health
4 and socioeconomic inequalities through the law -- for
5 example, the Well-being of Future Generations (Wales)
6 Act 2015 promotes equality as an objective for
7 society -- and also by policy and other funding
8 arrangements.

9 From the start, the Welsh Government's approach to
10 and understanding of the pandemic was informed by the
11 knowledge that every widespread disease outbreak is more
12 likely to produce disproportionately adverse effects on
13 those who are economically disadvantaged or suffering
14 from some other pre-existing health condition.

15 Since 2010, and uniquely in the UK, Welsh ministers
16 have been required by law to have regard to the
17 UN Convention on the Rights of the Child in their
18 decision-making. They were well used to doing so by the
19 time of the pandemic, and ministers' specific
20 appreciation of the impact of the virus on children
21 inevitably developed as evidence of that impact was
22 gathered and analysed.

23 Throughout the course of the pandemic, the Welsh
24 Government was acutely conscious of the impact of
25 restrictions on all sectors of society, and ensuring

191

1 representatives of other bodies such as the Welsh TUC,
2 the Welsh LGA, the Wales Council for Voluntary Action
3 and the police, attended the core Covid-19 group and
4 were regularly briefed on the pandemic, the relevant
5 data and intended decisions.

6 As has been commented upon by the Welsh TUC and
7 other CPs, the Shadow Social Partnership Council was
8 an important element that contributed to decision-making
9 in Wales during the pandemic. Its membership was
10 expanded and its operations were radically altered to
11 provide a weekly forum for consultation, and notably
12 informed an open discussion of forthcoming decisions.
13 It was attended by a broad cross-section of the
14 community, including the CBI, the Federation of Small
15 Businesses, trade unions, third sector parties, and the
16 future generations, Welsh language, Older Persons
17 Commissioners and the Children's Commissioner. The
18 council had direct access to Welsh ministers and senior
19 officials such as the Chief Medical Officer, the Chief
20 Scientific Adviser for Health and the chief executive of
21 the NHS in Wales. In the First Minister's own words,
22 meetings were challenging but constructive. The council
23 heard in advance of publication about the substance and
24 timing of intended decisions.

25 The Inquiry will rightly shine a light on the impact

190

1 that those most at risk were protected was a major and
2 constant consideration. That imperative came into sharp
3 focus early in the pandemic because of the emerging
4 evidence of the differential impact of the virus on
5 Black, Asian and ethnic minority communities. Evidence
6 emerged from prominent clinicians who observed that
7 Black, Asian and minority ethnic colleagues were more
8 vulnerable to catching the disease and suffering from
9 its more serious consequences.

10 In April 2020, the Welsh Government established
11 a Black, Asian and Minority Ethnic Covid-19 Advisory
12 Group to examine the disproportionate impact of the
13 virus. The group had two subgroups. The socioeconomic
14 subgroup looked at the broader context of the
15 disproportionate impact, and on 18 June 2020 it
16 submitted its report, whose recommendations were
17 immediately implemented. Another subgroup developed
18 a risk assessment tool to help health and social care
19 workers decide whether they were at higher risk from the
20 virus, and that too was swiftly implemented.

21 The Welsh Government's pre-existing Disability
22 Equality Forum was adapted to provide a means of
23 communication and consultation with disabled people;
24 a means, in Professor Debbie Foster's words, not
25 available to disabled people in other parts of the

192

1 country.

2 In June 2020, Professor Foster was asked by the
3 forum to write a report about the experiences of
4 disabled people in Wales during the pandemic. On any
5 view, the subsequent report made for powerful reading.
6 The Welsh Government committed to implement its
7 recommendations, it reaffirmed its commitment to the
8 social model of disability, and established the
9 Disability Rights Taskforce to implement the report's
10 recommendations. That valuable and necessary work,
11 sponsored by the Minister for Social Justice, continues.

12 There is a higher proportion of older people in
13 Wales than the rest of the UK, and so concern about the
14 impact of the virus and the response on their health and
15 well-being was of critical importance throughout. Data
16 and modelling in Wales took account of the higher
17 proportion of older people in the population, which in
18 turn informed decision-making. The Older People's
19 Commissioner was a member of the Shadow Social
20 Partnership Council, and in that forum -- and indeed
21 elsewhere -- she was a forthright and respected advocate
22 of the interests of older people.

23 My Lady, may I turn briefly to the question of
24 informal communication and WhatsApp messages.

25 These have received sustained and intense interest
193

1 restrictions of UK-wide programmes.

2 That problem is best demonstrated by the discussions
3 which led to the firebreak in Wales in October 2020.
4 The enhanced Job Support Scheme was a UK-wide scheme
5 implemented by the Treasury due to start on
6 1 November 2020. Following the Welsh Cabinet's decision
7 in principle to introduce a firebreak in Wales, when the
8 UK Government did not intend to take the same action, on
9 16 October 2020 the First Minister asked Rishi Sunak,
10 then the Chancellor, to bring forward the start of the
11 scheme by one week to coincide with the beginning of the
12 firebreak in Wales. The First Minister explained why
13 many staff in Wales would not be able to make claims on
14 the Job Retention Scheme for that period. He even made
15 an offer to reimburse the Treasury the additional cost
16 of bringing the scheme forward. The request was
17 declined due to "limitation on HMRC delivery timeline".
18 Quite what that meant has never been explained by the
19 Treasury.

20 Mr Sunak's recent suggestion that the Welsh
21 Government could and should have used an upfront
22 guarantee was never a practical possibility. The
23 problem was not solely the amount of money provided by
24 the UK Government, but the timing of public health
25 decisions in Wales and the availability of operational
195

1 in the Inquiry, and for that reason elsewhere. Given
2 that interest, one point is clear and, as was indicated
3 by Mr Poole in opening this morning, a careful
4 consideration of the documents including WhatsApps and
5 other messages shows that neither Welsh ministers nor
6 senior officials used WhatsApp or indeed any other form
7 of informal communication as a substitute for or
8 a supplemental means of decision-making.

9 My Lady, the Welsh Government has addressed you in
10 Module 2 and in writing in this module about the issues
11 which, from its perspective, affected intergovernmental
12 decision-making during the pandemic. As the
13 First Minister repeatedly said at the time, there were
14 obvious and necessary advantages to establishing
15 a regular rhythm of meetings between the heads of
16 government. That was not done, and it was not done
17 because the then Prime Minister was anxious to avoid
18 creating the impression that the UK was a federal state.
19 That concern with appearances did not recognise, and so
20 did not meet, the scale of events confronting all
21 four nations.

22 As was also discussed in Module 2, although there
23 was much to commend the Treasury's response to the
24 pandemic, equally the pandemic reinforced and
25 illustrated the unresponsiveness of the Treasury and the
194

1 support from HMRC. Undoubtedly Mr Sunak's evidence will
2 be discussed with the First Minister in due course.

3 Although this was a significant example of the
4 problems that could be caused by the existing funding
5 arrangements, unfortunately the October 2020 firebreak
6 was not the only incidence, and the problem remains to
7 this day unresolved. These limitations are flaws in the
8 system, not a single point of failure. The Treasury's
9 unresponsiveness to the need and public health
10 requirements of the devolved governments meant that
11 actions taken by the Treasury to put in place
12 interventions were based solely on instructions from
13 central government.

14 My Lady, finally, may I turn to the not
15 straightforward question of recommendations.

16 The First Minister has proposed two recommendations
17 touching upon reform of intergovernmental relations and
18 arrangements that allow the devolved governments equal
19 and fair access to funding in the event of a future
20 public health emergency. Undoubtedly the evidence will
21 reveal others.

22 A fundamental part of the Inquiry's work is the
23 formulation of efficient and effective recommendations
24 to put right any deficiencies or flaws that have been
25 identified in the evidence. Consideration of
196

1 recommendations is never straightforward, as my Lady may
 2 recall from previous experiences. At the start of
 3 Modules 1 and 2, the Welsh Government asked the Inquiry
 4 to publish details of its proposed arrangements for
 5 consideration of recommendations, and I repeat that
 6 request to you today.

7 My Lady, since the start of the Inquiry the Welsh
 8 Government has provided more than 100 statements and
 9 thousands of documents to the Inquiry. Over the next
 10 three weeks, you will hear evidence from the
 11 First Minister and other Welsh ministers as well as
 12 senior officials. As I said at the start, scrutiny is
 13 necessary and it can be uncomfortable, and the Welsh
 14 Government will continue to provide you and this Inquiry
 15 with every assistance, and crucially to answer the
 16 questions that the people of Wales rightly want asked.

17 Thank you.

18 **LADY HALLETT:** Thank you, Mr Kinnier.

19 Please try to allay the concerns of the Welsh
 20 Government in relation to divergence. Yes, you will
 21 have heard the word, and I've considered it in other
 22 modules, as you indicated, but I did say something in 2A
 23 that may be of some comfort to the Welsh Government.
 24 I think I commented at one stage: just because there's
 25 a divergence doesn't mean that England is right and

1 Scotland or Wales or Northern Ireland are wrong. So
 2 it's merely recording the fact that there is
 3 a divergence; it's not suggesting any particular nation
 4 is to blame for it. It may well be in some cases there
 5 is some responsibility attached, but it doesn't
 6 necessarily mean the devolved nation has got it wrong by
 7 going a different way from England.

8 **MR KINNIER:** I'm very grateful for that, my Lady.

9 **LADY HALLETT:** Thank you.

10 Thank you, everybody. I think you must be one of
 11 the most timely groups of core participants and Counsel
 12 to the Inquiry: finished almost on the dot of the time
 13 we had expected.

14 So thank you all very much indeed for your
 15 submissions, they were all instructive and sensible and
 16 I shall obviously bear them all very much in mind, and
 17 of course I shall bear in mind any of the written
 18 submissions that I have received, either supplementing
 19 your submissions today or if they are instead of any
 20 oral submissions from other core participants.

21 So thank you all very much indeed. 10 o'clock
 22 tomorrow.

23 **(4.33 pm)**

24 **(The hearing adjourned until 10 am**
 25 **on Wednesday, 28 February 2024)**

1	INDEX	PAGE
2		
3	Opening remarks by THE CHAIR	1
4		
5	Opening statement by LEAD COUNSEL TO THE	3
6	INQUIRY for MODULE 2B	
7		
8	Submissions on behalf of Covid-19 Bereaved	99
9	Families for Justice Cymru by MS GOWMAN	
10		
11	Submissions on behalf of John's Campaign	115
12	and Care Rights UK by MR STRAW KC	
13		
14	Submissions on behalf of Disability Wales	131
15	and Disability Rights UK by MR FRIEDMAN KC	
16		
17	Submissions on behalf of the Children's	145
18	Commissioner for Wales by MR GARDNER	
19		
20	Submissions on behalf of the Trades Union	161
21	Congress and Wales Trades Union Congress by	
22	MR JACOBS	
23		
24	Submissions on behalf of the Welsh Local	173
25	Government Association by MR ALLEN KC	

1	Submissions on behalf of the Welsh	185
2	Government by MR KINNIER KC	
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		

LADY HALLETT: [19] 1/6 1/8 3/11 30/9 30/21 98/21 99/2 112/23 113/1 115/11 131/4 144/24 145/3 160/23 161/4 173/11 185/9 197/18 198/9	197/8 100,000 [4] 81/14 81/16 86/16 87/18 11 [1] 54/15 11 February [2] 43/2 70/25 11 January [1] 31/23 11 January 2021 [1] 12/6 11 March [3] 53/4 53/16 54/16 11 May [1] 72/19 11 weeks [1] 61/25 11.11 am [1] 30/18 11.25 [1] 30/17 11.28 am [1] 30/20 12 [3] 33/24 56/1 139/18 12 April 2020 [1] 12/4 12 deaths [1] 63/10 12 February [2] 43/7 43/13 12 March [2] 54/25 55/3 12 May [1] 73/23 12 October [1] 81/18 12,300 [1] 8/13 12,510 [1] 99/9 12.58 pm [1] 98/24 125 [1] 124/10 13 [4] 34/2 42/23 73/23 89/14 13 April 2022 [1] 13/20 13 Covid-19 [1] 46/11 13 February [1] 43/18 13 January [1] 31/25 13 January 2021 [1] 13/11 13 January 2022 [1] 90/4 13 July [1] 74/15 13 March [3] 56/22 57/14 57/18 13 May [1] 74/3 13 October [1] 81/23 133,000 [1] 51/2 136 reported [1] 61/13 14 [3] 56/19 57/6 119/16 14 days [3] 31/15 46/16 158/2 14 December [2] 86/18 86/19 14 July 2021 [1] 14/14 14 March [1] 59/16 14 September [1] 78/17 14,000 [1] 51/3	145 [1] 13/13 15 [3] 53/9 57/6 74/16 15 April 2020 [2] 13/8 128/9 15 December [1] 86/22 15 March [1] 59/23 15 October [2] 81/8 82/9 15 September 2021 [1] 12/8 15-minute [1] 116/3 150 of [1] 13/9 16 [1] 62/25 16 April [1] 65/13 16 December [1] 87/2 16 January [1] 32/9 16 March [1] 60/14 16 May 2020 [1] 108/12 16 October 2020 [1] 195/9 16 September [1] 79/3 16,252 [1] 14/17 160,000 [2] 15/15 51/1 162,500 [1] 50/6 17 February [1] 44/24 17 March [3] 61/6 123/21 123/24 17 March 2020 [1] 124/7 18 [1] 46/8 18 August [1] 77/3 18 February [1] 45/9 18 June 2020 [1] 192/15 18 March [3] 61/11 62/19 62/25 18 September [1] 79/12 19 [55] 8/12 12/1 23/11 23/23 25/22 35/1 36/10 36/15 38/12 41/25 42/13 43/5 44/3 45/18 46/5 46/11 46/21 48/15 49/14 50/2 51/8 51/9 52/17 53/4 53/7 53/8 55/1 58/15 61/11 63/10 80/5 85/11 86/20 89/15 89/17 89/23 90/17 91/1 91/8 99/3 99/8 99/10 101/5 109/6 116/12 123/17 123/19 125/14 139/12 142/19 166/10 170/12 190/3 192/11 199/8 19 December [2] 87/6 89/15	19 February [1] 45/16 19 October [2] 82/13 109/24 2 2 February [1] 40/18 2 February 2024 [1] 99/11 2 March [1] 49/10 2 metres [1] 75/7 2 o'clock [1] 98/22 2 October [1] 80/21 2,000 [1] 85/17 2,600 [1] 46/6 2-metre [4] 75/9 75/14 75/15 168/13 2.00 pm [1] 99/1 2.2 [2] 38/15 38/16 2.5 [1] 81/17 20 [2] 14/5 50/24 20 February [1] 105/2 20 March [2] 63/9 63/25 20 minutes [2] 2/15 145/2 20,000 [1] 56/23 2000 [1] 145/9 2002 [1] 139/7 2010 [1] 191/15 2011 [1] 148/5 2015 [2] 18/21 191/6 2017 [1] 18/11 2018 [2] 133/16 137/17 2019 [3] 18/11 32/19 38/20 2019-nCoV [1] 41/14 2020 [98] 3/19 5/10 9/8 10/7 11/7 12/4 13/6 13/8 14/11 15/6 15/8 17/3 18/7 21/24 28/17 29/3 31/4 31/6 31/11 34/25 49/8 51/7 56/19 58/13 58/24 59/11 61/8 63/7 65/7 68/11 69/5 69/8 72/2 73/19 77/6 82/20 83/21 84/12 90/10 91/6 91/17 97/22 97/24 104/10 104/12 104/21 105/1 105/2 105/9 106/24 107/25 108/6 108/12 109/17 109/19 111/25 116/1 116/18 121/1 123/10 124/2 124/6 124/7 124/14 124/17 125/9 125/15 125/22 125/24 126/5 126/12 128/9 128/19 129/23 132/2 134/7 135/12 136/11 136/13 139/3 143/10	150/10 150/11 151/9 153/11 153/21 170/5 170/15 176/11 179/7 180/20 192/10 192/15 193/2 195/3 195/6 195/9 196/5 2020/2021 [1] 43/6 2021 [17] 12/6 12/7 12/8 13/11 14/14 14/17 15/15 43/6 84/10 88/20 88/25 89/2 98/2 122/9 122/23 125/22 180/14 2022 [11] 3/19 13/20 13/23 15/20 90/4 90/7 90/8 90/11 116/19 125/1 176/11 2023 [2] 24/18 101/21 2024 [3] 1/1 99/11 198/25 20th century's [1] 132/15 21 [2] 109/19 119/16 21 deaths [1] 12/8 21 December [1] 89/25 21 February [1] 45/22 21 January [2] 32/18 33/6 21 June 2020 [1] 128/19 21 September [1] 79/18 21-day [2] 90/3 178/9 22 [4] 21/24 69/4 108/5 116/19 22 February [1] 46/1 22 January [4] 33/17 34/6 34/18 34/24 22 March 2020 [1] 125/9 225 [1] 120/1 23 [5] 48/19 84/18 91/16 125/22 178/7 23 February [1] 46/10 23 hours [1] 153/14 23 January [1] 35/4 23 March [2] 49/4 64/3 23 October [2] 82/11 82/16 24 April [1] 65/16 24 January [5] 34/21 35/25 36/9 36/23 39/22 24 March [1] 64/13 24 November [1] 84/13 25 [2] 46/19 81/16 25 February [3] 39/14 46/12 47/4
' council ' [1] 69/23 ' Sorry ' [1] 116/7				
0				
0.25 [1] 45/1				
1				
1 April 2020 [3] 13/6 124/17 170/15 1 June [1] 74/8 1 metre [1] 75/7 1 November 2020 [2] 83/21 195/6 1,000 [2] 46/7 58/11 1,059 [1] 13/20 1,100 [1] 32/14 1,150 [1] 12/22 1,206 [1] 14/15 1,949 [1] 13/11 1.25 million [1] 50/5 1.45 [1] 81/19 1.7 million [1] 15/18 1.9 million [1] 24/19 10 [3] 9/7 41/15 42/5 10 am [1] 198/24 10 December [3] 86/8 86/14 89/9 10 March [1] 52/22 10 May [1] 69/4 10 May 2020 [1] 72/2 10 o'clock [1] 198/21 10,000 [2] 52/4 55/6 10-12 weeks [1] 51/21 10.00 am [1] 1/2 10.10 am [1] 1/4 100 [3] 42/9 81/14				

2	3.22 pm [1] 161/1 3.40 [1] 160/25 3.40 pm [1] 161/3 30 [1] 51/23 30 January [1] 39/4 30-50 [1] 63/11 30th highest [1] 26/6 31 January [2] 39/10 39/15 31 October 2020 [1] 84/12 335 [1] 64/4 34 [1] 124/10 345 [1] 63/10 35 [2] 60/17 64/4 36,000 [1] 57/17 370 [1] 86/16 38 [1] 119/16 39 [2] 118/10 126/14 391 [1] 14/5	6 February [1] 41/24 6 January [2] 32/14 88/20 6 March [1] 51/17 6,000 [1] 52/2 60 [2] 35/22 116/19 65 [1] 54/22 65s [1] 51/12 66 [1] 61/1 68 [1] 132/3	56/5 57/12 88/25 89/1 95/4 98/7 103/18 125/13 131/2 137/4 147/14 167/18 195/13 about [63] 2/15 11/14 11/22 16/8 18/5 18/19 20/24 26/23 27/11 27/15 28/25 31/10 43/11 44/20 45/2 68/19 70/11 72/25 73/13 86/10 90/15 91/13 91/17 92/18 95/17 95/22 96/18 109/1 112/5 112/6 115/19 115/24 118/23 119/5 119/7 121/20 126/8 130/3 133/9 135/11 140/22 141/4 141/4 142/11 144/2 145/20 166/22 168/9 176/14 176/24 177/6 177/14 178/13 180/4 181/5 182/13 183/17 184/4 184/14 190/23 193/3 193/13 194/10 above [5] 12/17 26/9 35/19 83/9 130/7 abroad [1] 77/6 absence [2] 107/7 123/6 absolutely [4] 8/24 76/10 80/3 113/2 academic [1] 70/25 academics [2] 31/10 144/6 accelerate [1] 43/4 accepted [2] 125/1 127/20 accepts [1] 174/4 access [9] 29/13 65/4 92/25 102/18 141/23 159/17 169/21 190/18 196/19 accessed [1] 20/11 accessible [1] 94/14 accident [1] 138/1 accommodating [2] 155/9 157/21 accommodation [1] 21/10 accompanies [1] 149/4 accordance [1] 139/8 according [2] 43/16 71/9 accordingly [2] 55/15 180/25 account [21] 15/1 17/14 27/16 117/16 117/17 121/25 122/18 124/24 125/7 126/3 127/5 127/10 144/9 145/25 147/6 151/13	153/15 155/6 163/10 167/21 193/16 accountability [3] 99/14 113/9 114/12 accountable [2] 113/21 114/25 accounts [2] 28/4 107/18 accurate [2] 14/23 148/21 accurately [2] 109/14 168/21 accusations [1] 138/21 achievable [2] 54/10 172/19 achieve [4] 41/6 46/17 81/21 154/19 achieved [1] 116/3 achieving [1] 103/3 acknowledge [3] 107/14 182/1 186/3 acknowledged [2] 133/17 173/20 acknowledgement [2] 113/4 114/7 acknowledges [1] 176/21 acknowledging [1] 162/14 acquiesced [1] 139/17 across [45] 5/6 8/11 13/5 13/24 14/2 15/18 20/13 22/25 23/22 26/4 39/20 49/9 51/23 63/14 64/2 64/3 67/20 67/23 73/18 74/12 78/9 80/6 84/19 84/20 86/15 88/23 89/11 89/17 107/21 132/6 144/1 144/12 144/19 147/7 152/8 161/14 161/15 162/19 162/21 164/7 179/6 181/4 183/15 186/6 188/10 act [23] 18/20 18/23 18/24 36/22 63/18 67/8 67/9 95/2 104/4 105/11 105/15 130/16 130/17 131/17 133/16 134/25 135/1 139/3 139/18 139/21 139/24 145/9 191/6 acted [2] 65/3 93/13 acting [1] 84/4 action [10] 40/9 41/8 49/7 50/12 50/17 63/17 79/16 104/14 190/2 195/8 actions [7] 33/12 36/5 57/19 59/23 149/13 150/23 196/11 activated [1] 33/18
25 January [2] 37/4 46/6 25 September [1] 80/15 25,000 [1] 51/4 250,000 [1] 50/7 26 February [1] 47/8 27 [1] 37/11 27 December [1] 84/18 27 February [2] 47/18 47/21 27 February 2024 [1] 1/1 27 November [1] 84/22 28 [2] 22/1 115/21 28 April [1] 66/7 28 August 2020 [1] 126/5 28 days [1] 158/5 28 December [1] 85/23 28 February [1] 48/14 28 February 2020 [2] 105/9 124/14 28 February 2024 [1] 198/25 28 January [1] 37/18 28 January 2020 [1] 106/24 28 May [1] 73/24 28 September 2020 [1] 116/1 283 [1] 32/22 29 [2] 48/18 73/24 29 April 2020 [2] 59/11 108/6 29 December 2021 [2] 14/17 15/15 29 January [1] 38/11 29 May [1] 74/8 29 November [1] 89/6 2A [7] 19/18 25/10 68/3 162/7 172/17 188/20 197/22 2B [12] 1/21 3/15 3/21 6/3 10/13 19/18 20/3 25/9 99/15 172/17 188/2 199/6 2C [2] 19/18 25/10	4 4 December [1] 85/14 4 February [2] 41/1 104/12 4 July [2] 74/14 75/6 4 March [1] 50/20 4,000 [1] 34/14 4.33 pm [1] 198/23 4.9 years [1] 18/14 400 [1] 37/23 400,000 [1] 161/16 41 [1] 127/19 41 cases [1] 32/2 41,839 [1] 13/23 42 [1] 127/19 425 cases [1] 38/15 43,000 [1] 13/25 44,000 [1] 15/13 48 [1] 161/13	7 7 March [2] 52/9 52/10 7 November 2023 [1] 101/21 7 September [1] 77/18 7.5 [1] 14/18 7.8 [1] 81/15 70 [1] 26/9 70,000 [2] 56/15 56/17 70s [1] 60/23 73 [1] 12/23 73 deaths [1] 12/5 75 [1] 46/17 750 [1] 170/9 76.5 years [1] 18/13 77 [1] 120/3	73 [1] 12/23 73 deaths [1] 12/5 75 [1] 46/17 750 [1] 170/9 76.5 years [1] 18/13 77 [1] 120/3	
29 December 2021 [2] 14/17 15/15 29 January [1] 38/11 29 May [1] 74/8 29 November [1] 89/6 2A [7] 19/18 25/10 68/3 162/7 172/17 188/20 197/22 2B [12] 1/21 3/15 3/21 6/3 10/13 19/18 20/3 25/9 99/15 172/17 188/2 199/6 2C [2] 19/18 25/10	4 4 December [1] 85/14 4 February [2] 41/1 104/12 4 July [2] 74/14 75/6 4 March [1] 50/20 4,000 [1] 34/14 4.33 pm [1] 198/23 4.9 years [1] 18/14 400 [1] 37/23 400,000 [1] 161/16 41 [1] 127/19 41 cases [1] 32/2 41,839 [1] 13/23 42 [1] 127/19 425 cases [1] 38/15 43,000 [1] 13/25 44,000 [1] 15/13 48 [1] 161/13	8 8 April 2020 [1] 107/25 8 January 2020 [2] 31/11 105/1 8 January 2021 [1] 84/10 80 [5] 44/3 47/19 50/23 50/23 51/23 80 deaths [1] 37/12 81,000 [1] 52/12 81.5 years [1] 18/12 83 [1] 12/6 83.3 [1] 119/22 884 patients [1] 13/8	8 8 April 2020 [1] 107/25 8 January 2020 [2] 31/11 105/1 8 January 2021 [1] 84/10 80 [5] 44/3 47/19 50/23 50/23 51/23 80 deaths [1] 37/12 81,000 [1] 52/12 81.5 years [1] 18/12 83 [1] 12/6 83.3 [1] 119/22 884 patients [1] 13/8	
3 3 August [2] 74/17 75/20 3 February [2] 41/13 46/3 3 July [1] 74/13 3 March [4] 49/24 50/3 50/11 62/16	5 5 June [1] 58/14 5 March [1] 51/6 5 million [1] 161/14 5,000 [1] 55/6 5-mile [1] 183/24 5.2 billion [1] 84/9 50 [6] 35/12 35/13 35/15 37/20 44/4 63/11 50,000 [1] 51/25 50-fold [1] 52/8 500 [4] 37/23 46/7 56/4 170/9 53 [1] 28/6 56 [1] 15/20 57th [1] 26/7 58 [1] 125/13 58th [1] 79/18	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	
3 August [2] 74/17 75/20 3 February [2] 41/13 46/3 3 July [1] 74/13 3 March [4] 49/24 50/3 50/11 62/16	6 6 April [1] 65/12	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	
3 August [2] 74/17 75/20 3 February [2] 41/13 46/3 3 July [1] 74/13 3 March [4] 49/24 50/3 50/11 62/16	6 6 April [1] 65/12	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	
3 August [2] 74/17 75/20 3 February [2] 41/13 46/3 3 July [1] 74/13 3 March [4] 49/24 50/3 50/11 62/16	6 6 April [1] 65/12	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	
3 August [2] 74/17 75/20 3 February [2] 41/13 46/3 3 July [1] 74/13 3 March [4] 49/24 50/3 50/11 62/16	6 6 April [1] 65/12	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	
3 August [2] 74/17 75/20 3 February [2] 41/13 46/3 3 July [1] 74/13 3 March [4] 49/24 50/3 50/11 62/16	6 6 April [1] 65/12	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	
3 August [2] 74/17 75/20 3 February [2] 41/13 46/3 3 July [1] 74/13 3 March [4] 49/24 50/3 50/11 62/16	6 6 April [1] 65/12	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	
3 August [2] 74/17 75/20 3 February [2] 41/13 46/3 3 July [1] 74/13 3 March [4] 49/24 50/3 50/11 62/16	6 6 April [1] 65/12	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	
3 August [2] 74/17 75/20 3 February [2] 41/13 46/3 3 July [1] 74/13 3 March [4] 49/24 50/3 50/11 62/16	6 6 April [1] 65/12	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	
3 August [2] 74/17 75/20 3 February [2] 41/13 46/3 3 July [1] 74/13 3 March [4] 49/24 50/3 50/11 62/16	6 6 April [1] 65/12	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	
3 August [2] 74/17 75/20 3 February [2] 41/13 46/3 3 July [1] 74/13 3 March [4] 49/24 50/3 50/11 62/16	6 6 April [1] 65/12	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	
3 August [2] 74/17 75/20 3 February [2] 41/13 46/3 3 July [1] 74/13 3 March [4] 49/24 50/3 50/11 62/16	6 6 April [1] 65/12	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	
3 August [2] 74/17 75/20 3 February [2] 41/13 46/3 3 July [1] 74/13 3 March [4] 49/24 50/3 50/11 62/16	6 6 April [1] 65/12	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	
3 August [2] 74/17 75/20 3 February [2] 41/13 46/3 3 July [1] 74/13 3 March [4] 49/24 50/3 50/11 62/16	6 6 April [1] 65/12	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	
3 August [2] 74/17 75/20 3 February [2] 41/13 46/3 3 July [1] 74/13 3 March [4] 49/24 50/3 50/11 62/16	6 6 April [1] 65/12	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	
3 August [2] 74/17 75/20 3 February [2] 41/13 46/3 3 July [1] 74/13 3 March [4] 49/24 50/3 50/11 62/16	6 6 April [1] 65/12	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	9 9 April 20 [1] 14/5 9 December [1] 85/15 9 January [1] 31/19 9 March [1] 52/14 9 October [1] 81/10 9.15 am [1] 69/11 900 [1] 13/1	
3 August [2] 74/17 75/20 3 February [2] 41/13 46/3 3 July [1] 74/13 3 March [4] 49/24 50/3 50/11 62/16	6 6 April [1]</			

A	78/15 80/13 97/16 99/18 140/20 185/3 adoption [2] 29/9 156/20 adult [2] 48/16 130/1 advance [7] 62/25 148/13 150/3 165/11 166/10 183/20 190/23 advanced [2] 139/7 183/2 advantage [1] 188/12 advantages [2] 168/12 194/14 adverse [6] 21/19 120/23 125/23 126/1 130/11 191/12 Adversity [2] 114/1 115/5 advice [50] 5/4 11/11 29/11 39/20 47/25 55/7 55/23 57/7 59/2 60/25 61/15 61/20 65/4 66/25 67/2 71/7 71/9 73/13 74/22 75/7 75/14 76/1 79/16 79/23 80/22 81/7 81/9 82/21 85/6 86/11 92/22 93/6 93/11 97/13 97/15 103/17 103/19 103/22 125/1 138/20 138/24 143/9 150/9 159/18 160/6 177/9 180/11 185/4 187/4 187/13 advise [3] 43/15 56/3 159/20 advised [25] 31/21 33/13 34/14 36/24 42/1 43/24 44/2 50/4 50/8 53/13 57/3 57/15 58/19 60/15 61/9 61/12 61/23 64/14 79/13 81/10 81/18 82/1 85/7 86/22 86/25 adviser [10] 11/1 32/16 34/20 102/8 105/7 106/25 110/9 122/6 124/17 190/20 advisers [13] 5/5 5/24 6/7 6/15 10/22 26/14 26/14 94/17 102/3 102/5 106/12 106/17 187/3 advises [1] 147/1 advising [4] 40/20 55/24 80/16 182/5 advisory [17] 11/6 11/7 11/8 11/14 33/17 48/2 48/4 88/3 91/8 92/5 92/24 93/2 93/9 93/11 132/18 138/25 192/11 advocate [2] 167/18 193/21	advocated [1] 189/15 advocating [1] 142/5 aetiology [1] 31/13 affect [3] 60/9 80/8 164/2 affected [13] 6/10 16/1 16/4 17/25 117/5 117/10 127/4 160/12 160/19 170/11 186/5 189/9 194/11 affecting [3] 58/6 151/1 155/24 affiliated [2] 161/13 161/17 afraid [1] 30/22 after [19] 1/15 2/21 4/19 15/3 46/4 46/5 51/21 62/21 67/2 79/2 96/9 97/8 105/8 111/24 146/16 148/17 150/2 174/23 186/14 after-effects [1] 186/14 afternoon [5] 99/6 161/8 171/1 173/5 173/15 afterwards [1] 68/20 again [27] 19/23 20/25 31/1 32/24 37/19 38/21 43/19 51/14 55/3 82/13 89/15 98/16 108/12 109/25 116/3 125/4 125/15 126/12 127/11 129/10 133/18 136/25 138/8 150/11 158/12 163/25 181/12 against [23] 5/1 8/5 9/19 19/19 20/22 31/21 56/3 57/3 61/9 65/4 70/19 97/1 99/12 100/1 106/9 109/10 126/25 138/21 146/18 169/6 188/4 188/5 188/22 age [11] 17/23 28/1 29/16 54/21 80/6 85/2 97/3 120/24 130/15 132/7 132/12 Age UK [1] 120/24 aged [1] 62/23 ageing [1] 20/6 ageism [1] 20/24 agencies [2] 158/9 184/19 agency [2] 49/24 50/1 agent [1] 164/23 ages [1] 20/20 aggravated [1] 144/14 aggressive [1] 46/20 agnostic [1] 76/10 ago [3] 8/1 48/15	162/6 agree [4] 35/7 116/12 123/11 170/25 agreed [14] 36/5 37/17 38/7 41/4 60/20 62/21 63/13 65/13 79/6 82/8 85/3 85/21 102/6 171/11 agreement [2] 43/17 168/3 agrees [2] 60/11 104/22 ahead [5] 57/6 61/18 73/17 86/5 87/15 aid [2] 61/4 152/24 Ailsa [1] 25/7 aim [5] 49/25 78/11 146/15 161/18 185/5 aimed [1] 57/19 aims [1] 103/3 airborne [4] 106/23 109/5 109/7 109/10 akin [1] 108/18 albeit [1] 170/3 alert [8] 49/12 68/10 72/4 85/22 87/3 87/21 88/23 90/1 alerted [1] 131/6 alignment [1] 112/9 alike [1] 133/10 all [63] 2/14 6/10 12/10 13/17 15/10 20/13 26/9 33/4 36/8 42/8 46/17 53/22 59/12 61/9 71/3 79/24 79/24 79/25 80/2 80/6 81/15 82/8 95/21 101/13 102/18 102/23 106/22 108/10 111/13 120/4 122/6 131/8 135/13 135/21 136/3 137/18 139/1 140/25 141/11 142/1 148/7 149/13 150/20 153/10 155/10 157/15 158/14 159/23 160/5 164/11 165/1 167/22 174/1 179/15 179/19 186/5 189/16 191/25 194/20 198/14 198/15 198/16 198/21 allay [1] 197/19 alleged [1] 94/15 alleges [1] 143/16 Allen [4] 173/12 173/14 185/9 199/25 allow [11] 63/6 74/7 84/17 84/19 84/21 102/19 102/24 112/21 153/19 156/6 196/18 allowed [8] 21/20 63/7 73/22 98/16 116/5 144/13 155/22 182/20	allowing [3] 56/15 57/19 156/5 allows [2] 26/19 155/21 almost [5] 12/22 103/9 103/12 109/24 198/12 alone [3] 20/11 121/15 144/6 along [5] 38/24 47/21 87/8 177/8 183/25 alongside [5] 43/5 48/3 97/15 147/5 185/4 Alpha [1] 14/10 Alps [1] 42/1 already [26] 4/3 6/21 6/25 11/15 16/14 16/25 25/20 28/16 29/1 31/7 42/24 45/8 61/20 66/6 70/12 72/1 76/15 85/1 90/14 91/1 92/23 110/22 140/22 141/22 149/20 164/12 also [114] 2/5 4/4 4/4 4/25 6/23 10/24 11/13 15/1 15/17 16/18 17/5 17/6 18/15 18/19 20/21 21/8 22/19 23/15 23/17 24/16 25/5 27/25 30/13 32/5 33/2 34/24 36/9 36/23 42/16 43/13 47/4 47/21 48/7 48/19 50/3 51/9 51/14 52/10 53/16 53/25 54/11 54/16 55/22 55/23 56/1 57/18 63/4 63/25 64/8 65/5 67/15 68/3 68/12 69/24 70/4 70/15 78/3 83/2 84/18 85/12 86/3 86/24 90/20 91/8 91/13 91/20 92/17 94/3 95/10 97/5 98/16 100/25 103/16 103/24 104/24 105/6 111/3 117/12 117/18 117/23 117/25 118/3 118/14 120/8 122/1 130/24 136/13 138/5 140/23 140/25 143/7 149/8 154/9 155/3 163/4 164/19 168/19 168/20 170/10 170/20 171/10 172/2 172/23 173/8 174/21 175/8 176/21 181/22 186/12 187/18 189/13 189/18 191/7 194/22 alter [1] 29/25 altered [2] 145/22 190/10 alternative [2] 65/9
----------	--	---	---	--

A	40/22 41/24 42/3 51/10 52/19 56/8 59/17 61/7 63/25 64/5 64/8 65/17 66/14 68/8 77/18 82/14 87/3 123/22 175/15 announcement [3] 62/5 66/17 109/23 announcements [3] 68/13 72/14 102/13 announcing [2] 57/19 87/11 annual [1] 56/9 another [9] 46/24 61/25 88/24 113/25 115/4 126/22 169/12 181/7 192/17 answer [3] 96/12 187/23 197/15 answered [3] 8/22 186/11 187/18 answering [1] 187/9 answers [7] 96/15 96/16 98/15 113/22 115/1 127/22 128/4 anti [1] 112/11 anti-Tory [1] 112/11 antibody [1] 15/4 anticipate [1] 105/12 anticipated [3] 5/15 107/22 151/15 anxious [1] 194/17 any [41] 8/13 31/14 31/20 31/21 40/2 54/18 58/21 63/22 66/17 69/2 71/19 75/2 75/3 76/11 81/9 83/4 99/23 104/1 111/7 114/2 115/6 115/13 116/5 116/7 118/5 126/19 135/3 146/13 147/13 150/22 158/5 173/19 174/14 179/5 180/2 193/4 194/6 196/24 198/3 198/17 198/19 anybody [2] 3/4 112/21 anything [2] 65/6 163/17 apologise [1] 148/7 appalling [2] 76/12 163/7 apparent [6] 61/18 61/21 133/14 150/25 153/6 156/12 apparently [1] 68/20 appeal [1] 77/14 appear [7] 70/4 75/25 92/6 99/7 145/6 171/23 175/19 appearances [1] 194/19 appeared [1] 163/11	appears [13] 17/19 39/18 50/15 66/17 71/17 110/3 122/17 125/11 127/20 166/4 171/8 171/12 172/1 application [2] 31/21 187/7 applied [6] 17/5 68/13 72/15 81/20 149/13 182/12 apply [2] 29/7 73/11 applying [2] 54/3 152/19 appreciate [1] 131/6 appreciated [2] 40/1 97/8 appreciation [2] 49/1 191/20 approach [40] 29/10 29/23 38/8 50/13 62/10 67/15 67/20 74/15 74/25 76/10 82/8 85/3 95/18 99/19 112/17 127/14 148/15 154/21 154/23 154/25 155/10 155/15 155/20 156/11 157/15 158/13 158/16 162/3 166/20 168/2 168/11 171/16 171/19 172/11 172/25 173/7 184/21 185/3 188/11 191/9 approaches [2] 155/13 157/13 appropriate [9] 2/3 30/8 85/3 91/25 93/5 95/7 126/4 156/6 185/5 appropriately [3] 93/12 166/25 171/12 approved [1] 82/13 approximately [5] 15/5 52/5 52/7 55/8 60/3 April [23] 12/4 13/6 13/8 13/20 14/5 58/13 58/24 59/11 65/10 65/12 65/13 65/16 66/7 107/25 108/6 123/10 124/17 128/9 136/11 136/13 150/10 170/15 192/10 April 2020 [5] 58/13 58/24 136/11 136/13 192/10 apt [1] 175/18 are [91] 1/10 1/11 1/19 2/14 8/23 8/24 14/24 18/15 19/23 20/8 20/12 20/17 20/19 20/25 24/17 27/18 33/21 33/25 34/3 34/4 41/20 41/22 42/10 42/21 43/16	44/22 54/23 62/24 68/2 73/1 73/5 73/12 78/25 79/7 80/19 92/12 92/15 99/13 104/24 107/18 110/13 116/4 116/16 117/6 117/8 117/25 120/12 121/18 122/10 124/18 124/19 129/18 131/18 131/22 134/21 135/6 135/20 140/10 142/6 142/22 143/23 144/5 145/13 146/9 146/16 148/9 149/5 149/10 150/13 157/20 157/23 160/6 161/11 165/9 165/25 174/25 176/14 177/5 179/1 179/14 179/17 180/4 180/5 180/13 183/9 186/17 187/22 191/13 196/7 198/1 198/19 area [14] 12/12 12/13 33/16 70/17 77/10 78/7 107/14 108/21 111/21 122/24 123/5 130/3 168/25 181/7 areas [18] 12/14 12/16 18/17 37/10 50/10 74/15 74/16 77/22 87/18 87/19 90/12 110/13 111/7 153/2 173/6 177/5 183/14 183/16 arena [2] 57/5 168/11 arguably [2] 8/9 139/6 argue [2] 30/2 95/4 argues [2] 181/20 182/7 argument [1] 107/10 arise [3] 39/24 49/1 146/8 arisen [1] 153/22 arising [5] 9/22 26/17 28/12 156/2 179/25 Armed [1] 105/13 armour [1] 106/1 arose [2] 154/3 177/14 around [21] 14/10 14/18 15/15 42/9 46/8 51/1 51/20 52/4 57/17 72/17 79/8 145/23 150/12 152/10 152/12 152/15 160/3 161/16 176/2 178/2 183/23 arrangements [9] 21/11 83/3 83/17 178/2 183/21 191/8 196/5 196/18 197/4 arrival [2] 17/2 49/19 arrive [2] 36/25 39/23 arrived [2] 5/9 46/2	arrogance [1] 99/24 arrows [1] 15/11 article [5] 36/11 36/18 38/12 38/14 124/15 articles [2] 148/8 149/25 artificial [1] 6/6 as [284] As I said [1] 197/12 ascertain [1] 151/21 Asia [1] 41/25 Asian [3] 192/5 192/7 192/11 ask [3] 65/5 94/9 103/17 asked [9] 64/22 76/22 83/23 147/9 179/9 193/2 195/9 197/3 197/16 asks [3] 106/20 109/4 173/22 aspect [5] 143/2 145/24 166/25 175/16 183/12 aspects [5] 6/10 6/23 7/2 170/6 175/1 aspiration [1] 140/15 aspirational [1] 134/24 aspirations [1] 133/6 Assembly [1] 61/10 asserted [1] 99/17 asserting [1] 102/10 assess [2] 19/10 168/21 assessed [5] 9/13 17/20 27/20 34/9 38/4 assessing [2] 171/4 188/9 assessment [4] 19/13 149/3 168/19 192/18 assessments [5] 126/7 126/8 126/23 156/20 169/8 assimilation [1] 93/21 assist [3] 57/21 93/16 160/9 assistance [1] 197/15 assistant [1] 161/23 assistants [1] 164/24 assisted [1] 133/2 assisting [2] 173/19 185/7 associated [3] 21/23 179/11 184/2 association [7] 121/9 153/20 168/7 173/14 173/17 189/20 199/25 Association's [2] 113/14 114/17
----------	---	--	---	--

A	160/1 160/2 161/21 163/19 167/19 167/25 168/14 171/22 173/23 174/17 176/10 177/18 178/6 178/21 178/22 178/22 183/19 184/13 186/3 186/8 187/3 192/1 192/14 192/19 194/13 197/2 197/12 197/24	autonomous [4] 29/10 29/16 161/11 177/11 autonomy [1] 127/3 autumn [3] 109/17 110/8 143/9 availability [1] 195/25 available [23] 13/17 15/8 26/24 38/6 52/4 83/13 88/4 92/15 93/3 93/16 96/11 102/19 106/21 122/13 125/16 127/17 141/9 150/1 159/22 160/2 177/8 187/2 192/25 average [6] 12/16 12/23 26/3 38/16 44/25 52/3 avoid [4] 16/17 166/1 180/19 194/17 avoidable [2] 9/10 111/14 avoidance [1] 147/11 avoided [4] 82/19 171/8 178/10 184/2 await [1] 96/17 awaited [1] 166/3 awaiting [1] 120/7 aware [9] 44/11 58/8 105/1 106/25 148/12 148/13 177/21 179/18 180/5 awareness [3] 48/24 132/16 141/21 away [1] 62/1	banned [1] 57/1 banning [2] 51/15 79/24 bar [1] 100/2 Barnett [1] 83/9 barometer [1] 171/3 Baroness [1] 116/9 Baroness Ros Altman [1] 116/9 barrier [1] 32/11 barriers [2] 142/14 142/15 bars [1] 80/1 base [2] 93/6 123/7 based [18] 12/10 17/22 23/21 34/10 38/14 65/21 74/22 85/6 99/19 107/6 111/9 136/15 137/25 138/8 154/24 175/10 177/18 196/12 baseline [2] 89/24 171/3 basic [3] 35/18 38/15 139/22 basis [7] 33/19 63/17 69/9 83/11 88/2 160/3 180/16 battle [2] 98/6 106/1 Bay [2] 10/14 66/21 be [251] bear [6] 8/17 23/19 23/20 101/17 198/16 198/17 bearer [1] 148/16 bearing [1] 111/12 bears [1] 135/5 became [9] 46/7 68/22 69/12 105/1 105/13 136/23 153/6 184/25 189/7 because [31] 2/7 9/16 21/6 21/10 22/5 27/23 30/1 69/19 70/22 83/5 97/1 115/2 116/5 117/3 118/1 118/3 124/4 124/25 129/6 132/14 141/8 144/13 146/8 153/2 158/18 159/16 172/6 185/18 192/3 194/17 197/24 become [8] 33/16 42/25 45/6 47/20 61/18 61/21 104/19 172/6 bed [2] 13/16 80/12 beds [9] 13/9 13/13 13/16 51/25 52/4 53/23 85/11 154/5 157/21 been [129] 1/7 2/21 5/14 6/21 8/9 12/19 15/5 15/21 20/18	21/12 23/5 23/6 24/3 24/5 24/14 29/24 30/4 32/4 32/5 32/6 32/14 33/9 34/9 35/7 37/18 40/6 40/12 45/14 45/20 46/3 49/19 57/1 57/16 58/15 58/23 60/17 62/21 63/5 63/11 66/17 69/20 70/12 72/24 75/25 76/3 76/13 82/18 82/20 82/21 87/19 88/19 89/16 90/4 90/18 92/13 92/20 95/15 96/12 96/14 100/14 101/25 102/2 102/19 103/21 104/13 104/15 106/4 107/2 109/7 109/9 110/11 111/7 112/12 113/3 113/16 114/6 114/19 116/24 119/9 124/8 125/24 126/15 126/17 126/22 126/24 126/24 127/4 127/5 127/9 128/16 129/1 129/13 129/15 130/12 144/13 144/21 145/18 148/17 148/23 148/24 148/25 149/11 150/16 151/1 151/11 155/10 155/25 157/3 163/23 165/12 165/19 166/8 168/8 170/6 171/12 172/1 172/11 174/13 176/16 176/18 176/19 176/20 182/16 183/1 188/1 190/6 191/16 195/18 196/24 before [28] 5/9 10/7 16/13 26/22 30/11 49/4 53/24 56/22 56/23 61/25 68/8 85/10 107/5 110/1 124/6 124/7 124/11 124/12 144/25 145/6 153/21 166/17 177/2 178/7 178/13 180/18 181/24 183/6 began [3] 45/23 91/17 132/16 beggars [1] 102/14 begin [5] 1/20 2/3 2/10 3/1 162/13 beginning [5] 2/9 50/15 143/20 183/19 195/11 begins [1] 185/23 begun [2] 51/21 80/8 behalf [21] 25/9 43/9 79/20 99/3 99/7 115/14 131/15 145/4 145/6 147/7 157/2 161/6 173/13 185/11
	at-risk [4] 9/12 9/20 10/7 94/24 Atherton [23] 10/25 33/12 33/15 34/22 36/24 38/24 39/21 43/8 44/9 45/11 47/9 50/4 53/7 53/9 53/13 53/16 61/12 81/19 82/5 85/15 86/24 89/13 89/21 attached [1] 198/5 attaching [1] 66/8 attempt [1] 167/10 attempting [1] 96/3 attempts [2] 27/12 170/14 attend [3] 70/24 79/20 186/23 attendance [1] 37/14 attended [11] 43/3 43/19 45/10 47/8 49/12 52/12 52/15 55/3 60/14 190/3 190/13 attendee [1] 71/10 attention [8] 27/5 27/12 118/17 118/23 119/3 128/18 130/12 130/22 attitudinal [1] 142/14 audience [1] 16/20 audiences [1] 182/4 auditing [1] 138/5 August [7] 15/9 74/17 75/20 77/3 77/8 126/5 188/12 austerity [3] 134/6 165/20 179/20 author [1] 91/19 authorise [1] 116/14 authorities [28] 18/9 71/22 71/25 81/16 127/24 154/8 157/1 174/1 177/16 177/20 178/18 178/19 179/17 179/20 179/24 180/5 180/7 181/1 181/16 181/22 182/1 182/21 183/20 183/22 184/6 184/11 185/2 189/22 authorities' [1] 184/1 authority [6] 77/11 98/9 177/4 179/12 183/10 184/20	back [15] 2/19 39/8 42/1 46/2 80/24 117/13 121/21 132/12 140/19 149/18 155/1 155/4 156/24 164/1 183/6 backdrop [2] 16/15 18/5 backgrounds [1] 132/21 bad [3] 96/14 100/16 134/2 badly [1] 172/6 balance [4] 75/10 95/11 126/10 126/25 balancing [4] 74/22 79/11 119/9 171/19 ballpark [1] 60/1 Bambra [3] 18/3 19/2 27/24 BAME [3] 91/8 170/18 170/21 ban [7] 57/9 57/10 105/19 125/21 126/5 126/12 126/15 Bangor [1] 77/25	B back [15] 2/19 39/8 42/1 46/2 80/24 117/13 121/21 132/12 140/19 149/18 155/1 155/4 156/24 164/1 183/6 backdrop [2] 16/15 18/5 backgrounds [1] 132/21 bad [3] 96/14 100/16 134/2 badly [1] 172/6 balance [4] 75/10 95/11 126/10 126/25 balancing [4] 74/22 79/11 119/9 171/19 ballpark [1] 60/1 Bambra [3] 18/3 19/2 27/24 BAME [3] 91/8 170/18 170/21 ban [7] 57/9 57/10 105/19 125/21 126/5 126/12 126/15 Bangor [1] 77/25	back [15] 2/19 39/8 42/1 46/2 80/24 117/13 121/21 132/12 140/19 149/18 155/1 155/4 156/24 164/1 183/6 backdrop [2] 16/15 18/5 backgrounds [1] 132/21 bad [3] 96/14 100/16 134/2 badly [1] 172/6 balance [4] 75/10 95/11 126/10 126/25 balancing [4] 74/22 79/11 119/9 171/19 ballpark [1] 60/1 Bambra [3] 18/3 19/2 27/24 BAME [3] 91/8 170/18 170/21 ban [7] 57/9 57/10 105/19 125/21 126/5 126/12 126/15 Bangor [1] 77/25

B	best [18] 4/19 16/17 29/22 30/10 70/21 75/3 94/4 112/9 135/19 140/10 154/12 160/7 166/24 179/22 181/11 187/22 188/17 195/2	body [4] 10/23 31/25 48/5 69/13	brings [2] 114/1 115/5	168/20 169/24 171/10 172/23 173/8 174/25 177/22 179/18 180/22 185/17 185/18 185/22 186/1 186/16 187/20 189/13 190/22 195/24 197/22 198/5
behalf... [7] 199/8 199/11 199/14 199/17 199/20 199/24 200/1	better [19] 70/19 81/9 88/15 114/4 115/8 133/16 136/6 140/5 166/10 173/24 176/20 177/15 181/2 181/9 181/21 182/22 183/11 183/22 185/6	bollocks [1] 166/19	British [2] 124/14 189/19	Bécares [6] 20/4 20/7 22/19 22/21 22/24 164/20
behavioural [4] 11/19 53/18 54/3 54/11	between [51] 3/19 6/20 7/2 18/17 34/24 38/1 38/2 56/18 61/22 62/25 66/23 69/4 69/14 70/8 71/13 72/25 73/6 73/20 74/8 75/11 83/3 95/11 103/17 110/14 111/8 111/22 112/2 126/10 129/2 134/11 136/9 140/12 145/20 153/1 154/6 154/14 164/13 170/24 171/15 171/24 172/4 172/8 176/10 176/15 183/16 184/23 187/19 188/11 189/6 189/11 194/15	bolstering [1] 106/8	broad [4] 7/15 50/13 59/9 190/13	B
behind [5] 55/8 100/18 125/12 150/15 150/22	Bevan [1] 77/11	border [5] 72/17 94/2 183/14 183/17 183/19 boundaries [1] 183/15	broader [8] 24/12 118/2 118/25 122/17 125/4 128/1 138/15 192/14	C
being [61] 18/20 18/23 19/1 19/23 23/17 24/13 33/4 37/6 53/2 55/21 62/13 63/20 64/22 64/24 66/3 67/13 68/25 73/1 87/24 88/9 93/25 94/6 98/20 108/6 109/7 109/24 116/6 116/16 116/17 127/12 127/13 127/14 128/8 129/6 129/11 130/7 131/2 134/21 134/25 134/25 135/3 135/19 138/6 139/15 141/14 141/16 143/23 152/20 154/2 163/11 165/5 168/5 169/7 171/18 174/1 174/8 179/8 183/3 183/4 191/5 193/15	beyond [3] 94/6 140/15 155/19	borough [2] 77/9 107/21	broadly [1] 117/17	Cabinet [26] 5/3 39/11 39/13 40/4 47/4 47/6 50/20 52/22 63/3 81/7 82/10 82/13 84/22 84/24 85/3 85/15 85/21 86/6 86/14 87/7 87/10 88/22 90/1 106/11 106/16 137/19
belated [1] 101/15	biggest [1] 119/20	both [27] 4/3 5/11 5/25 6/11 12/17 17/4 25/8 27/22 28/3 44/12 45/3 45/13 79/14 94/7 128/14 131/24 133/7 143/9 146/8 150/10 151/19 152/17 154/4 159/16 174/18 181/15 183/15	brought [1] 86/23	Cabinet's [2] 83/21 195/6
belief [2] 58/22 102/14	Bill [2] 61/8 95/3	bottom [2] 44/7 184/21	Brown [2] 148/10 150/5	Caerphilly [3] 53/6 77/9 77/19
believe [3] 45/4 45/7 185/2	billion [1] 84/9	bound [2] 28/20 131/9	bubble [3] 84/17 84/20 157/25	cafes [2] 74/11 80/1
believed [1] 76/5	Bishop [1] 48/17	bounds [1] 54/1	bubbles [1] 153/22	Cairney [1] 134/19
Bell [1] 161/23	bitterly [1] 100/8	boxes [1] 148/20	budgets [1] 179/20	calculated [2] 8/11 32/13
Bell's [1] 163/9	black [5] 12/15 12/17 192/5 192/7 192/11	Boxing [1] 90/2	build [1] 181/2	call [7] 81/23 86/24 88/12 116/6 116/25 135/5 179/13
below [5] 79/16 80/17 80/24 81/22 82/3	black [5] 12/15 12/17 192/5 192/7 192/11	Boxing Day [1] 90/2	building [2] 163/16 180/15	called [8] 19/23 19/25 56/21 59/8 129/4 139/12 159/19 167/12
below 1 [1] 79/16	Blaenau [2] 18/13 77/24	boys [1] 153/19	built [1] 159/14	calling [2] 89/7 126/17
benchmark [1] 188/22	Blaenau Gwent [1] 18/13	breach [1] 168/18	bulk [1] 26/12	calls [5] 65/11 65/12 100/9 137/20 155/25
beneficial [1] 156/8	blame [4] 100/19 110/3 164/1 198/4	breaches [2] 94/16 95/13	bullet [1] 72/22	came [8] 33/15 62/9 70/23 93/7 97/24 101/11 108/9 192/2
benefit [3] 4/4 134/23 151/6	blamed [1] 134/10	breadth [1] 167/11	burden [1] 163/6	campaign [16] 40/19 40/23 60/24 115/14 115/16 116/14 116/20 120/14 121/8 126/17 129/4 129/8 168/8 173/5 187/16 199/11
benefits [1] 57/8	blaming [1] 112/11	break [9] 30/12 30/14 30/19 78/25 79/2 98/22 145/1 160/24 161/2	business [6] 7/8 101/17 102/2 102/17 182/5 182/13	can [48] 1/24 3/5 12/9 13/3 13/18 14/1 14/4 14/20 22/7 30/25 33/20 41/10 41/12 41/18 42/15 44/6 44/7 53/20 54/2 59/21 59/25 72/21 72/22 73/8 79/24 98/16 113/1 113/22 115/1 116/2 126/18 133/6 133/18 138/17 139/14 139/23 144/19 144/25 159/13 164/1 165/17 167/23 168/1 173/19 176/6 181/11 182/9
Bennee [5] 47/22 79/20 141/12 141/17 143/10	blanket [5] 125/21 126/5 126/12 127/14 158/13	breaker [11] 79/7 79/23 81/3 81/8 82/3 82/5 82/7 82/9 82/11 82/22 82/24	businesses [4] 64/2 143/3 144/6 190/15	
bereaved [15] 9/25 99/3 99/8 99/13 100/9 100/25 101/3 101/8 102/15 107/18 110/17 110/24 171/1 187/15 199/8	blind [2] 105/17 105/17	breakers [2] 78/19 110/16	but [125] 1/12 1/19 1/22 2/5 4/2 4/24 5/16 6/22 7/1 7/17 7/24 12/25 13/17 16/13 17/5 19/23 30/10 30/13 32/25 34/4 37/12 40/13 41/6 46/22 56/15 56/23 57/9 58/4 58/18 63/5 63/8 68/18 69/8 75/15 82/3 85/4 89/22 89/23 90/20 96/7 96/9 96/14 97/5 98/15 100/5 101/17 102/24 107/7 110/4 117/25 118/3 118/18 118/20 119/6 119/8 119/10 121/13 122/25 123/2 123/14 124/5 125/12 125/17 126/7 127/24 128/24 129/22 130/4 130/4 130/23 131/9 131/11 131/12 132/9 133/17 134/14 134/20 135/14 137/5 137/21 138/14 140/14 141/4 143/1 143/3 143/17 143/22 145/22 147/13 148/23 149/21 154/2 154/13 156/25 157/11 159/9 159/18 160/2 161/11 162/8 162/18 165/23 166/3 166/7 167/23	
bereavement [1] 8/23	blindly [1] 105/16	brief [1] 44/23	bulletin [1] 117/17	
bespoke [2] 85/5 93/8	block [1] 35/22	briefed [1] 190/4	broke [1] 89/18	
	blue [1] 12/12	briefing [8] 31/12 31/17 40/18 49/15 53/17 54/11 60/12 68/20	brought [1] 86/23	
	board [2] 33/7 77/12	briefings [1] 182/9	Brown [2] 148/10 150/5	
	boards [2] 86/1 181/1	briefly [3] 20/1 170/23 193/23	building [2] 163/16 180/15	
	bodies [9] 18/24 18/24 19/9 31/8 93/11 173/3 177/5 189/6 190/1	Brightling [1] 24/22	built [1] 159/14	
		bring [7] 79/15 80/17 80/24 87/21 90/21 142/19 195/10	bulk [1] 26/12	
		bringing [2] 152/9 195/16	bullet [1] 72/22	

C				
<p>can... [1] 197/13 can't [2] 30/16 116/7 cancel [1] 105/19 cancellation [1] 56/1 cancelling [1] 56/15 cancer [1] 120/8 cannot [6] 42/19 141/1 141/10 148/16 187/6 188/2 canvassed [1] 19/25 capability [2] 43/4 104/2 capacity [14] 37/23 52/5 52/7 58/21 59/3 60/4 62/2 77/13 93/18 103/6 140/23 141/1 175/21 180/22 capita [1] 26/6 capture [1] 175/6 Cardiff [12] 1/10 1/11 4/12 10/14 25/16 56/16 56/17 56/20 56/24 57/6 66/21 77/24 Cardiff Bay [2] 10/14 66/21 Cardiff University [1] 25/16 care [123] 7/6 7/17 21/3 21/8 28/9 32/11 35/11 57/20 57/24 58/3 58/4 58/6 58/10 58/12 58/15 59/1 59/8 59/13 60/4 64/22 77/14 80/12 87/17 98/5 101/6 106/8 107/17 107/21 107/24 108/4 108/7 108/11 115/14 115/16 116/16 116/20 116/23 117/1 117/2 117/14 117/22 117/22 117/23 117/25 118/1 118/3 118/10 118/12 118/12 118/13 118/13 118/19 118/22 118/24 119/14 119/15 119/19 119/22 119/22 119/24 120/1 120/6 120/10 120/19 120/21 121/2 121/4 121/8 121/8 122/20 122/22 123/6 123/15 123/18 124/1 125/10 125/13 125/20 127/17 127/23 127/25 128/2 128/4 128/8 128/13 128/15 128/21 129/21 129/22 129/24 130/1 130/7 130/13 136/1 141/8 141/9 141/11 141/24 143/7 145/9 152/16 154/10 154/23 155/8</p>	<p>156/16 157/8 157/11 157/17 163/4 163/10 163/14 163/18 163/20 163/21 163/22 164/25 165/25 168/22 178/2 180/10 187/16 192/18 199/12 care home [8] 59/1 116/16 118/10 118/12 118/13 119/22 121/2 163/14 care homes [23] 21/3 21/8 58/12 58/15 101/6 107/17 107/21 107/24 108/4 108/11 117/22 119/22 119/24 123/15 124/1 125/10 125/13 136/1 141/8 141/11 152/16 178/2 180/10 Care Inspectorate [1] 141/9 care sector [8] 7/6 58/4 58/6 118/19 128/8 129/21 130/7 157/11 cared [1] 165/7 careful [3] 159/25 187/1 194/3 carefully [1] 150/20 caregiver [2] 116/14 126/16 carers [7] 120/9 120/15 120/19 128/25 130/4 143/5 170/19 Carers UK [1] 130/4 caring [3] 36/15 162/25 164/9 carried [3] 113/16 114/19 126/24 case [43] 21/6 21/12 27/19 33/1 34/10 38/4 38/10 38/22 39/1 39/6 42/2 42/7 42/10 44/25 47/10 47/11 47/17 47/19 48/15 49/17 50/4 51/22 51/24 53/5 53/15 53/23 53/25 55/1 57/16 61/2 79/12 86/7 87/16 95/7 105/8 105/16 124/9 129/3 130/19 134/17 138/11 142/25 152/10 cases [55] 14/5 14/6 14/15 14/18 14/19 31/12 32/2 32/14 32/22 33/2 33/4 34/14 36/10 37/7 37/21 38/15 41/14 41/20 42/13 42/21 45/12 45/14 45/23 46/11 46/14 46/16 48/18 52/24 53/10 55/5 55/6 55/10 55/21 57/22</p>	<p>61/14 63/10 63/12 77/5 77/9 78/23 78/25 80/14 81/14 81/16 85/17 86/4 86/5 88/20 89/14 89/17 89/19 89/23 109/25 126/23 198/4 catastrophic [1] 58/8 catch [1] 135/24 catching [1] 192/8 catered [2] 1/18 1/19 catering [1] 163/12 caught [2] 41/25 108/25 cause [5] 116/11 116/23 127/2 127/2 142/10 caused [15] 4/24 7/11 10/8 10/16 12/11 113/19 114/23 117/14 119/10 119/11 120/5 153/3 154/14 165/24 196/4 causes [4] 12/2 119/22 119/25 120/3 causing [1] 129/7 caution [2] 96/24 107/9 cautious [2] 66/12 171/16 caveat [2] 113/8 114/11 CBI [1] 190/14 cease [1] 172/7 ceased [1] 111/25 Cell [1] 11/9 cells [1] 153/14 central [7] 30/1 99/24 118/17 129/11 172/19 175/19 196/13 centrally [1] 175/15 centre [4] 1/10 1/15 40/15 138/6 centres [3] 73/21 78/10 179/13 centric [2] 103/1 138/23 century [1] 188/2 century's [1] 132/15 certain [6] 27/12 36/6 41/2 45/17 138/3 184/1 certainly [1] 96/14 certainty [1] 107/7 certificate [3] 8/12 12/2 99/10 chair [3] 1/5 70/5 199/3 chaired [10] 35/25 49/10 50/20 52/15 70/2 70/4 91/10 91/15 141/12 167/6 chairs [1] 86/1 challenge [5] 4/18</p>	<p>103/21 156/25 182/23 189/14 challenged [2] 111/2 128/3 challenges [5] 98/18 139/10 144/4 168/1 169/16 challenging [2] 66/6 190/22 Chamber [1] 91/6 champion [1] 145/12 chance [6] 35/12 35/13 35/15 112/9 137/25 140/6 Chancellor [4] 70/3 83/23 171/23 195/10 change [14] 30/25 38/7 55/11 59/15 68/9 75/6 75/8 87/1 90/4 108/9 113/24 115/3 142/5 166/22 changed [4] 59/12 62/24 158/10 174/8 changes [8] 23/12 65/22 114/2 115/6 126/4 126/15 156/6 178/22 changing [3] 54/4 75/12 108/13 chaos [2] 64/21 106/19 chaotic [1] 104/17 characteristics [7] 19/20 28/1 29/14 37/24 54/20 97/2 167/1 charge [1] 106/10 chart [8] 12/3 12/9 12/21 13/3 14/1 14/20 15/12 98/19 charts [3] 11/25 13/4 13/18 chat [1] 102/6 check [2] 120/15 120/16 chief [23] 10/25 11/1 11/4 15/24 17/10 32/16 32/17 34/21 36/8 105/6 106/24 110/9 122/2 122/5 124/16 132/17 134/22 136/10 147/19 174/21 190/19 190/19 190/20 Chief Statistician [1] 15/24 Chief Whip [1] 136/10 Chiefs' [1] 184/22 child [3] 24/3 146/24 191/17 childcare [1] 23/20 childhood [1] 23/25 children [29] 7/6 24/9 24/11 28/9 62/23 63/7</p>	<p>145/11 146/11 147/7 147/25 148/4 151/1 151/5 152/8 155/1 155/6 155/24 156/17 157/2 158/1 158/17 158/22 158/23 158/25 159/4 159/6 159/11 160/1 191/20 children's [42] 10/4 24/13 130/17 145/4 145/7 145/8 145/15 145/15 146/2 147/16 147/22 148/3 148/6 149/2 149/4 149/15 150/3 150/21 150/23 151/10 151/13 152/10 152/16 152/22 153/9 153/15 154/2 154/4 154/23 155/7 155/12 155/17 157/6 157/16 157/20 158/14 158/19 160/11 167/9 168/5 190/17 199/17 China [17] 29/4 31/13 31/15 31/22 32/2 33/13 36/14 37/12 37/21 38/9 39/2 41/5 41/14 42/13 42/19 45/13 47/10 China-focused [1] 41/5 Chinese [3] 31/23 38/12 39/8 choice [2] 58/2 171/24 choose [1] 77/2 chose [2] 69/18 156/14 chosen [2] 144/21 177/7 Chris [2] 24/21 122/4 Christmas [7] 84/23 85/10 86/13 87/1 87/4 87/5 87/5 Christmas Day [1] 87/4 chroeso [1] 99/6 chronology [9] 4/7 26/22 28/14 48/14 59/16 63/9 68/11 72/1 84/13 churn [1] 137/13 circuit [13] 78/19 79/7 79/23 81/3 81/8 82/3 82/5 82/7 82/9 82/11 82/22 82/24 110/16 Circuit Breakers [1] 78/19 circuit-breaker [3] 79/7 82/3 82/9 circuit-breakers [1] 110/16 circulating [3] 61/13</p>

<p>C</p> <p>circulating... [2] 73/14 86/20</p> <p>circumstance [1] 175/4</p> <p>circumstances [6] 8/16 17/14 87/20 93/7 109/1 141/5</p> <p>cite [2] 113/25 115/4</p> <p>cited [1] 124/15</p> <p>citizen [1] 140/12</p> <p>citizens [1] 7/23</p> <p>city [2] 1/14 31/13</p> <p>civil [14] 5/12 5/14 5/23 11/3 19/4 26/13 63/18 67/9 98/4 133/2 133/15 136/7 136/19 187/11</p> <p>claim [2] 88/8 101/18</p> <p>claimed [1] 88/8</p> <p>claims [3] 99/18 101/13 195/13</p> <p>Clare [2] 18/3 23/8</p> <p>clarification [2] 102/13 129/9</p> <p>clarified [1] 152/23</p> <p>clarity [8] 68/12 95/8 128/19 129/14 147/17 160/3 160/7 160/9</p> <p>class [1] 133/3</p> <p>classified [1] 32/9</p> <p>cleaners [1] 164/24</p> <p>clear [29] 18/8 32/20 32/24 33/1 33/2 39/19 47/12 58/23 67/13 68/15 73/10 78/8 102/6 104/18 106/23 107/8 110/5 111/6 111/16 125/24 151/10 156/15 157/18 159/16 159/25 169/9 180/4 181/18 194/2</p> <p>clearer [1] 160/9</p> <p>clearly [3] 102/1 150/21 180/13</p> <p>clients [1] 131/6</p> <p>clinical [2] 37/7 59/2</p> <p>clinicians [1] 192/6</p> <p>close [8] 21/10 27/5 38/19 62/3 62/18 62/20 63/13 104/7</p> <p>closed [2] 61/10 63/5</p> <p>closely [3] 37/2 147/5 176/8</p> <p>closing [4] 46/13 62/13 63/2 131/2</p> <p>closure [4] 64/1 64/9 79/25 85/8</p> <p>closures [4] 43/22 45/17 62/6 184/9</p> <p>clumsy [1] 105/11</p> <p>cluster [3] 31/12 36/14 45/22</p>	<p>CMO [14] 35/11 39/15 41/1 41/2 45/11 47/9 52/16 52/20 60/15 71/14 76/1 82/1 87/9 89/10</p> <p>CMOs [2] 55/22 82/6</p> <p>CNCRC [2] 146/24 148/6</p> <p>co [17] 40/10 66/22 91/6 97/21 103/7 105/4 106/5 140/13 140/15 140/15 141/1 141/1 141/12 144/15 176/3 176/15 189/21</p> <p>co-chaired [1] 141/12</p> <p>co-design [3] 140/15 141/1 176/15</p> <p>co-designed [1] 176/3</p> <p>co-morbidities [1] 144/15</p> <p>co-operation [1] 189/21</p> <p>co-ordinate [1] 91/6</p> <p>co-ordination [5] 40/10 66/22 97/21 103/7 105/4</p> <p>co-produced [1] 106/5</p> <p>co-production [3] 140/13 140/15 141/1</p> <p>coal [1] 132/15</p> <p>coalition [1] 116/19</p> <p>COBR [31] 29/13 33/19 35/25 36/5 38/21 45/9 47/8 49/10 52/14 53/12 55/3 55/10 56/1 56/2 56/8 60/12 60/14 60/20 61/3 62/21 63/12 63/15 68/17 69/2 81/25 89/7 89/9 89/10 89/15 90/18 111/25</p> <p>cohorts [1] 153/19</p> <p>coincide [1] 195/11</p> <p>coinciding [1] 78/22</p> <p>cold [1] 109/2</p> <p>collaborated [1] 168/19</p> <p>collaboration [2] 112/18 171/14</p> <p>collaborative [1] 138/12</p> <p>collaboratively [1] 141/19</p> <p>collapse [2] 141/24 166/1</p> <p>colleagues [5] 32/12 48/19 178/19 186/1 192/7</p> <p>collected [1] 181/13</p> <p>collection [3] 93/21 94/2 133/25</p>	<p>collective [1] 61/5</p> <p>college [5] 32/13 34/13 42/6 46/12 80/2</p> <p>College's [1] 35/17</p> <p>colleges [2] 80/7 86/17</p> <p>coloured [1] 15/11</p> <p>colours [1] 12/17</p> <p>combat [4] 7/13 10/9 93/1 94/1</p> <p>combination [1] 94/5</p> <p>combined [1] 12/14</p> <p>come [12] 2/19 11/5 59/4 64/6 68/11 101/9 117/13 118/20 121/21 128/16 155/3 168/1</p> <p>comeback [1] 139/13</p> <p>comes [2] 39/2 131/8</p> <p>comfort [1] 197/23</p> <p>coming [2] 43/1 45/6</p> <p>coming weeks [1] 43/1</p> <p>commencement [1] 37/17</p> <p>commencing [1] 13/8</p> <p>commend [1] 194/23</p> <p>commended [1] 154/11</p> <p>comment [2] 147/9 159/20</p> <p>commented [3] 22/2 190/6 197/24</p> <p>comments [2] 122/21 184/14</p> <p>commercial [1] 98/7</p> <p>commissioned [3] 78/5 85/6 136/21</p> <p>commissioner [43] 10/4 10/5 120/13 121/7 122/23 128/13 128/18 145/4 145/7 145/8 145/15 145/16 145/24 146/3 146/5 146/22 147/11 147/14 147/18 147/20 149/15 150/17 150/19 151/14 151/20 152/6 152/9 153/16 154/20 155/17 155/23 156/1 157/14 158/19 159/12 159/19 159/25 160/16 160/16 168/5 190/17 193/19 199/18</p> <p>Commissioner for [6] 10/5 145/7 145/16 146/3 146/5 158/19</p> <p>Commissioner to [1] 155/17</p> <p>Commissioner's [13] 130/18 145/21 146/20 146/25 147/8 150/9 151/23 156/3 156/22 157/3 159/5 159/7</p>	<p>159/9</p> <p>Commissioners [4] 167/9 167/10 184/24 190/17</p> <p>commissioning [1] 103/9</p> <p>commitment [5] 100/24 130/23 133/21 134/14 193/7</p> <p>committed [6] 138/1 140/7 142/3 186/17 186/18 193/6</p> <p>committee [3] 35/7 37/13 100/13</p> <p>common [6] 95/20 155/15 155/16 166/21 168/3 169/16</p> <p>commonplace [1] 189/21</p> <p>communicate [2] 120/17 150/22</p> <p>communicated [1] 93/12</p> <p>communicating [2] 28/25 31/7</p> <p>communication [14] 66/22 71/13 91/23 91/25 101/16 102/18 111/6 136/14 182/3 183/1 184/11 192/23 193/24 194/7</p> <p>communications [10] 68/16 92/13 92/19 94/10 94/14 101/12 102/4 102/17 152/24 181/6</p> <p>communities [5] 176/21 182/4 182/9 186/1 192/5</p> <p>community [12] 22/21 53/5 53/10 55/21 58/1 61/13 89/22 100/10 105/22 163/20 182/5 190/14</p> <p>companies [1] 98/7</p> <p>comparatively [2] 119/6 168/2</p> <p>compared [5] 20/9 21/9 50/10 132/5 155/8</p> <p>comparing [1] 188/3</p> <p>comparison [2] 25/25 100/4</p> <p>comparisons [1] 100/2</p> <p>competence [1] 70/17</p> <p>competing [1] 74/23</p> <p>complaint [1] 139/11</p> <p>complementary [1] 184/18</p> <p>complete [2] 6/8 64/21</p> <p>completed [6]</p>	<p>113/15 114/18 149/17 149/24 149/25 150/1</p> <p>completely [4] 55/12 76/9 103/10 158/4</p> <p>completing [1] 151/11</p> <p>complex [1] 94/12</p> <p>complexities [1] 180/20</p> <p>compliance [3] 92/21 152/21 184/15</p> <p>compliant [4] 145/17 150/7 151/12 182/23</p> <p>complications [2] 21/4 21/18</p> <p>complied [3] 92/20 130/17 148/25</p> <p>comply [2] 133/21 164/15</p> <p>component [1] 177/24</p> <p>composition [1] 93/10</p> <p>comprehended [1] 144/5</p> <p>comprehension [1] 144/11</p> <p>comprehensive [1] 66/15</p> <p>comprehensively [2] 19/10 44/23</p> <p>comprised [1] 11/9</p> <p>comprising [1] 167/6</p> <p>compromised [2] 134/5 138/14</p> <p>concentrated [1] 20/9</p> <p>concept [2] 153/22 188/19</p> <p>concepts [1] 177/23</p> <p>concern [16] 2/1 10/17 24/2 35/9 36/12 39/5 59/18 60/7 89/4 103/24 113/12 114/16 121/4 122/7 193/13 194/19</p> <p>concerned [12] 19/3 26/3 48/21 68/23 73/6 103/20 113/10 114/13 131/24 146/4 160/17 188/18</p> <p>concerning [5] 16/12 31/12 121/18 133/24 179/14</p> <p>concerns [18] 68/19 77/2 86/2 89/4 103/5 109/18 112/5 121/6 121/10 122/9 125/18 128/15 129/10 130/3 152/8 169/19 182/15 197/19</p> <p>concerted [1] 41/8</p> <p>concerts [2] 57/5 105/21</p>
--	--	---	---	---

C	consequences [23] 9/1 9/10 9/22 21/19 25/1 40/2 58/8 63/2 75/12 97/9 101/3 105/23 107/15 108/22 120/23 121/5 161/19 165/2 165/21 175/12 183/23 184/10 192/9	consult [2] 125/5 156/22 consultant [1] 64/18 consultation [13] 4/20 66/18 67/3 123/2 140/21 147/2 166/13 167/25 168/3 173/6 173/7 190/11 192/23	contradictory [1] 128/21 contrary [2] 101/19 104/16 contrast [3] 44/4 158/23 166/20 contrasts [2] 78/11 136/18 contributed [5] 58/17 59/5 123/13 170/13 190/8 control [21] 6/12 21/19 35/22 36/22 39/2 40/2 40/8 43/11 49/22 54/11 58/17 67/5 72/4 77/4 80/18 81/12 97/10 110/10 123/13 154/17 182/17 controlling [1] 35/23 controls [2] 110/11 179/25 convened [2] 37/19 47/4 convenient [1] 58/5 convention [4] 133/22 133/24 146/23 191/17 convergence [1] 157/8 conversation [1] 189/13 conversations [1] 177/21 conveyed [1] 162/16 Coordination [1] 40/15 cope [1] 179/23 copies [1] 92/17 core [42] 1/21 2/25 3/17 4/14 4/18 7/12 7/16 9/16 10/11 16/19 26/23 49/14 53/8 58/7 59/9 61/11 84/15 91/1 91/24 95/15 110/19 117/6 117/16 117/18 118/3 118/21 118/23 119/1 119/2 121/19 121/24 123/4 125/4 127/11 131/12 135/13 137/21 138/3 173/18 190/3 198/11 198/20 core participants [3] 2/25 135/13 198/20 corners [1] 161/15 coronavirus [30] 31/24 32/3 32/9 32/19 33/13 36/12 37/3 37/11 39/10 42/3 49/16 50/12 51/17 52/21 57/14 61/8 65/19 67/8 72/3 73/14 77/4 83/20 84/11 94/20 95/1 95/2 105/3 139/18 152/15 180/11	Conservative [1] 76/6 consider [18] 19/5 27/18 27/22 63/4 71/7 71/19 82/4 82/17 83/2 97/13 106/14 138/17 150/20 158/13 159/13 160/8 177/21 183/7 considerable [5] 27/4 78/9 139/13 143/3 174/4 considerably [3] 12/22 52/7 140/9 consideration [13] 28/3 40/11 50/18 65/9 94/24 96/9 119/8 157/5 178/17 192/2 194/4 196/25 197/5 considerations [5] 50/18 54/17 74/23 148/1 151/17 considered [29] 5/7 17/1 17/3 24/10 24/14 53/25 62/9 63/3 71/9 79/18 79/22 93/22 94/3 130/14 142/6 146/17 147/16 147/23 148/23 151/1 151/11 151/20 160/18 162/6 172/12 188/16 188/24 189/16 197/21 considering [2] 152/22 155/5 considers [6] 99/21 100/16 113/6 114/9 141/20 174/12 consisted [1] 91/2 consistency [3] 67/20 129/15 154/19 consistent [3] 111/6 157/24 169/4 consistently [3] 140/18 150/20 174/17 constant [1] 192/2 constitute [1] 144/18 constituted [2] 35/8 48/4 constitutional [1] 189/2 constraints [2] 138/25 154/12 construct [1] 139/9 constructive [2] 156/25 190/22	Coronavirus Act [1] 139/18 Coronavirus Bill [1] 61/8 correct [2] 112/4 142/14 corresponding [1] 110/23 cosiness [1] 138/14 cosmetic [1] 75/1 cost [1] 195/15 cough [1] 55/25 could [57] 3/8 11/23 12/19 35/15 53/19 54/3 55/13 58/22 60/6 60/9 64/19 65/6 67/4 69/25 70/21 74/2 78/22 79/5 80/10 82/18 86/2 95/24 96/14 106/3 107/2 107/6 107/9 111/13 120/21 132/10 133/7 137/18 138/25 152/23 153/23 154/12 159/24 160/21 166/18 172/5 173/24 174/2 174/13 176/12 176/16 176/18 177/3 177/5 178/1 178/6 178/14 179/11 182/21 183/2 184/2 195/21 196/4 council [12] 10/3 77/9 90/21 167/5 173/1 177/13 184/22 190/2 190/7 190/18 190/22 193/20 councils [1] 176/3 Counsel [7] 2/22 2/22 3/14 123/11 186/24 198/11 199/5 count [1] 13/4 counterfactual [1] 96/21 countermeasures [2] 4/25 43/14 counterpart [1] 133/17 counterproductive [1] 94/13 Countless [1] 99/11 countries [3] 25/25 41/7 41/21 country [7] 5/6 26/3 80/6 84/20 144/2 145/14 193/1 coupled [1] 6/9 courage [1] 116/10 course [30] 2/24 7/15 7/24 9/1 16/10 17/24 26/15 29/25 39/18 44/21 48/13 71/15 75/10 76/9 91/15 93/7 146/11 164/5 172/23 174/21 175/2 177/10
----------	---	--	---	--	---

C	89/23 90/17 91/1 91/8 99/3 99/8 99/10 101/5 109/6 116/12 123/17 123/19 125/14 139/12 142/19 166/10 170/12 190/3 192/11 199/8 Covid-19-related [2] 60/18 80/11 Covid-O [4] 69/3 69/7 70/4 71/15 Covid-related [1] 13/23 Covid-S [2] 69/4 69/6 CPS [2] 184/22 190/7 creaking [1] 166/1 create [3] 85/4 102/23 134/15 created [4] 90/25 136/15 177/1 178/16 creates [2] 142/4 142/18 creating [2] 131/20 194/18 creation [1] 178/8 creative [1] 170/11 credit [1] 156/24 crew [1] 46/7 CRIA [8] 149/3 149/5 149/11 149/17 149/19 149/23 151/11 157/3 CRiAs [1] 149/9 Crime [1] 184/24 criminal [1] 94/22 criminalised [1] 95/10 crises [3] 146/6 146/19 152/25 crisis [12] 5/6 18/6 111/20 131/24 131/25 136/20 137/4 138/16 146/8 146/9 146/13 147/24 critical [11] 29/24 96/18 120/10 120/21 121/16 124/21 134/21 141/2 148/2 181/22 193/15 criticism [1] 138/22 cross [6] 17/18 94/2 131/7 183/17 189/21 190/13 cross-border [2] 94/2 183/17 cross-government [1] 17/18 Cross-party [1] 189/21 cross-section [1] 190/13 crossover [1] 153/1 crucial [4] 40/11 99/25 110/20 143/8 crucial weeks [1] 143/8	crucially [2] 148/16 197/15 crude [1] 188/3 cruel [1] 186/9 cruise [1] 46/1 crystal [1] 111/16 crystal clear [1] 111/16 CSA [5] 41/2 55/4 76/1 82/1 87/9 CTI [1] 104/20 cultural [2] 18/22 19/1 culturally [1] 144/3 culture [3] 132/21 166/16 170/24 cultures [1] 138/12 current [11] 34/7 36/19 37/15 44/24 50/22 51/19 58/1 66/11 80/17 85/16 179/16 currently [5] 41/16 42/14 45/4 53/25 80/10 curve [4] 54/5 55/12 60/2 61/24 cusp [1] 60/16 custody [2] 153/7 153/17 customers [2] 172/7 172/7 Cymru [23] 9/25 99/4 99/8 99/20 100/7 100/16 103/20 104/22 106/18 106/20 107/1 107/19 108/17 108/23 109/4 109/8 112/14 113/6 113/9 114/9 114/13 187/16 199/9 Cynon [1] 77/23 Cynon Taf [1] 77/23	20/11 25/21 37/16 47/10 71/6 80/9 90/5 93/14 93/15 93/16 93/21 93/23 94/2 94/5 94/6 105/14 123/6 133/25 138/21 141/2 141/8 141/13 141/15 141/16 141/19 142/17 142/19 159/17 164/7 181/5 181/23 190/5 193/15 date [3] 36/23 44/25 123/22 dated [1] 41/13 David [2] 23/24 135/4 David's [1] 2/4 Davies [5] 115/19 115/20 115/24 115/25 116/24 Davies' [1] 116/18 day [36] 2/5 2/5 12/5 14/2 33/6 34/6 37/23 38/21 39/5 50/11 50/22 52/2 52/18 52/22 56/22 59/24 60/18 62/5 62/19 63/12 63/12 64/16 65/24 79/5 81/25 85/18 85/25 86/8 87/2 87/4 89/19 90/2 90/3 153/14 178/9 196/7 days [21] 26/8 31/6 31/15 38/2 46/14 46/16 55/24 61/22 62/21 66/13 79/6 80/10 80/15 82/25 89/17 89/18 98/14 143/14 155/25 158/2 158/5 deal [6] 11/5 29/17 29/19 90/16 90/25 178/4 dealing [2] 44/15 157/19 dealt [2] 131/10 163/24 death [24] 7/11 7/24 8/7 8/9 8/12 8/17 12/2 12/2 16/2 21/4 26/6 31/23 33/3 51/9 60/18 64/3 96/2 99/10 108/18 116/12 118/13 119/25 127/8 133/7 deaths [42] 8/11 12/1 12/5 12/6 12/8 12/10 12/12 12/13 12/14 12/18 12/19 12/21 13/1 14/7 16/2 32/23 37/12 51/5 54/13 54/15 58/15 60/17 61/14 63/10 64/4 64/4 78/24 79/1 79/2 79/10 85/12 96/22 98/17 99/9 118/10 118/11	119/19 119/21 119/22 120/2 141/11 164/11 debate [3] 58/7 75/13 172/8 debated [7] 37/24 43/19 51/14 52/18 56/1 63/3 75/18 Debbie [2] 91/20 192/24 debilitating [1] 186/14 debt [1] 132/13 debts [1] 9/9 decades [1] 20/18 deceased [4] 113/19 114/23 132/4 144/18 December [17] 14/17 15/15 38/20 84/18 85/14 85/15 85/23 86/8 86/14 86/18 86/19 86/22 87/2 87/6 89/9 89/15 89/25 December 2019 [1] 38/20 decentralised [1] 128/1 decide [6] 53/12 94/22 143/16 187/20 187/21 192/19 decided [9] 62/9 72/6 72/12 75/6 75/8 88/22 90/1 147/20 150/16 decision [114] 1/21 1/23 3/18 5/2 6/4 10/12 10/14 10/19 25/18 25/23 29/21 54/18 56/6 58/7 58/9 61/5 62/3 62/20 63/19 67/7 69/12 70/14 71/18 75/10 82/10 82/12 83/1 83/22 84/2 84/14 86/16 87/20 88/3 88/8 88/18 91/22 91/24 92/8 94/23 96/5 96/7 96/14 96/21 97/18 100/18 100/21 102/20 106/3 107/8 107/16 108/10 109/14 110/19 113/11 114/15 117/16 117/19 118/3 118/18 119/1 119/3 121/24 123/10 124/2 124/9 125/5 125/12 127/12 131/12 147/4 147/12 147/23 148/12 148/14 148/17 148/22 149/13 149/19 149/20 149/22 150/2 150/4 150/5 150/7 150/15 151/2 151/12 151/21 154/17 155/4 156/23 157/1 157/4 157/11 159/18 161/20 162/3 162/7 165/17 167/15
----------	---	---	--	---

D				
<p>decision... [14] 167/20 171/11 174/16 185/16 187/3 188/10 188/23 189/8 190/8 191/18 193/18 194/8 194/12 195/6</p> <p>decision-makers [17] 5/2 10/19 29/21 58/7 88/3 88/8 96/5 96/7 106/3 107/8 117/16 117/19 118/18 119/3 121/24 148/12 187/3</p> <p>decision-making [61] 1/21 3/18 6/4 10/12 10/14 25/18 25/23 61/5 69/12 70/14 71/18 91/22 91/24 92/8 96/14 96/21 97/18 100/18 100/21 102/20 109/14 110/19 113/11 114/15 118/3 119/1 125/5 127/12 131/12 147/4 147/12 147/23 148/22 149/13 149/22 150/4 150/7 150/15 151/2 151/21 154/17 155/4 157/4 157/11 159/18 161/20 162/3 162/7 165/17 167/20 171/11 174/16 185/16 188/10 188/23 189/8 190/8 191/18 193/18 194/8 194/12</p> <p>decisions [100] 4/8 4/15 4/18 5/17 5/25 6/17 7/12 7/16 7/19 10/13 16/12 26/15 26/23 28/15 30/5 57/21 58/5 59/10 62/9 67/1 68/8 70/11 70/15 71/23 73/12 73/16 82/19 83/8 84/3 87/24 90/10 92/10 93/6 95/16 95/20 95/22 96/1 96/6 96/15 101/1 101/23 107/6 108/5 110/4 110/20 110/23 117/6 117/8 118/23 119/9 121/20 123/4 137/18 140/22 141/3 141/5 147/16 148/13 149/18 149/23 150/12 150/18 150/20 150/25 151/3 151/7 151/8 152/2 152/4 156/12 156/15 156/19 159/12 159/20 159/22 159/23 160/4 160/6 160/12 160/18 167/11 171/24 175/4 177/15 178/7 178/13 178/21 183/24 187/4 187/11 188/4</p>	<p>188/5 188/16 188/23 189/9 189/10 190/5 190/12 190/24 195/25</p> <p>decisive [1] 49/6</p> <p>declaration [1] 54/18</p> <p>declared [3] 39/4 53/4 133/21</p> <p>declaring [1] 40/13</p> <p>decline [2] 79/2 127/7</p> <p>declined [2] 83/25 195/17</p> <p>declining [1] 105/19</p> <p>dedicated [2] 137/22 137/24</p> <p>deemed [1] 150/24</p> <p>deep [1] 134/10</p> <p>deeply [2] 82/23 172/14</p> <p>default [2] 112/11 142/9</p> <p>deficiencies [5] 101/4 103/5 162/8 165/16 196/24</p> <p>deficient [1] 105/25</p> <p>defined [1] 139/15</p> <p>deflect [1] 100/19</p> <p>degree [2] 33/1 176/22</p> <p>dehydration [1] 120/16</p> <p>delay [19] 4/21 24/15 33/5 43/20 50/14 52/17 53/13 55/15 59/19 60/8 71/20 82/24 108/13 108/18 109/20 110/4 124/20 128/7 143/18</p> <p>delayed [2] 1/3 96/16</p> <p>delays [2] 41/6 79/1</p> <p>deleted [2] 92/13 101/19</p> <p>deleting [1] 102/4</p> <p>deliver [2] 71/25 179/25</p> <p>delivered [6] 98/9 112/19 130/24 138/7 165/5 175/15</p> <p>delivering [1] 166/22</p> <p>delivery [7] 164/23 174/11 175/20 175/25 176/4 176/13 195/17</p> <p>Delta [1] 14/14</p> <p>demand [5] 52/1 52/4 52/6 53/23 178/15</p> <p>demands [3] 8/20 53/22 106/9</p> <p>dementia [1] 119/24</p> <p>democracy [1] 133/5</p> <p>demographic [3] 29/14 54/20 97/1</p> <p>demonstrate [1] 148/24</p> <p>demonstrated [3]</p>	<p>97/23 149/2 195/2</p> <p>demonstrates [2] 172/18 172/20</p> <p>demonstrating [1] 84/3</p> <p>denied [4] 69/1 84/6 116/17 129/23</p> <p>deny [1] 101/16</p> <p>department [1] 36/2</p> <p>departments [1] 137/10</p> <p>depend [1] 175/20</p> <p>dependency [1] 54/23</p> <p>deployed [2] 43/16 180/9</p> <p>deprioritised [1] 130/8</p> <p>deprivation [1] 22/6</p> <p>deprived [4] 18/9 18/10 18/17 106/1</p> <p>Deputy [4] 41/2 47/9 56/11 136/10</p> <p>Deputy CMO [2] 41/2 47/9</p> <p>derisory [1] 101/7</p> <p>describe [1] 2/11</p> <p>described [12] 84/1 135/3 141/13 158/22 163/7 163/11 163/13 164/20 167/16 168/5 171/9 182/19</p> <p>describes [5] 78/1 87/23 149/5 166/22 166/25</p> <p>deserve [1] 27/5</p> <p>design [3] 140/15 141/1 176/15</p> <p>designed [6] 5/1 76/5 77/4 168/20 175/19 176/3</p> <p>desirable [1] 154/25</p> <p>despite [14] 15/12 61/16 81/7 100/8 102/10 105/21 111/25 124/19 128/10 128/11 129/8 141/21 158/8 169/8</p> <p>detail [13] 7/14 11/5 27/3 27/4 62/7 119/16 120/12 121/22 122/15 167/16 177/22 179/2 181/23</p> <p>detailed [11] 5/22 7/5 7/18 16/7 17/7 24/8 25/11 31/16 45/19 119/5 180/2</p> <p>details [1] 197/4</p> <p>detecting [1] 37/7</p> <p>detection [1] 36/13</p> <p>deteriorating [1] 24/3</p> <p>deterioration [1] 121/12</p> <p>determinants [1]</p>	<p>24/12</p> <p>determining [1] 176/4</p> <p>devastating [7] 16/8 91/18 107/15 116/21 118/14 121/5 166/9</p> <p>devastation [1] 5/6</p> <p>develop [3] 175/17 179/1 181/3</p> <p>developed [6] 55/25 140/17 158/11 177/17 191/21 192/17</p> <p>developing [2] 91/3 134/14</p> <p>development [2] 42/3 155/18</p> <p>develops [1] 174/19</p> <p>devolution [10] 6/9 25/12 131/25 153/3 154/21 155/1 170/7 187/25 189/3 191/2</p> <p>devolved [35] 19/8 25/24 31/8 66/25 67/3 67/6 67/10 67/11 68/1 68/6 68/24 69/5 69/10 69/15 69/19 69/25 70/17 71/3 72/5 83/6 83/14 99/18 105/15 111/19 111/23 134/11 144/10 153/2 161/12 173/2 175/9 188/6 196/10 196/18 198/6</p> <p>DGs [1] 44/11</p> <p>DHSC [2] 40/20 46/10</p> <p>diagnostic [2] 42/4 43/4</p> <p>dialogue [4] 147/2 174/10 177/13 178/1</p> <p>Diamond [3] 15/23 46/2 46/3</p> <p>Diamond Princess [2] 46/2 46/3</p> <p>dichotomy [1] 172/1</p> <p>did [64] 8/20 15/2 16/22 19/4 19/9 27/11 30/23 31/20 49/2 49/5 59/3 65/3 66/1 66/24 69/4 70/5 70/24 74/7 77/1 77/1 81/7 82/25 85/23 94/21 95/7 97/16 102/11 103/15 103/17 104/1 104/4 104/6 105/16 106/16 108/13 108/15 108/20 109/13 110/1 111/13 112/5 125/13 127/24 128/16 128/22 132/17 133/20 133/23 136/5 136/18 143/22 150/4 150/17 153/18 156/6 158/25 170/8 177/19 181/13 182/2 194/19 194/20 195/8 197/22</p>	<p>didn't [8] 81/9 105/15 107/12 118/18 123/3 125/17 126/4 147/17</p> <p>die [2] 42/11 132/9</p> <p>died [5] 2/8 8/4 13/21 32/5 132/3</p> <p>differ [1] 153/24</p> <p>difference [3] 18/13 74/25 156/11</p> <p>difference's [1] 171/18</p> <p>differences [11] 29/15 72/25 73/5 73/19 74/1 97/3 170/23 171/17 171/18 183/16 184/18</p> <p>different [31] 16/4 19/12 20/15 27/14 29/23 63/20 67/15 67/22 68/25 71/10 71/11 74/4 74/24 75/2 78/10 79/20 82/19 131/7 132/22 134/8 135/8 136/17 138/2 144/20 144/21 153/17 154/24 171/19 183/8 189/23 198/7</p> <p>differential [1] 192/4</p> <p>differently [5] 16/5 20/14 63/20 99/17 160/21</p> <p>differing [2] 45/2 155/6</p> <p>difficult [8] 33/11 47/16 95/9 150/14 151/20 152/6 162/18 185/17</p> <p>difficulties [3] 153/4 154/3 169/20</p> <p>difficulty [2] 129/17 169/17</p> <p>dilemmas [1] 95/23</p> <p>dimension [1] 164/19</p> <p>Diolch [1] 115/10</p> <p>dire [1] 179/16</p> <p>direct [6] 5/25 67/5 83/6 152/2 159/8 190/18</p> <p>directed [1] 55/20</p> <p>direction [3] 73/2 178/25 181/19</p> <p>directions [1] 135/8</p> <p>directly [5] 29/11 150/25 154/9 158/22 160/19</p> <p>director [4] 17/9 35/1 37/4 104/24</p> <p>directorate [1] 180/14</p> <p>directorates [1] 137/12</p> <p>directors [2] 177/4 182/24</p> <p>disabilities [2] 21/23</p>

D	discrimination [3] 19/19 20/22 23/22	diverse [1] 182/8	39/21 43/3 43/8 43/19	4/8 19/12 19/21 40/16
disabilities... [1] 22/18	discuss [5] 81/8 84/22 89/7 102/1 102/12	diversion [1] 113/9	44/9 45/11 47/9 47/22	50/7 58/13 81/25
disability [19] 10/3 21/25 22/5 22/5 28/2 91/14 91/16 131/15 131/15 131/17 131/17 136/12 136/25 139/9 192/21 193/8 193/9 199/14 199/15	discussed [15] 37/16 39/10 39/12 40/4 46/12 47/5 50/21 54/11 62/13 62/14 69/8 75/25 82/9 194/22 196/2	dividing [1] 187/19	48/19 50/4 52/8 53/7 53/9 53/13 53/16 57/15 60/11 61/12 61/23 70/24 81/19 82/5 85/15 86/3 86/24 89/13 89/21 122/4 122/5	86/24 87/25 90/23 93/7 99/16 104/20 106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
Disability Wales [1] 131/17	discussion [6] 43/11 43/20 44/20 171/13 185/1 190/12	division [1] 144/16	Divisional [1] 124/9	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
disabled [37] 22/10 22/16 23/3 28/10 91/18 130/21 131/18 131/19 131/25 132/3 132/7 132/9 133/11 133/22 133/25 134/5 135/15 136/7 136/23 137/22 139/6 139/11 139/19 139/22 140/4 140/8 141/20 141/25 142/12 143/4 144/12 144/17 168/7 170/19 192/23 192/25 193/4	discussions [4] 83/18 102/20 153/16 195/2	divorced [1] 133/4	Dr Andrew Goodall [2] 11/2 33/8	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
disadvantage [1] 165/3	disease [12] 8/8 32/10 36/17 36/22 39/19 51/8 132/14 169/7 177/6 181/16 191/11 192/8	do [26] 1/6 1/7 1/24 2/15 13/15 25/13 29/6 56/14 80/17 83/7 92/8 99/17 100/22 112/5 116/2 139/23 139/25 140/10 142/22 160/16 161/5 164/2 171/7 185/5 185/6 185/20	Dr Atherton [21] 33/12 33/15 36/24 38/24 39/21 43/8 44/9 45/11 47/9 50/4 53/7 53/9 53/13 53/16 61/12 81/19 82/5 85/15 86/24 89/13 89/21	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
disadvantaged [1] 191/13	disengaged [1] 136/19	doctor [1] 163/16	Dr Clare Wenham [1] 23/8	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
disappearing [1] 102/10	disinclination [2] 68/21 76/11	document [1] 147/13	Dr Goodall [1] 86/3	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
disappointed [1] 100/8	disjointed [1] 104/18	documented [1] 20/18	Dr Orford [9] 43/3 43/19 47/22 48/19 52/8 57/15 60/11 61/23 70/24	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
disappointment [1] 158/20	disorders [1] 9/3	documents [4] 103/4 186/23 194/4 197/9	Dr Quentin Sandifer [1] 34/24	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
disastrous [1] 108/21	display [1] 99/24	does [18] 26/16 27/8 40/3 44/11 70/4 83/14 92/6 96/19 101/17 127/6 133/8 137/10 138/15 150/5 150/6 150/17 175/2 175/5 134/20 197/25 198/5	Dr Rachael Evans [1] 24/22	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
disastrously [1] 135/7	disproportionate [8] 22/17 23/10 54/24 117/15 168/23 170/17 192/12 192/15	doing [7] 4/17 5/22 16/13 16/17 143/22 146/24 191/18	Dr Rob Orford [1] 34/20	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
discharge [9] 4/15 58/9 107/17 107/24 108/3 123/10 125/2 147/5 148/19	disproportionately [2] 23/16 191/12	domain [1] 26/4	Dr Robert Orford [1] 11/1	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
discharged [9] 7/22 32/4 58/12 59/12 107/20 107/23 108/6 123/23 124/1	disputed [1] 143/19	domiciliary [2] 118/12 120/1	Dr Wenham [1] 23/9	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
discharges [1] 125/11	disputes [1] 135/10	dominant [1] 69/12	draft [3] 95/2 147/1 147/9	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
discipline [1] 140/16	disruption [2] 24/12 111/4	don't [1] 30/24	drafted [2] 179/5 180/23	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
disclosed [6] 92/1 101/13 101/14 101/25 103/4 186/22	distancing [7] 46/16 57/11 59/20 75/7 94/11 152/13 168/13	done [20] 29/18 29/20 49/7 65/6 96/23 96/23 122/7 130/4 131/22 141/8 153/23 155/22 160/20 160/21 165/18 177/5 179/22 182/21 194/16 194/16	dragged [1] 109/22	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
disclosure [9] 103/7 103/25 104/16 105/9 105/24 106/23 113/17 114/21 187/23	distressing [1] 163/13	door [1] 165/6	Drakeford [6] 10/20 102/11 107/4 140/11 166/24 172/3	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
discontinued [1] 180/8	distributed [1] 135/24	dot [1] 198/12	Drakeford's [1] 107/11	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
discourse [1] 76/14	distribution [1] 127/23	doubling [4] 38/1 79/5 80/9 86/10	dramatically [1] 46/22	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
discrete [1] 139/5	distributor [1] 26/4	doubt [4] 58/16 123/12 147/11 162/8	draw [4] 7/1 27/12 85/4 130/22	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
discretionary [1] 168/15	district [1] 163/20	down [3] 42/23 88/18 108/7	drawn [1] 20/25	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
	diverge [1] 66/4	DPO [8] 131/19 136/16 136/22 137/6 138/17 142/13 142/24 143/21	dreadful [1] 9/9	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
	diverged [3] 67/24 88/7 183/15	DPOs [3] 136/8 136/10 140/22	drew [1] 128/18	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
	divergence [16] 48/8 48/11 48/12 67/19 67/21 72/8 74/21 110/13 111/5 111/7 114/12 155/13 188/19 197/20 197/25 198/3	Dr [41] 11/1 11/2 23/8 23/9 24/22 33/8 33/12 33/15 34/20 34/24 36/24 38/24	dubiously [1] 101/15	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
	divergences [1] 111/9		Duchy [1] 70/3	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
	divergent [1] 110/18		due [23] 13/14 16/10 23/1 28/1 28/3 32/2 48/12 56/9 56/19 78/9 83/20 130/14 148/5 148/10 149/1 149/7 150/6 157/16 158/14 174/21 195/5 195/17 196/2	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
	diverging [1] 68/24		duration [1] 137/15	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
			during [47] 2/7 2/24	106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
				106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
				106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
				106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
				106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
				106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
				106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
				106/2 113/11 114/15 119/23 127/18 139/12 141/21 145/22 146/13 149/22 151/2 151/4 151/18 154/13 155/18 162/14 163/6 167/12 169/4 169/22 173/20 175/3 177/11 178/11 181/8 181/12 182/12 185/7 185/16 190/9 193/4 194/12
				106/2 113/11 114/15 119/23 127/18 139/12 1

E	98/10 108/18 140/4 155/9 157/17 165/8	160/15	195/4	114/22 114/22
easy... [1] 167/25	electrified [2] 104/13 104/15	encourages [1] 159/12	enhancing [1] 139/20	escalation [1] 45/11
Eat [1] 75/20	element [2] 84/15 190/8	end [12] 10/18 30/23 37/22 39/17 48/23	enough [10] 76/13 77/17 82/2 122/7	escape [3] 35/14 132/17 138/25
ebbed [1] 16/3	elements [2] 76/6 177/24	56/10 66/10 92/1 97/8 118/4 129/5 186/20	137/8 138/10 142/22 174/15 177/17 177/20	especially [3] 111/24 134/4 189/7
echoed [1] 105/6	elevated [1] 61/20	endeavour [2] 26/17 140/17	enquire [4] 4/17 96/19 97/19 97/22	essence [2] 10/14 166/5
economic [15] 9/7 9/19 18/22 18/25 19/5 19/11 23/15 23/19 54/22 75/11 75/17 75/22 97/14 184/5 184/8	eliminate [1] 165/18	endeavours [1] 135/19	enquired [1] 8/21	essential [10] 63/6 64/9 73/21 80/4 120/9 126/16 141/23 142/14 146/16 183/18
economically [3] 75/16 144/3 191/13	else [1] 120/4	endorse [2] 130/19 130/25	ensure [8] 1/17 43/16 56/4 67/19 111/15 138/20 145/12 152/21	essentially [4] 86/12 108/2 125/21 153/12
economics [6] 134/9 134/16 134/17 142/25 143/1 143/7	elsewhere [3] 141/22 193/21 194/1	endorsed [1] 47/18	ensures [1] 98/20	establish [1] 145/14
economies [1] 184/10	email [6] 44/7 44/8 52/9 59/22 64/16 64/20	endorsing [1] 108/3	ensuring [5] 57/12 129/16 147/22 149/6 191/25	established [15] 23/11 43/1 45/6 49/13 61/4 91/5 93/2 100/12 102/23 109/6 145/9 188/1 189/11 192/10 193/8
economy [5] 56/12 66/16 74/20 171/25 178/12	emailed [2] 48/19 86/3	endured [1] 162/24	entail [1] 6/16	establishing [4] 100/11 106/4 173/1 194/14
edge [1] 153/3	embedded [1] 166/17	enforce [1] 71/25	enter [1] 163/16	establishment [1] 103/2
education [6] 7/6 7/17 62/5 97/14 157/23 159/3	embraced [1] 173/8	enforced [3] 94/21 95/14 134/21	entertainment [2] 64/1 85/8	estimate [5] 14/23 15/17 42/6 60/1 79/3
educational [1] 9/4	emerged [5] 14/10 45/22 89/3 132/2 192/6	enforcement [11] 94/18 94/25 95/11 169/1 178/4 178/20 178/23 182/23 184/18 185/1 185/4	entire [1] 9/3	estimated [12] 24/18 34/13 35/18 38/1 38/2 38/14 41/15 41/16 42/12 51/25 55/6 57/17
effect [22] 10/15 18/7 26/2 26/20 30/3 49/8 60/13 64/6 70/18 71/4 80/6 82/15 84/1 84/4 84/12 85/14 87/13 116/7 125/23 150/10 166/9 182/13	emergence [3] 29/4 37/2 97/25	enforcing [1] 180/11	entirely [1] 95/25	ethics [1] 44/25
effected [1] 130/24	emergencies [3] 29/17 33/18 90/16	engage [2] 112/16 158/25	entities [3] 90/18 90/20 90/24	ethnic [9] 20/8 20/16 20/19 23/4 28/10 164/20 192/5 192/7 192/11
effective [18] 35/23 41/22 43/25 48/5 58/20 79/17 80/20 82/23 91/25 94/9 103/2 106/4 142/13 166/6 169/25 174/13 184/19 196/23	emergency [23] 5/8 5/12 17/1 17/5 18/6 19/4 28/20 35/2 35/6 35/8 39/5 40/15 56/4 57/12 93/8 98/11 118/16 118/16 133/14 144/8 157/19 174/15 196/20	engaged [3] 66/21 71/18 177/16	entitled [3] 8/24 36/11 79/19	ethnicity [2] 28/2 164/19
effectiveness [4] 5/20 25/23 79/19 175/12	emerges [1] 180/19	engagement [20] 103/8 112/5 133/25 140/8 142/13 162/10 173/7 174/5 174/8 174/13 174/15 176/11 176/12 176/17 176/23 183/10 183/22 184/6 184/20 184/21	entrenched [1] 191/3 132/23	estimates [1] 44/25
effects [7] 6/1 23/12 126/1 136/22 186/14 186/14 191/12	emerging [3] 28/19 34/10 192/3	engages [1] 172/22	environment [1] 18/22 18/25	ethnically [1] 20/8 20/16 20/19 23/4 28/10 164/20 192/5 192/7 192/11
efficiency [1] 175/12	eminent [1] 8/3	engaging [2] 71/20 178/3	environmental [2] 18/22 18/25	EU [1] 69/22
efficient [1] 196/23	Emmanuel [1] 91/11	England [47] 14/22 15/8 20/10 22/5 34/6 38/11 42/3 50/10 51/9 52/10 59/15 60/10 61/19 61/22 68/14 70/23 71/1 71/8 72/15 72/17 73/6 73/23 74/5 74/13 74/18 78/11 83/13 84/5 87/12 108/9 128/5 131/22 134/17 134/23 135/25 141/17 143/15 156/19 158/19 165/19 166/5 168/15 170/4 170/9 188/4 197/25 198/7	envisaged [1] 90/19	Europe [1] 37/4
effort [1] 36/21	emotional [1] 121/14	engages [1] 172/22	envisioned [1] 179/8	European [1] 36/10
efforts [4] 98/4 129/8 154/11 160/13	emphasise [2] 10/12 180/21	engaging [2] 71/20 178/3	epidemic [10] 36/20 43/21 45/18 46/22 50/10 51/20 53/21 54/4 80/19 110/11	evaluate [1] 65/22
eight [2] 60/3 132/11	emphasising [1] 134/20	England [47] 14/22 15/8 20/10 22/5 34/6 38/11 42/3 50/10 51/9 52/10 59/15 60/10 61/19 61/22 68/14 70/23 71/1 71/8 72/15 72/17 73/6 73/23 74/5 74/13 74/18 78/11 83/13 84/5 87/12 108/9 128/5 131/22 134/17 134/23 135/25 141/17 143/15 156/19 158/19 165/19 166/5 168/15 170/4 170/9 188/4 197/25 198/7	epidemics [1] 23/10	Evans [2] 24/22 137/16
eighth [1] 52/14	employed [1] 164/21	English [8] 71/5 71/6 87/19 103/1 112/20 112/23 113/1 114/6	epidemiological [4] 7/10 37/15 37/24 54/5	even [19] 8/17 36/20 40/12 80/8 89/12 102/13 122/9 124/3 129/25 134/17 150/16 156/9 159/14 163/19 170/3 178/22 180/1 185/17 195/14
either [6] 33/3 121/10 132/17 156/14 172/8 198/18	employees [1] 90/22	English-centric [1] 103/1	epidemiologists [1] 42/5	evening [3] 63/13 82/14 86/24
elder [1] 132/13	employer [1] 167/7	English-only [1] 71/6	epidemiology [2] 11/19 38/13	event [8] 33/15 35/7 38/8 53/21 58/21 69/2 146/16 196/19
elderly [7] 20/22	employers [2] 90/22 169/5	enhance [2] 168/22 181/3	equal [1] 196/18	events [13] 4/7 16/12 26/22 28/15 53/14 90/10 95/15 97/15 97/24 109/17 154/18 177/9 194/20
	employment [1] 22/12	enhanced [2] 35/3	Equalities [1] 130/16	
	empty [2] 13/16 167/25		Equalities Act [1] 130/16	
	enable [4] 29/5 112/8 143/13 170/21		equality [9] 91/14 91/16 134/14 136/12 137/20 148/18 170/16 191/6 192/22	
	enabled [2] 184/12 189/13		equally [5] 20/12 29/7 104/14 138/2 194/24	
	enabling [1] 168/17		equate [1] 50/25	
	enacting [1] 178/20		equated [1] 15/20	
	encapsulated [1] 176/6		equation [1] 132/8	
	encouragement [1]		equations [1] 132/12	
			equivalents [1] 151/4	
			erred [1] 107/9	
			errors [6] 113/4 113/18 113/18 114/7	

E	161/22 161/24 164/12 167/23 169/5 169/9 170/16 172/17 172/20 176/25 181/17 187/2 187/14 187/24 189/18 189/19 191/21 192/4 192/5 196/1 196/20 196/25 197/10 evidence-based [1] 99/19 evidencing [1] 28/8 evident [2] 18/15 105/22 evidential [1] 54/17 evolved [3] 133/13 156/1 158/12 exacerbated [3] 9/5 24/6 149/21 exacerbation [1] 10/8 examination [10] 3/16 6/15 6/16 7/18 91/21 111/21 185/15 187/1 188/19 189/2 examine [13] 6/23 48/1 48/7 58/5 62/8 64/25 74/21 92/24 103/16 106/21 111/9 111/11 192/12 examined [7] 5/20 6/21 7/14 27/3 93/15 186/23 187/14 examining [5] 2/24 46/25 91/22 92/10 96/5 example [32] 17/22 18/10 67/13 68/9 73/21 105/18 109/12 110/15 111/10 117/13 118/7 118/9 118/12 119/2 120/15 120/20 120/24 122/2 122/22 123/9 125/8 125/18 125/18 127/5 127/16 128/6 129/20 130/3 154/22 184/25 191/5 196/3 examples [8] 118/20 118/24 124/13 128/24 129/22 130/6 150/14 156/15 exceed [3] 52/5 81/1 81/4 exceeded [1] 86/15 exception [1] 189/24 exceptions [1] 19/3 excerpts [1] 115/18 excess [5] 12/18 13/1 13/25 14/7 120/2 exchanges [1] 92/7 Exchequer [1] 83/23 exclusive [1] 172/10 executive [6] 11/4 33/7 74/5 169/3	174/21 190/20 exercise [9] 43/7 43/10 49/24 49/25 67/5 96/13 153/20 187/6 188/3 exercised [4] 63/20 146/21 148/11 148/24 exercises [3] 94/3 113/15 114/18 exercising [2] 67/25 148/7 exhausting [1] 162/24 existed [3] 17/6 90/15 178/1 existing [16] 9/4 10/6 19/6 19/10 19/18 23/2 29/16 72/11 90/24 136/11 137/5 154/21 178/16 191/14 192/21 196/4 expand [3] 16/6 25/19 167/10 expanded [1] 190/10 expectancy [3] 18/11 18/14 18/17 expected [10] 12/20 55/9 57/22 61/24 76/25 149/6 149/10 150/19 156/14 198/13 expedience [1] 143/7 expedient [1] 139/23 expedition [1] 57/25 experience [6] 54/24 88/11 139/5 144/22 149/15 173/25 experienced [2] 21/4 27/14 experiences [13] 27/1 88/14 98/19 101/2 116/22 117/10 152/22 156/4 161/20 162/25 170/22 193/3 197/2 experiencing [1] 89/22 experiment [1] 78/2 expert [8] 20/1 20/21 24/20 25/5 71/3 73/13 177/8 180/10 expertise [8] 22/19 103/6 104/5 138/19 140/13 176/19 179/12 181/3 experts [12] 6/22 11/10 11/18 19/17 19/21 19/23 24/23 25/8 29/12 122/19 125/6 136/1 explain [7] 2/23 3/21 90/11 120/15 120/17 137/23 187/12 explained [8] 65/20 66/4 93/24 120/12	120/24 181/11 195/12 195/18 explanation [2] 72/18 122/12 explicitly [1] 78/12 exploration [1] 7/15 explore [8] 14/8 49/25 59/9 71/21 78/7 127/25 129/19 130/9 explored [8] 4/11 68/2 68/4 76/19 90/12 151/15 154/16 170/5 exploring [2] 122/14 131/1 explosion [1] 9/2 exponential [2] 80/14 81/10 exposed [2] 23/17 164/17 exposure [4] 31/16 164/6 164/13 164/22 express [2] 162/15 186/4 expressed [7] 20/7 20/16 21/16 23/1 121/3 122/6 122/9 expressing [1] 59/18 extend [1] 108/10 extended [3] 84/12 156/9 167/7 extensive [6] 124/10 174/20 175/9 176/12 176/18 184/6 extent [28] 5/14 6/21 9/12 9/20 27/15 27/19 58/7 63/21 66/22 66/24 74/21 75/2 91/23 92/20 93/2 93/12 93/20 93/23 94/4 112/15 119/5 136/18 140/9 147/15 156/8 176/2 176/14 178/15 external [2] 31/9 33/5 extra [1] 178/16 extraordinarily [1] 30/4 extraordinary [2] 37/13 135/8 extremely [4] 2/13 3/12 95/22 95/25	face [13] 23/17 23/17 80/3 80/3 89/2 89/2 98/17 109/17 109/21 110/16 110/21 127/8 150/13 faced [5] 10/7 22/16 87/25 95/23 164/6 facilitated [1] 159/6 facilitating [1] 100/24 facilities [2] 108/8 125/10 facing [2] 151/18 180/12 fact [13] 16/18 39/24 40/3 56/20 86/5 117/9 119/20 125/12 167/4 179/7 183/14 184/15 198/2 factor [4] 108/14 121/16 157/18 176/5 factored [1] 154/2 factors [2] 21/11 75/3 facts [1] 56/23 factual [1] 26/11 failed [11] 50/16 78/2 105/11 109/21 113/10 114/14 119/3 124/23 140/18 153/14 182/18 failing [1] 169/6 failure [20] 58/16 67/19 97/6 97/11 97/12 97/12 97/18 107/13 107/14 108/22 117/15 117/18 121/25 122/18 123/12 125/5 125/6 178/15 184/2 196/8 failures [1] 101/5 fair [3] 185/18 187/1 196/19 fairly [3] 1/25 95/14 100/23 fall [5] 9/7 85/24 149/14 156/14 187/17 falling [1] 90/6 falls [1] 157/11 false [2] 69/21 172/1 falsely [1] 182/19 families [13] 8/17 9/25 84/19 99/3 99/8 152/8 157/2 158/3 171/1 186/2 186/9 187/15 199/9 families' [1] 156/3 family [9] 39/7 39/9 39/16 51/11 116/14 117/1 120/9 121/2 153/19 far [11] 13/20 16/11 26/1 30/5 61/16 95/22 118/13 135/5 149/17 162/13 167/11 far-reaching [3] 30/5 95/22 167/11 fashion [2] 133/13 140/2 fast [3] 60/16 79/6 147/23 fatal [2] 39/19 135/10 fatality [5] 33/2 42/7 44/25 47/19 51/24 father [2] 107/20 108/25 fear [1] 69/21
----------	--	---	---	--

F	fighting [1] 99/13	89/9 91/5 92/4 97/24	flaw [2] 122/18 128/1	111/22 147/12 171/12
feature [3] 155/20 166/15 189/8	figure [6] 8/14 13/24 22/1 22/8 32/15 57/17	101/3 101/20 102/8 104/25 105/1 105/3 105/8 106/11 106/15 111/23 115/19 115/20 115/24 115/25 118/9 119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	flawed [1] 118/24	formalised [1] 103/9
features [1] 135/6	figures [4] 10/22 58/14 132/2 132/13	105/8 106/11 106/15 111/23 115/19 115/20 115/24 115/25 118/9 119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	flaws [4] 118/25 172/11 196/7 196/24	formally [3] 37/18 82/12 82/25
February [44] 1/1 11/7 15/20 29/25 30/3 39/14 40/16 40/18 41/1 41/13 41/24 42/5 43/2 43/7 43/13 43/18 44/24 45/9 45/16 45/22 46/1 46/3 46/10 46/12 47/4 47/8 47/18 47/21 48/14 48/18 48/23 49/8 62/15 70/25 89/2 97/22 99/11 104/9 104/12 104/21 105/2 105/9 124/14 198/25	film [10] 2/11 2/16 2/19 2/21 3/8 28/5 162/17 163/1 165/22 183/19	111/23 115/19 115/20 115/24 115/25 118/9 119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	flexible [1] 143/12	formation [1] 140/21
February 2020 [3] 11/7 97/22 104/21	final [4] 59/7 111/17 129/20 159/15	First Minister [55] 5/3 10/19 17/8 36/24 39/21 45/10 49/11 49/13 49/15 49/18 52/16 52/23 53/17 55/4 56/8 60/15 63/25 65/11 65/25 66/7 68/14 68/19 70/7 72/19 73/9 78/1 81/24 82/4 82/14 83/23 84/1 87/2 87/6 87/10 87/23 89/5 89/5 91/5 92/4 102/8 106/11 106/15 132/25 136/10 143/16 167/6 185/24 186/20 187/10 194/13 195/9 195/12 196/2 196/16 197/11	flights [2] 35/5 39/3	formed [1] 11/6
February 2021 [1] 89/2	finally [11] 4/10 94/15 94/18 98/3 103/24 106/10 135/6 171/14 182/7 184/14 196/14	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	Fliss [2] 47/22 79/20	former [8] 10/20 11/2 17/8 66/7 67/18 68/19 72/9 158/18
February 2022 [1] 15/20	finance [1] 137/17	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	Fliss Bennee [2] 47/22 79/20	forming [1] 167/11
fed [1] 160/18	finances [1] 9/8	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	flooded [1] 182/16	forms [1] 16/15
federal [2] 69/23 194/18	financial [7] 7/8 84/11 140/23 169/12 169/17 169/19 170/6	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	flow [2] 7/10 44/16	formulaic [1] 68/23
federalist [1] 70/1	find [2] 44/18 136/8	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	flowed [1] 16/3	formulating [2] 92/25 106/5
Federation [1] 190/14	findings [4] 113/24 114/3 115/3 115/7	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	flu [3] 43/5 43/6 50/9	formulation [1] 196/23
feed [3] 123/3 140/18 150/4	finish [2] 184/14 185/10	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	focus [18] 6/13 10/12 16/23 24/25 62/18 71/5 72/24 103/1 105/12 117/4 117/21 118/1 118/3 138/21 157/10 162/2 165/14 192/3	forthcoming [1] 190/12
feedback [2] 122/25 181/17	finished [2] 141/14 198/12	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	focused [10] 6/3 18/21 41/5 43/10 46/25 123/2 137/12 144/8 173/22 191/3	forthright [1] 193/21
feeding [1] 156/3	firebreak [19] 67/14 82/15 82/18 83/1 83/5 83/18 83/22 85/20 86/13 98/1 109/20 109/23 110/8 143/10 143/13 195/3 195/7 195/12 196/5	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	fold [4] 15/6 52/6 52/8 120/8	Fortunately [2] 88/24 90/3
feel [1] 125/13	first [142] 3/20 4/6 5/3 10/19 11/25 12/4 12/21 13/2 13/7 14/4 14/7 14/10 15/3 16/21 17/8 31/23 32/1 32/18 33/17 35/25 36/9 36/24 38/14 39/6 39/11 39/21 40/25 41/24 42/6 43/13 45/10 47/5 48/15 49/11 49/11 49/13 49/14 49/15 49/16 49/16 49/18 51/8 52/16 52/23 53/5 53/17 53/20 54/7 55/1 55/4 56/8 60/6 60/15 60/18 63/25 64/13 65/11 65/11 65/20 65/25 66/7 68/14 68/19 69/15 69/19 70/7 72/19 72/22 73/9 73/21 74/13 74/15 74/20 76/3 77/19 78/1 81/13 81/24 82/4 82/14 83/23 84/1 87/2 87/6 87/8 87/10 87/23 88/1 88/12 89/5 89/5	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	follow [7] 55/9 97/17 105/16 128/22 147/18 150/14 156/19	forum [15] 68/22 69/14 91/14 91/16 102/21 121/8 122/22 128/4 128/13 128/21 136/12 190/11 192/22 193/3 193/20
feet [1] 109/23	first weeks [1] 136/20	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	followed [11] 2/25 14/16 30/11 50/8 51/12 74/13 74/16 74/20 109/20 112/20 152/20	forward [11] 87/21 98/19 102/15 122/14 127/25 131/1 160/10 173/19 185/7 195/10 195/16
Feldman [1] 135/4	first-hand [1] 101/3	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	following [19] 1/10 2/16 12/9 52/22 56/8 61/3 66/15 86/8 87/2 87/7 91/15 94/19 110/8 142/7 145/10 156/25 158/5 160/15 195/6	Foster [2] 91/20 193/2
Felicity [2] 141/12 143/10	firstly [5] 108/6 118/22 122/25 123/17 130/10	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	fora [3] 103/14 106/5 167/15	Foster's [1] 192/24
Felicity Bennee [2] 141/12 143/10	fiscal [1] 91/7	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	forced [1] 30/4	fostering [1] 156/20
fell [1] 157/16	fish [1] 103/14	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	forces [1] 184/20	found [1] 169/4
felt [6] 30/5 33/10 163/15 163/18 167/18 167/20	fit [5] 104/3 131/11 140/5 144/25 149/19	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	forecast [1] 45/19	foundational [1] 155/14
Ferguson [1] 32/12	fits [2] 155/10 157/15	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	forensic [1] 180/2	four [33] 6/20 20/13 21/25 26/9 36/8 38/2 48/15 55/8 61/3 61/24 62/1 69/22 70/2 73/20 80/15 82/6 82/25 84/14 111/8 134/3 135/21 143/22 144/5 144/12 157/21 161/15 171/6 184/20 185/19 187/8 188/10 188/14 194/21
festive [2] 84/15 84/21	five [8] 12/16 12/23 24/2 52/6 62/1 89/17 122/11 135/10	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	foreseeable [2] 24/24 106/9	four days [3] 38/2 80/15 82/25
few [10] 8/1 104/25 123/1 124/13 127/18 143/8 143/14 162/6 164/3 176/24	five days [1] 89/17	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	foreseen [2] 9/23 63/22	four nations [17] 20/13 21/25 26/9 36/8 69/22 73/20 84/14 111/8 134/3 135/21 143/22 144/5 144/12 171/6 185/19 188/10 194/21
few weeks [1] 104/25	five years [1] 24/2	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	foreword [1] 65/20	four weeks [2] 55/8 61/24
fewer [1] 13/20	five-fold [1] 52/6	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	forge [1] 112/8	four years [2] 48/15 187/8
FFP2 [1] 109/12	five-year [2] 12/16 12/23	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	forgotten [2] 121/17 163/18	fourth [6] 4/7 45/9
FFP3 [1] 109/13	flashbacks [1] 164/3	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	form [10] 25/6 51/1 84/17 84/20 93/8 93/9 137/11 172/19 172/21 194/6	
Field [1] 38/13	flattening [1] 47/1	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11	formal [5] 33/19 92/7	
fields [2] 7/17 11/19	flavour [1] 103/12	119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136/10 136/20 142/8 143/16 143/25 144/9 145/14 165/9 167/6 174/20 175/2 176/10 179/3 183/9 185/24 186/20 187/10 190/21 194/13 195/9 195/12 196/2 196/16 197/11		
fifth [1] 127/16		119/2 120/2 121/19 127/18 128/25 132/25 133/12 135/10 136		

F	108/21 110/7 110/20 124/20 137/24 151/15 165/9 177/12 183/15	144/14	Gove [2] 70/3 87/7	grey [1] 12/11
fourth... [4] 125/18 125/18 142/21 182/15	Furthermore [1] 76/16	geography [2] 78/10 134/8	govern [1] 139/8	grief [1] 8/18
fragmented [1] 106/8	future [24] 18/20 45/4 73/17 78/13	get [7] 1/13 30/24 81/9 109/25 131/10 140/15 147/24	governing [3] 70/16 133/3 134/3	grievous [1] 9/2
frail [1] 140/4	future [24] 18/20 45/4 73/17 78/13	Gething [25] 10/21 36/3 37/1 38/24 43/8 47/5 47/9 49/12 50/20 52/16 57/18 64/16 77/18 85/25 86/3 86/8 86/14 86/19 102/9 115/21 116/1 125/9 127/21 127/22 137/15	government [371] government's [50] 3/17 4/16 5/21 6/17 7/4 8/5 8/9 10/11 17/16 17/25 28/18 29/9 38/8 48/6 50/11 50/13 55/11 55/17 58/18 62/17 63/23 67/7 72/14 72/18 88/6 91/7 93/17 94/10 96/13 97/17 102/3 104/6 104/7 104/17 105/25 108/5 111/14 112/16 113/7 114/10 130/22 139/25 149/4 155/15 156/7 168/2 188/3 188/23 191/9 192/21	ground [4] 129/7 130/24 138/7 154/15
frame [1] 71/5	framework [6] 5/15 57/19 57/23 65/19 66/1 66/8	gets [1] 30/25	governmental [3] 150/15 155/13 158/22	grounds [1] 17/22
frameworks [1] 171/11	France [2] 36/9 61/6	getting [1] 148/1	governments [20] 6/11 6/20 7/3 25/24 30/7 66/20 72/5 72/9 74/7 83/6 83/14 95/21 159/17 160/5 171/5 171/15 188/7 188/14 196/10 196/18	groundwork [1] 5/14
Frank [2] 10/25 34/22	fraudulent [1] 182/16	give [10] 4/7 16/7 25/17 69/21 108/15 113/21 114/25 124/13 129/21 187/14	governors [1] 144/6	group [53] 11/7 11/8 17/17 23/5 24/10 33/17 40/23 43/14 43/15 45/2 48/2 49/14 51/18 53/9 57/15 61/11 70/6 91/1 91/8 99/20 100/8 100/16 103/20 104/22 105/3 105/3 106/18 106/20 107/1 107/19 108/17 109/4 109/8 110/7 112/14 113/6 113/10 114/9 114/13 118/4 118/5 122/4 130/10 132/19 133/2 137/21 138/25 155/7 157/22 171/2 190/3 192/12 192/13
free [2] 44/16 151/3	freelancers [1] 170/11	given [36] 9/15 19/24 25/20 27/5 27/24 28/4 29/9 29/14 36/21 39/21 40/12 49/1 50/18 53/14 58/6 63/1 65/9 72/13 82/20 89/25 90/9 94/24 109/8 111/5 118/22 128/4 129/1 130/12 140/2 153/24 154/1 163/11 180/6 186/22 187/4 194/1	Gowman [5] 98/23 99/2 99/4 115/11 199/9	grouped [1] 153/19
freezing [1] 30/23	frequently [2] 136/13 159/19	gives [1] 14/23	GP [1] 140/3	groups [28] 9/12 9/20 10/7 11/14 19/12 19/19 21/15 21/16 27/12 27/21 28/9 60/22 61/4 80/6 85/2 91/10 92/3 94/15 94/25 136/20 137/11 146/10 153/21 157/24 164/11 170/18 177/1 198/11
frictions [1] 167/23	Friday [4] 56/22 57/14 63/9 82/15	giving [3] 26/18 42/7 46/23	gradient [2] 18/8 22/7	growing [3] 48/24 79/4 89/11
Friedman [4] 131/14 131/16 144/24 199/15	gather [1] 56/15	Glamorgan [1] 77/25	Gradually [1] 90/6	growth [3] 46/22 81/11 110/10
friend [1] 117/2	gathered [2] 16/11 191/22	global [5] 32/21 35/16 36/12 45/12 48/11	granular [1] 100/17	guarantee [2] 141/10 195/22
friends [2] 8/18 77/7	gathering [1] 56/17	globally [1] 26/7	graph [1] 12/17	guard [1] 100/1
frontline [5] 56/4 57/12 62/23 162/23 189/12	gatherings [15] 43/23 43/25 51/14 51/16 53/18 54/12 56/2 56/3 56/7 56/25 57/4 57/9 64/12 105/19 177/9	gloss [2] 113/7 114/11	graphs [1] 13/15	guidance [35] 11/11 107/24 109/11 122/11 128/6 128/8 128/9 128/15 128/16 128/20 128/21 128/23 129/2 129/9 129/15 129/16 147/1 147/9 151/18 152/3 152/5 152/12 152/14 152/17 153/5 153/10 155/5 156/7 157/16 158/1 158/10 159/20 168/15 178/24 185/4
frustrated [1] 166/7	GDP [1] 9/8	GMB [1] 163/10	Grassroots [1] 140/22	guided [1] 154/24
frustration [1] 168/25	gearing [1] 40/13	go [9] 42/23 60/6 63/7 63/8 67/12 73/8 143/13 164/1 164/2	greater [21] 21/8 21/18 30/2 30/3 41/7 54/15 59/4 75/14 85/1 85/19 130/12 140/6 140/9 146/10 147/17 165/3 165/4 173/6 176/19 179/2 181/14	guidelines [1] 154/6
frustrations [1] 158/20	gender [3] 23/8 23/21 142/8	goals [1] 166/23	greatest [3] 10/16 10/16 136/2	guiding [1] 48/5
fuelled [1] 101/7	general [15] 7/9 22/23 60/7 62/10 68/18 68/21 74/18 94/25 113/6 114/10 129/20 152/11 161/23 161/25 167/14	God [1] 163/1		guilty [1] 66/5
fulfilled [1] 149/7	generally [9] 20/10 22/3 94/7 148/18 163/5 165/3 167/18 171/12 174/6	goes [1] 135/4		gulf [1] 134/9
full [9] 46/24 64/8 65/14 87/13 102/18 102/19 113/21 114/25 179/6	gender [3] 23/8 23/21 142/8	going [10] 55/13 57/6 98/14 134/6 143/4 160/10 161/4 163/3 165/10 198/7		
fuller [1] 174/12	generation [1] 9/3	gone [2] 109/2 178/6		
fully [6] 1/25 100/22 149/25 174/19 177/11 181/10	generations [4] 18/20 135/1 190/16 191/5	good [10] 1/6 1/9 57/11 99/6 111/7 137/7 148/21 161/8 173/15 184/25		
functions [2] 146/22 148/8	generic [1] 157/13	Goodall [4] 11/2 33/8 34/22 86/3		
fund [2] 151/3 170/11	generous [3] 160/24 160/25 160/25	goods [1] 184/1		
fundamental [2] 73/2 196/22	genesis [1] 95/2	Gore [1] 48/17		
fundamentally [1] 136/17	genuinely [2] 58/23 112/8	got [2] 22/7 198/6		
funding [13] 83/3 83/8 83/9 83/13 83/17 110/4 135/11 139/1 180/5 180/7 191/7 196/4 196/19	geographically [1] 20/9			
furlough [1] 135/11	geographies [1]			
further [23] 13/19 24/20 35/14 37/16 59/19 60/7 68/4 77/22 80/18 81/2 81/12 83/21 88/17 103/13				

G	101/3 126/25 127/1 138/13	18/9 20/18 21/19 22/4 23/5 23/6 24/5 24/14 27/8 29/10 29/18 29/20 29/24 30/4 30/13 31/16 32/14 33/10 33/20 40/6 40/11 41/10 42/15 44/6 44/19 45/17 46/20 49/3 49/7 50/24 53/19 54/14 57/1 57/3 57/10 58/22 59/21 61/18 62/23 63/5 64/19 65/6 66/17 69/20 71/22 72/21 75/25 76/4 76/24 78/12 78/22 82/18 83/6 83/8 88/8 88/19 92/13 92/20 96/12 96/14 96/17 96/22 97/6 99/18 101/8 101/13 101/25 102/2 103/14 103/15 104/1 104/6 104/13 104/14 106/3 106/12 107/2 107/9 109/7 109/9 110/11 111/7 112/12 113/15 114/19 116/3 116/15 118/17 119/9 126/15 126/22 126/24 126/24 127/4 127/5 127/9 128/16 128/24 129/1 129/13 129/15 129/17 130/12 131/22 134/13 135/24 137/10 138/2 140/6 142/24 144/12 144/13 144/20 146/9 146/22 148/5 148/23 148/25 149/12 153/20 154/16 157/5 157/22 158/3 159/8 163/23 163/23 163/24 164/20 165/12 165/19 166/19 167/16 168/8 170/6 171/8 171/12 171/19 171/24 172/1 172/11 173/24 174/2 174/13 175/7 176/12 176/16 176/18 176/20 177/3 177/5 177/15 178/1 178/6 178/10 178/14 179/11 180/12 181/6 182/10 182/21 183/2 183/11 183/22 184/2 184/6 184/12 186/9 186/22 187/17 188/1 191/16 191/16 193/25 195/21 196/24 197/21 198/18	177/7 he [15] 2/25 20/23 21/7 21/15 33/9 48/20 69/18 70/5 76/3 76/4 86/6 102/11 104/24 166/18 195/14 Heading [1] 89/3 heads [1] 194/15 headset [1] 112/21 health [130] 7/17 7/23 9/3 9/6 9/18 9/21 10/20 10/23 10/23 11/2 11/20 17/9 17/16 17/23 18/3 18/6 18/8 18/10 18/15 19/5 19/9 20/17 20/19 22/23 23/2 23/12 23/13 24/3 24/13 24/13 24/25 27/23 29/15 29/17 31/8 31/11 31/19 34/6 34/20 35/1 35/2 35/8 35/10 36/4 36/12 39/4 40/14 40/23 42/2 48/20 51/6 51/18 52/9 54/16 54/19 54/19 54/22 57/20 63/16 65/23 67/6 67/8 68/9 71/14 73/15 75/18 76/8 77/11 77/12 77/22 81/18 82/7 86/1 86/2 86/9 86/11 86/22 93/8 94/10 94/13 97/3 98/5 102/9 104/23 105/2 105/7 106/8 110/10 117/24 120/15 121/1 122/5 124/17 132/17 137/16 141/24 151/17 151/19 151/22 151/25 151/25 152/14 152/25 153/24 154/1 154/18 154/23 155/6 157/19 158/9 164/17 169/3 169/16 169/20 179/5 179/8 180/6 180/9 181/1 181/21 186/16 190/20 191/1 191/3 191/14 192/18 193/14 195/24 196/9 196/20 healthcare [8] 36/14 41/22 108/23 109/13 162/23 164/24 165/21 165/25 Heaney [1] 125/9 hear [18] 3/25 9/24 10/1 10/24 11/17 15/22 16/16 18/5 25/14 27/11 98/23 145/19 146/1 158/21 160/13 161/24 189/19 197/10 heard [30] 4/3 6/8 6/25 8/15 11/15 16/15 17/7 18/2 18/19 24/21	25/5 27/9 28/5 28/13 31/4 67/16 68/18 75/24 90/14 90/18 101/9 103/14 104/11 158/18 161/22 164/12 181/24 183/12 190/23 197/21 hearing [12] 1/9 2/18 3/5 3/11 3/12 10/18 26/12 26/12 91/12 91/19 102/15 198/24 hearings [8] 1/11 1/13 1/20 2/4 4/14 19/16 19/22 162/13 heart [1] 75/12 heartfelt [1] 7/25 heavily [2] 88/3 137/7 heavy [2] 113/8 114/11 heed [2] 29/10 107/13 held [11] 23/16 43/8 45/9 49/24 56/9 57/5 58/23 70/2 70/8 141/17 152/6 help [8] 75/21 118/25 120/16 120/17 130/5 144/19 179/9 192/18 helped [1] 120/19 helpful [2] 54/3 128/9 Henderson [4] 25/7 25/11 25/20 71/4 her [12] 76/5 83/11 115/19 115/24 128/19 138/3 143/11 147/11 147/14 152/9 158/20 159/19 Her Majesty's [1] 76/5 here [17] 1/9 1/16 1/17 2/14 2/17 4/12 6/5 16/20 25/13 26/16 27/18 73/3 73/14 133/18 142/1 155/20 156/11 here' [1] 116/8 heroism [1] 98/4 heterosexual [1] 22/23 hide [1] 100/18 hierarchy [1] 143/17 high [20] 7/12 8/8 13/19 32/10 41/19 42/20 47/15 49/13 55/23 55/25 79/10 88/21 89/11 89/22 96/13 109/25 119/18 123/17 124/18 146/5 high-consequence [1] 8/8 higher [16] 12/22 15/6 21/7 22/4 41/15 42/13 45/7 52/7 81/14
Gwent [2] 18/13 77/24 Gymru [1] 99/6 gyms [1] 80/1	handful [1] 31/9 handling [1] 17/5 haphazard [1] 103/10 happen [1] 138/2 happened [5] 12/20 142/1 159/8 179/12 180/20 happening [2] 100/4 144/4 harbouring [1] 32/14 hard [5] 49/19 93/19 99/23 131/9 163/25 harder [1] 8/17 hardest [1] 87/24 hardship [2] 7/25 8/23 harm [22] 4/24 4/24 110/25 114/5 115/9 116/21 117/15 117/20 118/15 119/2 119/4 119/10 119/10 119/15 121/19 121/21 121/24 126/9 126/10 127/1 127/2 127/13 harmed [2] 9/4 135/20 harmful [1] 99/21 harms [7] 27/13 79/11 79/19 119/7 122/8 122/10 122/11 harnessed [1] 177/3 harrowing [1] 116/21 Hart [1] 65/25 has [71] 2/9 2/21 4/3 6/21 11/12 11/15 15/4 16/11 22/7 28/6 29/1 34/9 51/21 72/24 76/10 76/13 78/3 78/6 79/9 84/7 90/14 90/17 92/1 92/12 92/17 99/20 100/10 100/12 100/14 102/19 103/20 104/20 113/3 113/10 114/6 114/14 117/9 124/8 133/6 133/13 134/18 134/22 139/7 142/8 142/19 144/2 145/18 146/21 148/17 148/24 149/11 155/10 160/6 163/22 164/12 166/7 168/5 168/6 169/2 172/3 172/25 183/1 186/10 186/10 190/6 191/3 194/9 195/18 196/16 197/8 198/6 have [195] 1/6 1/13 2/7 2/18 8/9 8/15 8/20 11/23 12/9 12/19 13/3 14/1 14/20 15/17 15/21 16/21 16/22	18/9 20/18 21/19 22/4 23/5 23/6 24/5 24/14 27/8 29/10 29/18 29/20 29/24 30/4 30/13 31/16 32/14 33/10 33/20 40/6 40/11 41/10 42/15 44/6 44/19 45/17 46/20 49/3 49/7 50/24 53/19 54/14 57/1 57/3 57/10 58/22 59/21 61/18 62/23 63/5 64/19 65/6 66/17 69/20 71/22 72/21 75/25 76/4 76/24 78/12 78/22 82/18 83/6 83/8 88/8 88/19 92/13 92/20 96/12 96/14 96/17 96/22 97/6 99/18 101/8 101/13 101/25 102/2 103/14 103/15 104/1 104/6 104/13 104/14 106/3 106/12 107/2 107/9 109/7 109/9 110/11 111/7 112/12 113/15 114/19 116/3 116/15 118/17 119/9 126/15 126/22 126/24 126/24 127/4 127/5 127/9 128/16 128/24 129/1 129/13 129/15 129/17 130/12 131/22 134/13 135/24 137/10 138/2 140/6 142/24 144/12 144/13 144/20 146/9 146/22 148/5 148/23 148/25 149/12 153/20 154/16 157/5 157/22 158/3 159/8 163/23 163/23 163/24 164/20 165/12 165/19 166/19 167/16 168/8 170/6 171/8 171/12 171/19 171/24 172/1 172/11 173/24 174/2 174/13 175/7 176/12 176/16 176/18 176/20 177/3 177/5 177/15 178/1 178/6 178/10 178/14 179/11 180/12 181/6 182/10 182/21 183/2 183/11 183/22 184/2 184/6 184/12 186/9 186/22 187/17 188/1 191/16 191/16 193/25 195/21 196/24 197/21 198/18 have the [1] 12/9 haven't [1] 30/11 having [12] 6/11 12/24 28/12 37/18 46/5 72/12 90/9 95/15 148/14 169/21 176/3	25/5 27/9 28/5 28/13 31/4 67/16 68/18 75/24 90/14 90/18 101/9 103/14 104/11 158/18 161/22 164/12 181/24 183/12 190/23 197/21 hearing [12] 1/9 2/18 3/5 3/11 3/12 10/18 26/12 26/12 91/12 91/19 102/15 198/24 hearings [8] 1/11 1/13 1/20 2/4 4/14 19/16 19/22 162/13 heart [1] 75/12 heartfelt [1] 7/25 heavily [2] 88/3 137/7 heavy [2] 113/8 114/11 heed [2] 29/10 107/13 held [11] 23/16 43/8 45/9 49/24 56/9 57/5 58/23 70/2 70/8 141/17 152/6 help [8] 75/21 118/25 120/16 120/17 130/5 144/19 179/9 192/18 helped [1] 120/19 helpful [2] 54/3 128/9 Henderson [4] 25/7 25/11 25/20 71/4 her [12] 76/5 83/11 115/19 115/24 128/19 138/3 143/11 147/11 147/14 152/9 158/20 159/19 Her Majesty's [1] 76/5 here [17] 1/9 1/16 1/17 2/14 2/17 4/12 6/5 16/20 25/13 26/16 27/18 73/3 73/14 133/18 142/1 155/20 156/11 here' [1] 116/8 heroism [1] 98/4 heterosexual [1] 22/23 hide [1] 100/18 hierarchy [1] 143/17 high [20] 7/12 8/8 13/19 32/10 41/19 42/20 47/15 49/13 55/23 55/25 79/10 88/21 89/11 89/22 96/13 109/25 119/18 123/17 124/18 146/5 high-consequence [1] 8/8 higher [16] 12/22 15/6 21/7 22/4 41/15 42/13 45/7 52/7 81/14	
had [141] 1/22 5/11 5/14 5/18 5/25 10/15 10/15 12/20 15/5 16/21 17/20 17/20 21/12 24/3 26/6 26/20 29/12 29/23 30/2 31/14 32/2 32/4 32/4 32/5 32/6 32/22 33/3 33/9 35/7 38/18 39/8 39/16 40/7 41/25 41/25 45/14 45/20 46/3 46/9 48/20 49/19 50/15 50/17 52/21 53/5 56/23 57/8 57/16 58/15 60/17 61/15 62/21 63/10 63/11 63/22 70/11 70/17 71/2 76/3 76/17 80/7 80/12 81/16 81/17 82/19 82/21 86/6 87/19 88/7 88/11 89/12 89/13 89/16 90/4 92/25 95/2 96/23 102/6 107/15 108/8 109/2 109/2 109/3 109/25 112/4 116/9 120/22 120/25 121/5 125/16 125/24 125/25 126/17 132/3 133/15 133/16 133/19 134/7 134/19 135/21 137/16 141/14 141/18 147/20 147/21 150/2 150/16 151/1 151/5 151/10 153/22 155/25 157/1 157/3 159/17 162/8 164/3 164/8 164/10 164/15 167/22 175/3 175/9 175/9 175/11 175/15 176/18 177/6 177/25 178/19 179/20 179/22 181/19 182/11 184/4 184/7 188/12 188/14 190/18 192/13 198/13 hadn't [1] 116/24 Hale [4] 25/8 25/21 26/1 26/5 half [6] 18/18 58/25 71/2 78/20 78/22 79/8 half term [3] 78/20 78/22 79/8 hampered [1] 160/2 Hancock [2] 35/11 36/1 hand [6] 40/21 67/21	101/3 126/25 127/1 138/13 handful [1] 31/9 handling [1] 17/5 haphazard [1] 103/10 happen [1] 138/2 happened [5] 12/20 142/1 159/8 179/12 180/20 happening [2] 100/4 144/4 harbouring [1] 32/14 hard [5] 49/19 93/19 99/23 131/9 163/25 harder [1] 8/17 hardest [1] 87/24 hardship [2] 7/25 8/23 harm [22] 4/24 4/24 110/25 114/5 115/9 116/21 117/15 117/20 118/15 119/2 119/4 119/10 119/10 119/15 121/19 121/21 121/24 126/9 126/10 127/1 127/2 127/13 harmed [2] 9/4 135/20 harmful [1] 99/21 harms [7] 27/13 79/11 79/19 119/7 122/8 122/10 122/11 harnessed [1] 177/3 harrowing [1] 116/21 Hart [1] 65/25 has [71] 2/9 2/21 4/3 6/21 11/12 11/15 15/4 16/11 22/7 28/6 29/1 34/9 51/21 72/24 76/10 76/13 78/3 78/6 79/9 84/7 90/14 90/17 92/1 92/12 92/17 99/20 100/10 100/12 100/14 102/19 103/20 104/20 113/3 113/10 114/6 114/14 117/9 124/8 133/6 133/13 134/18 134/22 139/7 142/8 142/19 144/2 145/18 146/21 148/17 148/24 149/11 155/10 160/6 163/22 164/12 166/7 168/5 168/6 169/2 172/3 172/25 183/1 186/10 186/10 190/6 191/3 194/9 195/18 196/16 197/8 198/6 have [195] 1/6 1/13 2/7 2/18 8/9 8/15 8/20 11/23 12/9 12/19 13/3 14/1 14/20 15/17 15/21 16/21 16/22	18/9 20/18 21/19 22/4 23/5 23/6 24/5 24/14 27/8 29/10 29/18 29/20 29/24 30/4 30/13 31/16 32/14 33/10 33/20 40/6 40/11 41/10 42/15 44/6 44/19 45/17 46/20 49/3 49/7 50/24 53/19 54/14 57/1 57/3 57/10 58/22 59/21 61/18 62/23 63/5 64/19 65/6 66/17 69/20 71/22 72/21 75/25 76/4 76/24 78/12 78/22 82/18 83/6 83/8 88/8 88/19 92/13 92/20 96/12 96/14 96/17 96/22 97/6 99/18 101/8 101/13 101/25 102/2 103/14 103/15 104/1 104/6 104/13 104/14 106/3 106/12 107/2 107/9 109/7 109/9 110/11 111/7 112/12 113/15 114/19 116/3 116/15 118/17 119/9 126/15 126/22 126/24 126/24 127/4 127/5 127/9 128/16 128/24 129/1 129/13 129/15 129/17 130/12 131/22 134/13 135/24 137/10 138/2 140/6 142/24 144/12 144/13 144/20 146/9 146/22 148/5 148/23 148/25 149/12 153/20 154/16 157/5 157/22 158/3 159/8 163/23 163/23 163/24 164/20 165/12 165/19 166/19 167/16 168/8 170/6 171/8 171/12 171/19 171/24 172/1 172/11 173/24 174/2 174/13 175/7 176/12 176/16 176/18 176/20 177/3 177/5 177/15 178/1 178/6 178/10 178/14 179/11 180/12 181/6 182/10 182/21 183/2 183/11 183/22 184/2 184/6 184/12 186/9 186/22 187/17 188/1 191/16 191/16 193/25 195/21 196/24 197/21 198/18 have the [1] 12/9 haven't [1] 30/11 having [12] 6/11 12/24 28/12 37/18 46/5 72/12 90/9 95/15 148/14 169/21 176/3	25/5 27/9 28/5 28/13 31/4 67/16 68/18 75/24 90/14 90/18 101/9 103/14 104/11 158/18 161/22 164/12 181/24 183/12 190/23 197/21 hearing [12] 1/9 2/18 3/5 3/11 3/12 10/18 26/12 26/12 91/12 91/19 102/15 198/24 hearings [8] 1/11 1/13 1/20 2/4 4/14 19/16 19/22 162/13 heart [1] 75/12 heartfelt [1] 7/25 heavily [2] 88/3 137/7 heavy [2] 113/8 114/11 heed [2] 29/10 107/13 held [11] 23/16 43/8 45/9 49/24 56/9 57/5 58/23 70/2 70/8 141/17 152/6 help [8] 75/21 118/25 120/16 120/17 130/5 144/19 179/9 192/18 helped [1] 120/19 helpful [2] 54/3 128/9 Henderson [4] 25/7 25/11 25/20 71/4 her [12] 76/5 83/11 115/19 115/24 128/19 138/3 143/11 147/11 147/14 152/9 158/20 159/19 Her Majesty's [1] 76/5 here [17] 1/9 1/16 1/17 2/14 2/17 4/12 6/5 16/20 25/13 26/16 27/18 73/3 73/14 133/18 142/1 155/20 156/11 here' [1] 116/8 heroism [1] 98/4 heterosexual [1] 22/23 hide [1] 100/18 hierarchy [1] 143/17 high [20] 7/12 8/8 13/19 32/10 41/19 42/20 47/15 49/13 55/23 55/25 79/10 88/21 89/11 89/22 96/13 109/25 119/18 123/17 124/18 146/5 high-consequence [1] 8/8 higher [16] 12/22 15/6 21/7 22/4 41/15 42/13 45/7 52/7 81/14	

H	homes [29] 21/3 21/6 21/8 58/12 58/15 77/14 101/6 107/17 107/21 107/24 108/4 108/11 117/22 119/22 119/24 123/15 124/1 125/10 125/13 136/1 141/8 141/11 152/11 152/16 155/7 155/8 157/20 178/2 180/10	147/15 148/10 148/22 148/24 151/10 153/24 154/1 154/22 159/13 160/8 160/17 160/20 163/13 163/15 168/9 173/23 174/19 176/10 179/6 181/10 181/18 188/12 189/10	I finish [1] 184/14 I first [1] 105/1 I have [2] 116/3 198/18 I hope [1] 30/22 I introduce [1] 9/16 I know [2] 1/12 1/21 I make [1] 176/24 I must [3] 10/12 112/20 175/17 I need [1] 179/1 I note [1] 107/10 I now [2] 11/21 95/16 I planned [1] 145/2 I propose [5] 16/14 20/1 26/23 28/14 90/11 I repeat [1] 197/5 I represent [2] 115/16 173/16 I said [1] 3/12 I shall [5] 3/4 30/16 98/22 198/16 198/17 I start [1] 117/3 I suspect [1] 30/10 I think [7] 22/3 78/7 104/25 164/1 185/10 197/24 198/10 I turn [9] 148/3 151/17 153/1 155/13 157/8 158/17 159/15 193/23 196/14 I want [4] 73/10 181/5 183/6 186/2 I was [2] 30/9 30/21 I will [4] 11/5 16/10 48/12 186/7 I wish [1] 175/1 I would [2] 161/5 186/12 I'd [3] 115/18 117/13 118/20 I'll [2] 121/21 160/25 I'm [9] 1/15 16/18 30/21 30/22 112/20 131/5 160/22 161/4 198/8 I'm afraid [1] 30/22 I've [10] 10/11 16/6 27/25 91/1 92/23 110/22 126/2 130/7 164/3 197/21 Ian [1] 15/23 ICU [2] 13/21 85/11 ideal [1] 1/12 identified [8] 17/17 21/2 21/13 23/5 27/20 95/16 116/24 196/25 identifies [2] 15/1 94/19 identify [7] 55/21 104/4 113/12 114/15 120/18 124/23 126/14 identifying [1] 126/1	ie [1] 33/19 if [65] 2/15 2/17 3/4 4/18 8/2 21/4 30/21 30/25 33/20 41/7 41/10 41/19 42/15 42/16 42/20 42/23 44/6 44/22 47/17 50/8 52/25 54/2 55/24 59/21 60/6 63/22 64/19 65/6 72/21 72/22 73/8 75/15 76/25 78/25 79/17 80/17 82/23 83/8 84/24 85/23 95/7 96/22 104/5 109/16 112/4 112/4 116/6 130/6 133/19 133/21 138/3 141/20 142/22 148/25 149/11 153/23 153/25 163/24 166/1 166/5 166/7 172/5 172/9 175/23 198/19 ignored [2] 109/22 123/3 ill [3] 32/4 95/24 173/21 ill-judged [1] 95/24 illness [3] 22/14 32/2 130/15 illustrate [3] 117/12 118/2 127/11 illustrated [3] 83/17 119/13 194/25 illustrates [2] 125/4 154/22 imbalance [1] 134/11 immediate [4] 60/13 79/22 83/6 86/25 immediately [2] 86/23 192/17 imminent [1] 49/2 imminently [1] 104/19 immune [1] 38/17 impact [64] 2/9 2/11 2/16 2/21 3/8 7/19 10/1 10/16 16/9 17/21 22/17 24/12 26/24 27/2 27/8 28/5 28/7 28/8 43/10 43/22 45/17 45/19 46/21 54/15 54/24 62/6 63/22 76/17 78/5 78/23 79/1 91/18 94/15 97/4 97/14 103/15 104/6 117/7 120/25 130/11 146/10 147/15 149/3 150/21 162/17 163/1 165/22 170/16 170/17 176/20 177/7 177/22 183/25 184/7 184/8 184/9 190/25 191/20 191/21 191/24 192/4 192/12
higher... [7] 85/2 87/18 118/13 169/14 192/19 193/12 193/16	Hong [1] 46/4 Hong Kong [1] 46/4 hope [6] 30/22 98/16 110/6 127/25 129/18 130/9 hoped [2] 1/22 151/15 horrendous [1] 7/25 horrors [1] 162/18 horse [1] 70/1 hospital [20] 13/5 13/8 13/11 52/4 54/25 58/9 58/12 59/12 60/19 64/17 64/21 80/25 81/4 81/11 85/11 87/15 107/17 107/21 108/25 164/24 hospitalisation [3] 50/25 51/2 51/23 hospitalisations [4] 52/2 78/24 79/10 80/11 hospitalised [4] 13/19 32/3 50/6 55/20 hospitality [6] 63/13 64/1 64/9 75/23 85/8 151/9 hospitals [6] 58/1 101/6 117/23 118/14 123/18 178/14 hot [1] 30/25 hotel [1] 1/16 hotline [1] 168/17 hour [1] 30/12 hours [1] 153/14 House [1] 116/9 household [4] 36/14 46/15 60/8 60/22 households [5] 74/3 74/4 74/8 79/25 84/17 houses [1] 84/17 housing [1] 22/13 how [62] 3/21 3/22 7/21 7/21 9/18 13/4 13/16 17/20 17/24 43/20 48/3 48/4 48/5 62/8 62/18 63/5 65/3 66/20 73/13 74/2 74/2 91/24 92/15 93/19 94/9 94/20 95/11 95/22 96/22 102/15 116/5 131/11 134/21 138/17 140/10 141/18 144/10 145/20 146/21	HSSG [1] 59/22 Hubei [1] 39/9 huge [1] 14/16 hugely [1] 75/16 human [36] 32/6 32/6 32/8 32/8 32/20 32/20 34/11 34/11 34/15 34/15 35/20 35/20 36/16 36/16 38/9 38/9 38/18 38/18 47/14 47/14 116/5 116/17 130/17 130/23 134/14 134/20 142/22 144/21 145/16 146/6 146/7 146/14 146/16 153/15 158/6 162/19 humanist [1] 133/5 humanitarian [2] 146/6 146/13 humanities [1] 133/4 humanity [1] 135/16 hundreds [1] 92/1 husband [4] 115/20 115/25 116/2 116/7 Hutt [5] 91/15 136/9 137/19 138/1 139/21 hygiene [2] 40/21 41/4	I I apologise [1] 148/7 I appear [2] 99/7 145/6 I be [1] 160/24 I can [2] 1/24 116/2 I can't [1] 30/16 I commented [1] 197/24 I conclude [1] 183/6 I did [1] 197/22 I do [1] 25/13 I emphasise [1] 180/21	

I	imposing [2] 77/21 110/1	77/9 80/8 86/4 120/2 170/9	170/14 191/2 191/4	190/12 191/10 193/18
impact... [2] 192/15 193/14	imposition [4] 9/22 59/19 67/13 84/23	increased [14] 12/18 22/13 22/15 23/1 23/18 89/25 111/4 120/8 127/8 153/2 164/6 164/22 167/5 176/22	inequality [2] 23/22 144/16	infrastructure [2] 141/2 144/15
impacted [4] 3/3 4/8 112/16 154/8	impossible [1] 128/22	impression [3] 69/21 163/22 194/18	inevitable [4] 8/7 67/22 97/7 172/16	inherent [1] 139/10
impacting [2] 100/23 189/10	improve [3] 18/25 169/10 181/14	improved [2] 93/22 168/10	inevitably [4] 114/4 115/8 154/14 191/21	inherently [1] 154/24
impacts [15] 9/13 19/5 23/16 23/19 24/7 27/4 27/16 27/21 41/7 75/17 75/18 168/24 170/18 184/5 186/15	improvement [2] 24/4 173/4	improving [1] 18/21	inexplicable [1] 124/20	initial [8] 13/22 60/1 65/7 104/17 150/9 157/1 157/4 157/6
impairment [1] 139/11	inadequate [5] 101/7 105/23 128/6 169/15 173/22	inalienable [1] 165/24	infect [3] 38/16 44/3 44/4	initially [7] 69/7 77/10 139/17 156/19 174/8 176/17 184/21
impede [1] 150/23	inappropriate [1] 121/20	incalculable [1] 7/24	infected [13] 14/24 15/2 15/5 15/14 15/18 15/21 42/10 46/7 46/9 47/20 50/23 58/18 123/14	initiative [1] 179/4
imperative [2] 135/17 192/2	incentivising [1] 95/12	incentivising [1] 95/12	infection [25] 7/11 8/22 14/21 16/2 21/5 21/9 21/17 23/7 36/13 39/6 43/11 49/22 51/22 54/13 58/16 61/19 76/17 80/25 81/3 85/18 85/23 86/15 88/16 90/5 123/13	initiatives [1] 179/11
imperatives [1] 171/20	incidence [6] 80/5 80/25 81/3 81/13 85/2 196/6	incidence [6] 80/5 80/25 81/3 81/13 85/2 196/6	infection-related [1] 54/13	injury [1] 7/24
Imperial [6] 32/13 34/13 35/17 41/3 42/6 46/12	incident [2] 40/14 54/18	incident [2] 40/14 54/18	infections [16] 14/2 14/13 16/2 36/14 42/8 50/7 59/1 59/4 60/16 79/4 80/10 81/13 84/25 85/18 89/12 152/15	inmates [1] 153/13
Imperial College [4] 32/13 34/13 42/6 46/12	incidents [2] 49/21 168/18	incidents [2] 49/21 168/18	infectious [9] 8/8 32/10 34/1 34/4 41/20 42/21 108/3 124/18 164/22	input [10] 50/17 70/13 71/23 113/16 114/19 117/17 123/1 140/20 167/20 184/1
Imperial College's [1] 35/17	inclination [1] 76/11	inclination [1] 76/11	inflammation [1] 127/14	INQ000074895 [1] 41/10
implement [5] 71/25 83/1 83/12 193/6 193/9	include [6] 10/22 43/5 60/11 127/22 129/22 146/20	include [6] 10/22 43/5 60/11 127/22 129/22 146/20	inflexible [1] 127/14	INQ000090562 [1] 72/21
implementation [2] 51/10 61/4	included [6] 17/15 23/11 57/23 78/12 90/18 169/17	included [6] 17/15 23/11 57/23 78/12 90/18 169/17	influence [3] 29/20 152/4 174/16	INQ000237386 [1] 42/15
implemented [7] 60/21 79/17 81/3 82/23 192/17 192/20 195/5	includes [4] 2/4 2/5 146/11 151/3	includes [4] 2/4 2/5 146/11 151/3	influenced [2] 170/6 181/19	INQ000271613 [1] 53/19
implementing [5] 60/8 67/23 78/19 82/24 153/4	including [34] 5/2 11/18 17/8 20/6 35/4 37/25 41/3 52/12 60/17 60/21 67/17 79/23 84/6 87/12 92/3 92/4 94/3 104/8 106/7 109/11 120/7 123/5 141/23 142/4 146/7 153/13 170/18 171/1 172/23 174/23 177/7 189/19 190/14 194/4	including [34] 5/2 11/18 17/8 20/6 35/4 37/25 41/3 52/12 60/17 60/21 67/17 79/23 84/6 87/12 92/3 92/4 94/3 104/8 106/7 109/11 120/7 123/5 141/23 142/4 146/7 153/13 170/18 171/1 172/23 174/23 177/7 189/19 190/14 194/4	influenza [4] 17/15 38/5 44/4 95/3	INQ000299062 [1] 64/19
implications [2] 71/8 102/25	inclusive [1] 136/14	inclusive [1] 136/14	influx [2] 58/17 123/14	INQ000309706 [1] 33/21
implied [2] 32/7 35/21	inclusivity [1] 142/9	inclusivity [1] 142/9	inform [6] 73/16 73/16 156/22 159/18 174/16 180/16	INQ000309816 [1] 59/21
importance [11] 9/15 30/1 33/16 37/5 69/2 92/22 128/19 151/6 151/14 185/22 193/15	income [1] 144/14	income [1] 144/14	informal [10] 91/23 92/13 92/19 101/11 101/16 102/16 102/18 103/10 193/24 194/7	INQ000320721 [1] 44/6
important [24] 5/17 10/13 13/15 17/18 18/4 62/22 68/7 76/18 100/7 111/20 117/7 130/8 130/10 130/14 141/12 142/5 145/23 147/21 157/12 162/18 166/15 169/12 179/4 190/8	incomes [1] 169/14	incomes [1] 169/14	information [20] 4/19 27/15 29/5 29/11 40/19 44/13 44/16 47/24 70/11 73/13 86/9 86/10 122/3 122/12 122/19 125/7 125/16 160/5 174/9 181/13	INQ000412042 [1] 11/23
importantly [2] 123/3 189/16	incomplete [1] 133/13	incomplete [1] 133/13	informed [10] 5/5 37/20 44/20 82/5 86/19 87/10 178/21	inquiry [107] 1/16 1/22 1/24 2/9 2/22 3/14 3/16 4/3 4/5 4/14 4/22 5/7 5/20 5/22 7/21 8/22 11/12 16/11 16/15 16/21 16/25 27/6 27/9 28/6 29/1 56/25 58/22 63/3 76/9 78/3 78/6 83/2 90/14 91/13 92/1 92/10 92/12 92/14 92/17 92/19 94/9 95/17 95/19 96/18 97/19 97/22 98/15 100/1 100/12 100/14 100/20 103/4 103/16 104/11 106/14 106/21 109/4 111/8 111/11 113/18 113/22 113/24 114/22 115/1 115/3 117/4 124/12 131/21 131/24 135/13 138/17 141/10 142/4 143/21 143/25 144/7 144/19 145/10 145/11 145/19 146/4 151/16 152/24 156/7 158/13 159/13 160/8
impose [3] 49/3 86/12 95/5	inconsistent [2] 158/6 182/18	inconsistent [2] 158/6 182/18		
imposed [5] 83/17 119/11 120/5 126/12 184/15	incorporated [1] 148/9	incorporated [1] 148/9		
	increase [10] 47/11 47/17 55/7 63/11 77/5	increase [10] 47/11 47/17 55/7 63/11 77/5		

I	94/4 173/17 188/17 193/22	195/7	167/15 169/12 169/23 171/14 180/22 181/8 183/9	174/13 174/21 175/25 176/3 177/7 177/13 182/2 185/15 185/22 187/23 187/23 189/4 190/9 190/10 192/9 192/16 193/6 193/7 194/11 197/4
inquiry... [20] 160/19 161/22 161/24 162/13 164/12 165/13 173/16 173/23 183/12 186/18 186/24 187/21 190/25 194/1 197/3 197/7 197/9 197/14 198/12 199/6	interface [1] 103/16	introduced [10] 75/20 79/8 80/20 85/13 110/8 136/2 168/14 170/3 170/4 183/3	issue-specific [1] 167/15	itself [11] 24/11 30/5 100/11 120/22 125/1 133/20 140/7 144/2 144/11 146/8 148/23
Inquiry's [6] 27/7 91/21 100/24 185/15 187/9 196/22	intergovernmental [8] 6/19 6/24 111/18 135/7 135/18 183/12 194/11 196/17	introducing [1] 85/7	issued [12] 31/11 31/19 35/6 37/1 37/5 52/20 55/23 107/25 140/3 151/19 152/14 153/11	J
insight [3] 97/7 183/23 184/17	internal [1] 172/15	introduction [5] 11/21 60/12 65/10 79/22 170/10	issues [39] 2/1 2/23 4/10 59/7 66/19 68/2 68/21 69/7 76/23 78/14 82/17 88/13 94/19 95/16 100/23 121/18 123/2 131/5 131/7 131/10 137/20 141/22 142/8 146/7 155/3 155/24 157/6 165/12 165/14 175/11 177/14 179/1 179/14 179/15 181/10 183/17 184/8 185/1 194/10	Jacobs [4] 161/4 161/7 173/11 199/22
insightful [1] 101/10	internally [1] 44/10	intubated [1] 13/13	it [300]	jagged [1] 153/3
insist [1] 67/21	international [8] 25/21 35/8 39/5 61/9 70/16 70/23 121/3 133/23	invaluable [1] 184/17	it's [16] 1/7 2/3 13/15 56/14 117/7 117/22 117/24 117/25 118/1 122/1 124/19 181/7 182/8 182/15 198/2 198/3	James [1] 20/4
insofar [2] 7/3 20/2	Internationally [1] 47/11	investigate [2] 1/25 100/22	Italy [8] 45/23 45/24 47/12 47/14 48/17 52/19 53/14 55/9	Jane [6] 91/15 102/7 136/9 137/19 138/1 139/21
inspection [2] 92/16 100/17	interpersonal [1] 46/17	investigation [2] 21/16 38/13	item [2] 59/25 60/7	Jane Hutt [5] 91/15 136/9 137/19 138/1 139/21
Inspectorate [1] 141/9	interpret [1] 178/24	investment [5] 180/18 180/24 181/8 181/20 183/11	item 3 [1] 59/25	January [54] 3/19 5/10 10/7 12/6 13/11 17/3 18/7 28/17 29/25 30/3 31/4 31/6 31/11 31/19 31/23 31/25 32/9 32/14 32/18 33/6 33/17 34/6 34/18 34/21 34/24 34/25 35/4 35/25 36/9 36/23 37/4 37/11 37/18 38/11 39/4 39/10 39/15 39/17 39/22 40/4 46/6 65/7 84/10 88/20 89/10 90/4 90/10 97/8 97/21 98/2 104/9 104/12 105/1 106/24
Inspectorate [1] 141/9	interpretation [1] 152/20	invite [3] 113/20 114/24 158/12	its [111] 1/24 2/13 3/16 7/11 7/22 7/23 7/23 8/3 9/14 11/6 17/21 26/8 28/23 28/23 28/24 29/16 32/18 35/6 49/3 49/12 53/5 53/11 53/11 55/18 58/8 61/15 62/6 62/10 65/3 65/4 69/2 70/19 70/24 72/2 75/6 75/21 76/10 77/3 78/10 88/12 91/9 93/6 93/8 95/2 95/18 96/1 96/3 99/17 99/18 100/5 100/5 100/15 100/22 101/14 102/22 103/3 103/14 106/18 108/13 109/22 111/15 113/11 113/16 114/14 114/20 122/11 133/17 133/21 134/4 134/6 135/21 136/1 136/6 137/5 138/20 138/22 138/23 138/23 140/18 141/10 142/5 142/18 143/13 146/21 156/23 156/24 161/16 162/8 167/22 173/25 174/3	Jane [6] 91/15 102/7 136/9 137/19 138/1 139/21
instance [3] 176/25 177/16 182/24	interpreted [3] 47/24 113/3 129/6	invited [6] 69/6 69/6 69/11 82/4 123/1 170/15	issuing [1] 152/2	January 2020 [10] 3/19 5/10 10/7 17/3 18/7 28/17 31/4 31/6 90/10 104/12
instances [1] 92/12	interpreters [1] 30/14	inviting [1] 135/9	January 2021 [1] 98/2	Japanese [1] 46/4
instead [6] 55/20 70/2 96/5 100/18 106/18 198/19	interrelationship [1] 7/2	invoked [1] 35/1	Jenny [3] 115/19 115/24 116/18	Jerk [1] 103/12
instigated [1] 65/11	interrupted [1] 120/21	involve [2] 135/17 177/19	job [5] 83/19 83/20 84/11 195/4 195/14	JMC [1] 69/16
instinctively [1] 76/7	interruptions [1] 120/6	involved [8] 23/17 26/20 88/9 91/3 153/16 155/17 157/1 178/1	jobs [3] 164/18 164/23 164/25	John [2] 122/4 163/1
instituted [1] 153/17	intersection [1] 164/13	Iran [1] 47/12	John's [13] 115/14 115/16 116/14 116/20 120/14 121/8 126/17 129/4 129/8 168/8 173/5 187/16 199/11	John's Campaign [11] 115/16 116/14 116/20 120/14 121/8
institution [2] 145/17 153/8	intersects [1] 3/23	Ireland [13] 14/22 15/9 25/12 30/7 72/6 73/24 74/5 74/12 74/19 87/8 131/23 188/1 198/1		
institutions [1] 152/17	intervention [2] 80/16 143/1	irrespective [1] 135/20		
instructed [2] 19/17 25/8	interventions [12] 9/15 53/18 54/3 60/13 61/1 80/13 105/13 106/2 106/6 110/14 183/4 196/12	is [282]		
instructions [1] 196/12	interviewed [1] 121/3	isn't [3] 122/12 179/18 180/21		
instructive [1] 198/15	into [59] 1/20 2/20 4/17 8/21 16/20 17/14 27/16 30/4 36/20 50/17 58/9 61/24 64/6 70/13 70/23 71/10 71/23 87/3 87/13 87/20 88/20 88/25 89/3 97/22 102/25 103/19 104/13 107/17 108/2 108/4 117/16 121/25 122/18 123/4 123/14 124/1 124/23 125/7 126/3 127/4 127/9 132/12 134/6 137/10 143/13 148/9 150/4 153/14 153/19 155/5 155/19 156/2 156/14 160/18 165/10 167/21 181/1 183/23 192/2	isolated [1] 127/7		
insufficient [4] 25/2 70/13 110/10 121/23	introduce [8] 9/16 52/25 82/11 83/22 86/11 143/9 168/19	isolate [4] 106/7 125/14 158/2 169/13		
insufficiently [1] 143/12		isolated [1] 127/7		
insular [1] 177/2		isolation [20] 6/8 33/14 41/19 42/19 45/12 46/14 46/15 51/11 51/11 51/12 54/14 55/24 59/5 60/21 95/13 120/22 121/4 125/9 169/17 169/22		
integrity [1] 138/22		issue [25] 9/11 9/15 17/18 44/14 51/13 56/25 57/1 58/22 62/6 63/21 75/17 94/18 109/5 121/23 123/9 140/2 152/11 166/12		
intellectual [1] 22/18				
intend [5] 25/13 27/22 48/1 96/19 195/8				
intended [3] 168/22 190/5 190/24				
intense [2] 168/25 193/25				
intensive [2] 60/4 80/12				
intent [1] 178/25				
interacted [1] 111/19				
interactions [1] 188/11				
interest [3] 88/16 193/25 194/2				
interests [5] 29/22				

J	Kate Bell [1] 161/23 Kate Bell's [1] 163/9 KC [8] 115/15 131/16 173/14 185/12 199/12 199/15 199/25 200/2 keep [6] 62/18 72/6 72/12 73/14 77/15 148/21 keeping [2] 62/21 116/8 Kent [1] 14/10 kept [4] 98/14 116/16 165/5 177/10 Keshav [1] 91/10 key [46] 4/7 4/10 5/2 5/24 6/17 7/2 10/18 10/23 16/12 16/14 26/15 26/17 26/22 27/21 28/12 28/15 29/1 29/21 44/15 54/17 67/1 90/9 90/12 91/2 92/5 92/9 93/10 95/15 96/6 98/13 106/4 113/16 114/20 116/16 123/15 129/23 145/18 146/15 148/1 155/19 165/6 175/16 177/19 179/16 181/8 182/2 key workers [2] 98/13 129/23 kick [1] 56/22 kick-off [1] 56/22 killed [1] 135/20 Kilpatrick [1] 44/8 kind [1] 69/22 King's [2] 2/22 123/11 King's Counsel [2] 2/22 123/11 Kingdom [4] 135/18 144/1 144/10 185/20 Kinnier [4] 185/10 185/12 197/18 200/2 Kirsty [2] 62/4 159/3 Kirsty Williams [2] 62/4 159/3 knee [1] 103/12 knew [5] 100/6 133/19 136/1 143/10 189/9 know [12] 1/12 1/21 86/1 92/14 92/19 93/19 95/9 111/21 116/2 130/23 131/8 187/7 knowing [3] 144/2 163/15 187/7 knowledge [12] 95/24 96/11 96/18 114/1 114/1 115/5 115/5 138/23 173/24 176/19 177/17 191/11 known [12] 11/8 11/9	22/21 23/15 24/18 53/9 58/24 109/8 124/6 124/7 124/11 177/6 knows [1] 1/23 Kong [1] 46/4 Korea [1] 47/12	127/6 178/22 186/7 188/9 188/12 lasted [1] 12/25 lasting [1] 163/22 lasts [1] 2/14 late [13] 11/7 12/7 30/21 62/19 73/18 77/5 77/7 82/20 89/2 104/11 122/9 136/4 149/17 later [37] 7/9 9/17 11/5 11/17 14/9 15/22 20/24 25/14 27/6 29/9 30/5 30/9 39/13 58/4 59/8 59/14 62/7 66/13 67/14 69/3 74/5 80/15 80/21 81/9 88/4 88/10 108/7 108/9 109/24 110/22 131/11 136/3 143/14 170/3 174/9 176/21 187/18 latest [3] 48/21 80/9 104/12 latter [2] 72/10 174/22 latterly [1] 69/8 laudable [1] 130/22 launched [3] 40/19 60/24 170/21 law [11] 25/15 25/16 133/23 134/16 134/17 135/5 140/16 148/9 173/1 191/4 191/16 lawmaking [1] 134/18 laws [3] 94/20 95/1 135/2 lawyers [1] 144/6 lay [1] 131/6 lead [14] 3/14 34/25 36/1 53/1 55/14 70/6 85/1 95/10 97/17 98/16 104/23 126/4 137/19 199/5 leaders [4] 71/18 72/5 184/24 189/25 leadership [6] 40/10 91/9 97/18 97/20 97/23 105/4 leaderships [1] 189/23 leading [7] 2/22 13/1 65/18 104/2 105/17 106/10 152/18 learn [7] 98/19 110/1 136/9 140/10 185/20 186/15 186/18 learned [3] 88/14 113/15 114/18 learning [5] 29/3 86/17 132/7 156/18 156/21 learnings [2] 113/12 114/16	learnt [4] 113/23 113/23 115/2 115/2 least [17] 18/17 27/6 32/20 36/13 41/15 58/17 61/22 81/21 88/11 122/21 123/13 132/8 141/17 142/18 164/15 164/16 171/23 leave [2] 2/18 3/5 leaving [1] 178/23 led [21] 13/18 22/16 47/22 63/19 68/20 75/1 83/18 105/11 119/14 121/13 127/14 131/19 136/22 137/16 138/2 145/10 152/19 160/6 179/10 183/2 195/3 Lee [1] 56/11 Lee Waters [1] 56/11 left [10] 3/22 7/23 28/17 46/5 84/25 137/25 163/22 163/23 180/12 186/10 legacy [1] 132/17 legal [4] 63/16 146/20 168/14 189/2 legislation [10] 67/8 95/8 134/24 135/5 147/2 152/12 153/4 156/7 157/15 180/23 legislative [1] 155/18 leisure [2] 64/1 164/10 length [2] 83/5 107/11 lengthy [1] 158/4 lens [2] 96/19 117/8 less [12] 8/25 18/10 22/11 41/21 41/22 53/2 95/6 122/10 130/14 130/14 151/10 165/3 lesson [2] 44/15 140/25 lessons [9] 113/14 113/22 113/23 114/18 115/1 115/2 140/10 185/20 186/18 let [2] 109/25 144/6 letter [7] 59/18 66/13 89/6 115/24 116/18 116/20 116/25 letters [5] 85/25 115/19 117/3 117/12 140/3 letting [1] 86/1 level [19] 7/12 21/7 28/21 34/7 35/3 71/14 85/4 85/22 86/23 86/25 87/3 87/21 88/23 90/2 90/15 96/13 103/21 112/5 178/6
K	Kate [2] 161/23 163/9			

L	limiting [1] 44/1	184/16 184/17 184/19	134/23	149/23 164/11 192/1
level 2 [1] 90/2	line [5] 12/15 12/17	184/21 185/2 189/22	Lord Chief [1] 134/22	majority [4] 14/12
level 3 [1] 85/4	98/6 156/15 187/19	199/24	Lord Thomas [1]	45/12 120/3 157/20
level 4 [6] 85/22	linkage [1] 139/14	locally [4] 45/22	134/23	make [29] 2/18 3/1
86/23 86/25 87/3	linked [2] 24/4	175/16 181/11 182/11	Lords [1] 116/9	5/18 29/18 57/20
87/21 88/23	122/17	lock [1] 88/18	losing [1] 39/2	68/14 68/15 73/12
leveler [1] 144/16	links [3] 3/22 48/17	lockdown [28] 45/23	loss [9] 8/14 8/16	75/8 82/25 94/5 95/8
levels [9] 37/6 54/24	78/10	49/4 50/2 52/19 59/17	8/20 114/5 115/9	95/16 95/21 107/21
61/19 79/10 81/1 81/5	list [4] 66/19 94/19	64/9 65/14 65/17	120/10 162/1 162/14	113/24 115/3 131/9
112/3 167/19 174/18	139/15 139/15	72/10 74/1 77/19	186/3	133/20 135/3 138/1
LGA [2] 189/20 190/2	listen [3] 112/21	78/15 78/19 78/21	losses [1] 186/7	138/11 150/6 150/18
LGBTQ [3] 22/20	116/13 160/14	82/15 82/18 83/1 87/4	lost [9] 2/6 69/2	167/12 175/3 176/24
22/22 23/3	listened [3] 121/10	87/14 88/1 88/17	99/11 104/9 106/2	185/19 195/13
liaising [1] 106/4	129/11 189/17	96/21 97/25 98/1	144/11 186/2 186/6	makers [17] 5/2
liaison [1] 136/15	listening [6] 27/7	110/1 116/5 177/24	186/9	10/19 29/21 58/7 88/3
libraries [1] 151/5	115/10 158/21 159/1	184/12	lot [2] 72/15 72/24	88/8 96/5 96/7 106/3
lie [1] 166/10	159/11 166/23	lockdowns [6] 9/1	loved [7] 113/20	107/8 117/16 117/19
lies [2] 9/16 140/14	lists [2] 165/20	10/10 61/7 67/16 78/6	114/24 121/15 186/2	118/18 119/3 121/24
life [16] 7/23 8/2 8/14	165/22	109/21	186/6 186/9 186/10	148/12 187/3
8/20 18/11 18/14	literally [1] 96/1	locked [4] 116/8	low [12] 34/7 34/7	making [69] 1/21
18/16 20/24 96/1 98/8	little [8] 67/14 70/9	122/23 136/23 142/10	34/10 61/16 64/22	3/18 6/4 10/12 10/14
114/5 115/9 121/15	72/13 119/7 130/4	Locked Out [3]	89/24 100/3 103/21	25/18 25/23 30/4 54/5
129/5 133/4 164/3	163/19 165/17 179/2	122/23 136/23 142/10	110/25 143/5 169/14	61/5 69/12 70/14
life-saving [1] 98/8	live [4] 22/12 113/20	lockstep [1] 30/6	171/5	71/18 91/22 91/24
lifetime [1] 186/7	114/24 186/13	Lodi [1] 45/25	lower [2] 12/24 85/21	92/8 94/23 96/14
lifted [3] 46/23 84/19	lived [2] 101/2	Lombardy [2] 45/23	lowest [1] 18/12	96/21 97/18 100/18
90/8	144/18	45/25	lunchtime [1] 56/22	100/21 102/20 109/14
lifting [2] 65/16	livelihoods [3]	London [7] 35/10	M	110/19 113/11 114/15
178/11	171/21 172/5 172/9	41/3 43/8 52/12 87/13	machine [1] 164/8	118/3 119/1 125/5
light [11] 19/6 88/20	lives [18] 2/6 4/16	175/10 175/24	machinery [3] 137/9	127/12 131/12 147/4
92/8 96/11 114/2	60/23 72/4 72/5 88/17	London-based [1]	138/12 138/14	147/12 147/23 148/22
115/6 117/19 121/20	98/5 99/11 112/13	175/10	made [51] 4/19 8/17	149/13 149/22 150/4
142/20 161/19 190/25	130/13 133/7 160/11	loneliness [1] 116/11	10/14 27/12 51/7 51/8	150/7 150/15 151/2
like [21] 22/23 90/18	171/20 171/24 172/5	long [13] 9/21 24/18	57/18 62/5 66/17	151/12 151/21 154/17
90/20 101/6 115/18	172/9 185/25 186/10	24/20 24/23 24/24	70/15 72/19 82/10	155/4 157/4 157/11
116/6 116/16 117/13	living [7] 21/2 21/6	25/1 25/3 30/24 63/5	83/13 96/10 99/22	159/12 159/18 161/20
118/20 134/20 135/9	21/9 21/10 72/16	79/1 126/13 138/12	101/1 102/19 109/24	162/3 162/7 163/13
135/21 137/9 138/3	111/4 141/25	177/2	110/20 110/22 113/5	165/17 167/20 171/11
138/19 138/24 141/3	Llandudno [1] 56/10	Long Covid [5] 24/18	113/18 114/2 114/8	174/16 178/13 185/16
154/18 157/24 167/22	Llanelli [1] 77/24	24/20 24/23 24/24	114/22 115/6 119/9	188/10 188/23 189/8
186/12	local [79] 17/9 18/9	25/3	125/24 126/1 126/15	189/8 190/8 191/18
likelihood [4] 22/14	37/6 67/16 71/16	long-standing [1]	127/17 135/22 139/13	193/18 194/8 194/12
45/3 45/7 108/15	71/18 71/21 71/22	138/12	140/22 141/3 141/6	male [1] 18/11
likely [30] 9/13 22/11	71/25 77/10 77/19	long-term [2] 9/21	142/25 154/12 159/22	man [1] 106/13
27/20 32/13 34/5	77/22 78/2 78/5 78/15	25/1	160/14 160/19 170/25	manage [5] 55/18
35/21 39/25 41/5	79/14 81/15 86/1	longer [2] 12/25	175/7 176/19 178/7	125/10 146/9 154/1
41/22 43/10 44/3	90/20 93/14 93/16	55/19	180/25 183/4 187/4	154/12
45/19 50/25 53/1	94/5 94/12 98/9	Longfield [1] 158/19	188/16 193/5 195/14	manageable [1]
53/23 54/1 54/13	113/13 114/17 126/7	longstanding [1]	Maelor [2] 54/25	155/22
54/15 89/12 97/4	127/24 137/17 138/7	20/17	60/19	managed [2] 6/5
97/10 116/11 132/8	138/20 138/21 154/8	look [15] 7/2 42/16	Maesteg [1] 140/3	153/21
146/9 164/21 169/19	157/1 168/6 173/13	50/16 59/25 67/14	magnitude [1] 45/16	management [14]
169/20 169/21 176/1	173/17 174/1 174/6	72/22 93/2 102/15	main [2] 70/3 127/21	6/1 6/12 6/15 16/13
191/12	174/11 175/25 176/3	122/14 131/1 135/13	maintain [4] 88/23	19/4 22/25 25/18
likened [1] 100/14	176/19 177/4 177/13	161/4 173/23 184/13	101/22 143/2 145/24	26/21 37/8 53/11 65/2
limitation [1] 195/17	177/16 177/20 178/6	185/7	maintained [3]	67/6 88/1 88/6
limitations [4] 14/8	178/18 178/19 179/9	looked [4] 1/15 29/1	116/25 123/24 156/9	managing [3] 27/17
65/5 83/16 196/7	179/12 179/17 179/19	132/23 192/14	maintaining [1]	152/15 179/13
limited [12] 20/10	179/24 180/5 180/6	looking [3] 4/22 17/4	180/1	mandating [2]
32/7 32/11 38/3 93/18	181/1 181/16 181/22	29/8	Majesty's [2] 76/5	109/12 110/25
101/15 101/25 123/1	182/1 182/21 182/24	looks [2] 74/10	83/11	manner [2] 74/11
143/1 153/20 157/24	183/9 183/20 183/21	173/19	major [8] 24/24 40/14	177/2
182/10	183/22 183/24 184/1	loom [1] 165/15	54/18 58/5 63/1	many [52] 7/8 8/18
	184/6 184/10 184/11	Lord [2] 134/22		8/24 13/4 13/16 15/21

M	match [8] 44/18 52/11 56/18 56/21 57/3 99/23 105/20 176/8 mate [1] 106/17 material [3] 44/10 101/13 101/14 Matt [1] 35/11 Matt Hancock [1] 35/11 matter [11] 17/24 39/18 59/7 67/7 73/20 92/23 108/20 148/19 151/25 152/23 187/19 matters [13] 7/8 8/6 19/24 26/20 27/7 62/24 96/1 135/14 153/2 156/2 158/11 161/11 177/14 mature [2] 172/18 185/3 maximise [1] 93/24 maximum [1] 62/2 may [60] 3/19 11/21 15/8 32/7 45/8 46/20 47/20 54/23 68/11 69/4 71/6 72/2 72/19 73/6 73/23 73/23 73/24 73/24 74/3 74/8 79/2 79/15 81/1 81/4 88/8 90/8 90/11 96/12 96/25 97/5 108/12 111/25 116/19 123/25 124/2 124/6 125/15 125/22 129/17 131/10 134/13 137/22 148/23 150/11 150/22 156/7 157/5 157/22 160/8 160/9 170/6 171/18 175/19 179/7 185/16 193/23 196/14 197/1 197/23 198/4 May 2020 [7] 15/8 68/11 111/25 124/2 124/6 125/15 179/7 May 2021 [1] 125/22 May 2022 [3] 3/19 90/8 90/11 maybe [1] 1/18 me [4] 1/23 26/16 30/25 181/25 meal [1] 151/3 mean [2] 197/25 198/6 meaning [2] 55/16 157/23 meaningful [6] 70/13 71/23 162/9 167/22 168/1 174/10 meaningfully [4] 113/11 114/14 167/24 172/22 means [8] 6/5 18/24 35/14 91/25 94/20	192/22 192/24 194/8 meant [10] 93/19 97/4 116/7 120/10 129/5 147/8 152/16 159/23 195/18 196/10 measure [10] 7/21 8/13 126/22 148/5 148/10 149/2 149/5 149/12 150/8 150/22 measured [1] 122/11 measures [38] 10/9 21/19 23/6 26/4 31/20 35/22 40/2 41/5 43/12 46/13 49/22 52/25 54/12 57/23 59/20 60/20 65/21 72/15 76/8 76/20 77/12 77/14 77/17 78/2 80/17 80/19 80/24 81/12 82/2 87/12 97/10 99/19 109/9 111/1 146/9 152/13 164/16 177/6 mechanical [2] 13/9 13/12 mechanism [1] 138/20 mechanisms [2] 28/24 102/24 media [4] 31/23 68/20 177/19 178/23 medical [23] 10/25 17/10 21/7 26/14 31/7 32/17 34/21 36/8 51/13 120/6 120/7 120/18 120/19 124/14 132/18 139/10 139/13 139/16 147/19 156/20 164/25 189/20 190/19 medication [1] 169/21 medicinal [1] 98/13 medicine [4] 38/11 41/4 98/10 120/20 medics [2] 64/23 98/6 meet [12] 53/22 69/4 69/18 74/2 74/4 74/6 81/7 111/25 155/11 178/15 182/18 194/20 meeting [36] 33/6 34/18 34/19 36/3 37/13 37/15 37/20 38/24 41/1 41/9 42/16 43/2 43/13 43/18 45/9 45/10 46/11 47/8 48/21 49/11 50/21 52/14 53/8 59/23 61/3 69/23 70/25 79/18 81/25 81/25 82/5 86/14 87/7 89/7 91/16 94/11 meetings [20] 62/14 68/22 69/7 69/11	69/14 69/25 70/2 70/5 70/8 71/15 74/7 111/22 135/10 136/9 151/25 159/6 166/18 184/23 190/22 194/15 Meirion [2] 115/20 115/25 Meirion Davies [1] 115/25 member [5] 107/19 108/23 116/9 163/10 193/19 members [12] 5/3 11/18 16/19 22/20 39/7 39/16 46/15 79/25 100/15 121/2 173/25 177/14 membership [1] 190/9 men [1] 18/18 Men's [2] 52/10 56/18 Mencap [1] 121/7 mental [6] 9/3 23/2 117/24 121/1 121/12 169/20 mention [2] 66/1 131/10 mentioned [9] 8/12 12/1 16/25 27/2 47/23 49/15 72/2 91/1 99/10 merely [2] 75/1 198/2 merits [2] 7/18 52/17 Merthyr [1] 77/23 Merthyr Tydfil [1] 77/23 message [4] 72/3 72/12 101/12 108/19 messages [14] 53/2 92/2 92/3 92/8 92/15 101/18 101/25 102/1 102/10 159/1 160/1 182/3 193/24 194/5 messaging [11] 68/10 72/7 73/5 91/24 92/2 109/11 111/15 111/15 147/10 159/16 160/10 met [19] 31/25 32/24 35/25 37/19 38/21 40/24 51/18 52/22 55/3 57/15 60/14 61/11 82/13 84/22 89/9 89/15 90/23 91/14 105/4 metre [5] 75/7 75/9 75/14 75/15 168/13 metres [1] 75/7 metric [1] 8/6 Michael [4] 18/3 70/3 78/4 122/6 Michael Gove [1] 70/3 mid [6] 82/22 105/21	122/23 125/24 135/12 136/8 mid-2020 [1] 125/24 mid-2021 [1] 122/23 mid-March [2] 105/21 136/8 mid-October 2020 [1] 135/12 mid-September [1] 82/22 middle [1] 38/19 midnight [2] 64/6 87/22 might [6] 4/5 16/20 29/24 30/3 138/2 153/24 migrant [1] 170/20 MIGs [2] 61/4 69/3 mild [1] 50/24 mile [1] 183/24 million [4] 15/18 24/19 50/5 161/14 mind [6] 111/12 148/14 148/15 177/10 198/16 198/17 minded [1] 56/3 mini [1] 69/22 minimal [1] 24/25 minimisation [2] 113/8 114/11 minimum [1] 158/2 mining [1] 132/15 minister [83] 5/3 10/19 10/21 17/8 17/8 36/4 36/24 39/21 45/10 49/10 49/11 49/13 49/15 49/18 52/13 52/15 52/16 52/23 53/17 55/4 56/8 56/12 60/15 62/4 63/25 64/5 65/11 65/25 66/7 66/8 66/14 67/18 68/14 68/19 70/7 71/14 72/19 72/23 73/9 78/1 81/24 82/1 82/4 82/14 83/23 84/1 84/7 87/2 87/6 87/10 87/23 89/5 89/5 89/6 91/5 92/4 102/8 102/9 106/11 106/15 111/24 115/20 115/25 132/25 136/10 137/19 137/22 137/24 143/16 159/3 167/6 171/23 185/24 186/20 187/10 193/11 194/13 194/17 195/9 195/12 196/2 196/16 197/11 Minister's [6] 49/14 64/13 65/20 76/3 101/20 190/21 ministerial [9] 40/24 43/7 43/17 61/3 65/10 69/11 81/23 86/24
----------	---	--	---	---

M	78/16 78/17 85/6 93/15 102/22 104/1 104/5 122/3 141/7 193/16	162/7 172/17 Module 2B [11] 1/21 3/15 3/21 6/3 10/13 20/3 25/9 99/15 172/17 188/2 199/6 Module 3 [1] 187/20 Module 6 [2] 157/10 187/20 module's [3] 6/13 27/21 185/22 modules [13] 4/3 7/9 19/18 25/9 28/13 131/7 140/25 154/16 161/22 187/18 188/20 197/3 197/22 Modules 1 [4] 4/3 28/13 161/22 197/3 Modules 2 [3] 19/18 25/9 188/20 moment [8] 30/10 107/3 116/4 121/22 134/2 175/6 178/22 183/7 moments [1] 8/1 Monday [4] 49/10 49/15 82/13 86/18 money [4] 83/8 179/14 180/21 195/23 monitor [1] 43/15 monitoring [1] 37/2 Monmouthshire [1] 18/12 monopolised [1] 134/7 month [3] 39/13 109/24 143/13 month's [1] 124/20 months [9] 29/3 29/24 46/24 116/4 118/9 121/14 127/7 127/18 150/2 monumental [1] 163/6 moral [1] 64/22 morally [1] 135/17 morals [1] 136/15 morbidities [1] 144/15 morbidity [1] 7/11 more [98] 7/5 11/5 12/23 13/1 14/23 15/2 15/21 16/7 18/9 20/8 22/11 27/10 29/18 29/20 32/14 32/15 34/3 34/4 49/7 52/20 52/25 53/3 54/6 56/4 58/11 60/9 61/16 65/6 68/22 70/10 71/1 73/25 74/14 76/18 77/7 80/20 81/16 86/21 97/5 99/12 116/8 116/11 117/16 118/5 118/11 119/16 120/12 121/21 122/15	123/3 129/4 129/20 132/1 132/8 133/20 136/12 137/12 139/3 139/6 140/17 146/10 150/25 152/20 154/3 164/21 167/16 168/20 169/19 169/19 169/20 169/25 171/9 172/18 174/6 174/9 174/13 176/12 177/5 177/6 177/7 177/13 178/1 178/16 179/17 183/3 183/9 183/23 184/5 184/7 184/10 184/19 185/4 186/1 188/2 191/11 192/7 192/9 197/8 Moreover [1] 178/8 Morgan [1] 44/12 morning [10] 1/6 1/9 162/17 163/1 165/23 176/9 183/19 187/5 188/21 194/3 mortality [4] 21/18 57/17 164/7 164/9 most [32] 1/19 2/1 3/3 8/6 18/17 20/19 33/2 35/21 39/25 70/22 70/25 79/16 82/23 84/2 85/3 88/21 91/3 100/23 101/10 102/7 108/16 120/11 137/14 139/22 164/17 166/25 169/16 174/19 182/10 188/14 192/1 198/11 motivated [2] 75/3 111/10 Motorpoint [1] 57/5 Motorpoint Arena [1] 57/5 mounting [1] 109/18 move [11] 28/14 31/4 53/13 54/2 72/9 85/22 86/17 86/25 87/3 87/13 90/1 moved [3] 55/15 87/19 88/25 movement [2] 52/25 178/5 moves [1] 144/1 moving [5] 2/13 3/12 28/4 88/20 106/20 MPs [1] 116/19 Mr [68] 2/21 3/13 31/2 36/1 37/1 38/24 43/8 47/5 47/9 49/12 50/20 52/13 52/16 57/18 64/16 69/17 70/6 77/18 84/7 85/25 86/3 86/8 86/14 86/19 87/7 98/21 102/11 107/4 107/11 115/13 115/15 115/21 116/1	122/3 123/11 125/9 125/9 125/12 127/21 127/22 131/4 131/14 131/16 144/24 144/25 145/5 160/23 161/4 161/7 171/17 173/11 173/12 173/14 176/9 185/9 185/10 185/12 187/5 194/3 195/20 196/1 197/18 199/12 199/15 199/18 199/22 199/25 200/2 Mr Allen [2] 173/12 185/9 Mr Drakeford [2] 102/11 107/4 Mr Drakeford's [1] 107/11 Mr Friedman [2] 131/14 144/24 Mr Gardner [2] 144/25 160/23 Mr Gething [21] 37/1 38/24 43/8 47/5 47/9 49/12 50/20 52/16 57/18 64/16 77/18 85/25 86/3 86/8 86/14 86/19 115/21 116/1 125/9 127/21 127/22 Mr Gething's [1] 125/12 Mr Gove [1] 87/7 Mr Hancock [1] 36/1 Mr Heaney [1] 125/9 Mr Jacobs [4] 161/4 161/7 173/11 199/22 Mr Johnson [4] 52/13 69/17 70/6 171/17 Mr Kinnier [2] 185/10 197/18 MR KINNIER KC [2] 185/12 200/2 Mr Nelson [1] 122/3 Mr Poole [7] 3/13 31/2 98/21 123/11 176/9 187/5 194/3 Mr Straw [2] 115/13 131/4 Mr Sunak [1] 84/7 Mr Sunak's [2] 195/20 196/1 Mr Tom Poole [1] 2/21 Mrs [4] 115/19 115/24 116/18 116/24 Mrs Davies [1] 116/24 Mrs Jenny [2] 115/24 116/18 Ms [5] 98/23 99/2 99/4 115/11 199/9 Ms Gowman [3] 98/23 99/2 115/11
----------	---	---	--	---

<p>M</p> <p>much [31] 1/8 14/23 21/8 27/17 36/16 69/13 98/17 98/21 100/20 115/11 115/23 125/21 131/4 131/12 132/10 133/18 134/16 137/25 141/4 142/15 142/18 144/24 157/24 160/23 173/11 182/21 185/9 194/23 198/14 198/16 198/21</p> <p>multi [2] 49/24 50/1</p> <p>multi-agency [1] 50/1</p> <p>multidisciplinary [1] 137/11</p> <p>multiple [3] 41/7 68/14 129/8</p> <p>multiplied [1] 8/18</p> <p>municipalities [1] 45/24</p> <p>must [26] 8/5 8/21 10/12 18/24 96/23 98/3 98/18 100/1 100/3 101/1 101/8 104/7 111/8 111/11 112/20 113/24 114/2 115/3 115/6 138/18 175/17 177/10 180/16 181/23 182/20 198/10</p> <p>mutually [1] 172/9</p> <p>my [80] 1/7 6/24 9/24 15/22 16/17 17/24 18/19 25/14 27/11 30/8 31/3 39/18 62/24 68/18 71/18 91/19 99/5 99/7 101/10 107/10 107/20 108/25 111/17 111/17 112/19 112/19 113/3 114/6 115/10 115/16 116/2 117/3 117/21 126/2 131/20 132/23 134/19 134/22 141/20 142/21 143/16 143/20 144/23 145/2 145/6 146/5 159/15 160/11 160/22 161/8 165/1 165/9 166/12 167/24 170/23 172/11 172/13 173/10 173/15 174/3 176/25 180/21 181/5 181/24 182/15 182/15 183/6 185/6 185/13 185/25 186/1 186/4 186/20 187/25 193/23 194/9 196/14 197/1 197/7 198/8</p> <p>my Lady [63] 1/7 6/24 9/24 15/22 17/24 18/19 25/14 27/11 30/8 31/3 39/18 62/24</p>	<p>68/18 71/18 99/5 99/7 101/10 107/10 111/17 112/19 113/3 115/16 117/3 131/20 132/23 134/19 134/22 141/20 142/21 143/16 143/20 144/23 145/2 145/6 146/5 160/11 160/22 161/8 165/1 165/9 166/12 167/24 170/23 172/13 173/10 173/15 174/3 176/25 180/21 181/5 181/24 182/15 183/6 185/6 185/13 186/20 187/25 193/23 194/9 196/14 197/1 197/7 198/8</p> <p>N</p> <p>namely [7] 5/13 15/15 28/17 47/1 50/13 50/23 85/8</p> <p>narrative [2] 4/7 171/16</p> <p>narrow [1] 129/7</p> <p>nation [5] 20/25 70/2 72/20 198/3 198/6</p> <p>nation's [1] 146/18</p> <p>national [20] 2/5 15/23 17/13 37/6 40/9 41/25 49/4 52/19 59/17 61/7 61/10 64/8 79/15 90/18 97/20 105/4 131/18 145/16 179/5 184/22</p> <p>National Assembly [1] 61/10</p> <p>nationally [3] 14/13 79/6 80/11</p> <p>nationals [1] 37/10</p> <p>nations [29] 20/13 20/15 21/25 26/9 36/8 52/11 56/18 69/22 71/11 73/20 84/14 108/12 111/8 133/22 134/3 135/21 136/3 136/6 143/22 144/2 144/5 144/12 146/23 171/6 185/19 186/6 188/10 188/17 194/21</p> <p>nationwide [2] 64/5 159/4</p> <p>nature [9] 5/16 6/9 94/7 128/2 134/4 147/3 150/19 174/7 182/9</p> <p>Nazroo [6] 20/4 20/7 20/21 21/2 21/13 164/20</p> <p>nCoV [1] 41/14</p> <p>near [1] 45/4</p> <p>nearly [6] 12/23 26/4 39/13 58/14 59/14 116/23</p>	<p>Neath [2] 77/25 153/10</p> <p>necessarily [4] 66/11 138/10 152/21 198/6</p> <p>necessary [13] 5/16 48/3 62/8 88/18 94/23 103/2 105/13 112/9 166/8 185/18 193/10 194/14 197/13</p> <p>necessitated [1] 147/4</p> <p>need [27] 1/14 1/18 1/19 21/7 30/14 36/19 37/16 40/8 44/11 49/6 53/14 80/13 80/15 82/18 83/2 95/16 97/19 101/22 111/5 117/25 140/16 158/21 168/9 175/24 178/13 179/1 196/9</p> <p>needed [18] 13/21 28/3 35/22 52/1 79/15 80/18 81/12 81/20 82/22 83/10 107/5 120/11 136/9 139/20 145/12 152/1 177/23 181/9</p> <p>needing [7] 117/14 117/21 118/22 119/14 119/15 119/19 125/19</p> <p>needs [10] 1/19 21/15 44/10 104/5 116/13 155/12 156/18 156/21 158/23 160/14</p> <p>negative [2] 107/25 126/19</p> <p>neglected [1] 129/25</p> <p>negligible [1] 44/22</p> <p>negotiate [1] 166/24</p> <p>negotiating [1] 44/22</p> <p>neighbourhood [1] 18/16</p> <p>Neil [1] 32/12</p> <p>Neil Ferguson [1] 32/12</p> <p>neither [2] 183/20 194/5</p> <p>Nelson [1] 122/3</p> <p>NERVTAG [3] 31/25 32/24 93/4</p> <p>Netherlands [1] 61/6</p> <p>never [13] 98/16 103/8 133/17 137/21 140/13 143/4 164/1 172/4 177/11 180/2 195/18 195/22 197/1</p> <p>new [25] 14/2 31/10 37/21 38/11 48/2 48/24 49/2 49/9 55/21 55/23 55/25 72/7 72/15 80/9 85/17 86/20 86/21 87/9 87/11 88/10 90/24 93/8 136/14 153/4</p>	<p>179/18</p> <p>New England [1] 38/11</p> <p>newly [1] 14/5</p> <p>Newport [1] 77/23</p> <p>news [2] 45/22 179/18</p> <p>next [23] 2/24 4/11 13/3 14/1 14/13 14/20 19/14 28/6 28/14 44/20 74/20 81/21 90/11 109/4 109/17 114/3 115/7 170/23 175/8 179/14 184/4 186/24 197/9</p> <p>NHS [20] 7/5 11/3 33/7 33/8 40/13 43/11 53/21 54/6 60/23 62/1 64/15 72/3 81/5 85/1 104/19 129/24 168/20 168/21 189/7 190/21</p> <p>NHS Wales [1] 33/7</p> <p>Nick [1] 21/21</p> <p>night [1] 87/22</p> <p>nine [4] 18/18 45/13 60/3 120/8</p> <p>nine weeks [1] 60/3</p> <p>nine years [1] 18/18</p> <p>nine-fold [1] 120/8</p> <p>no [42] 1/7 15/1 17/13 20/13 32/6 33/25 34/3 34/17 35/14 37/14 37/19 38/6 40/8 41/8 43/11 46/9 51/15 53/6 55/19 58/15 64/21 71/2 76/10 84/10 95/20 112/12 116/4 121/15 123/12 126/9 126/10 127/2 128/9 129/8 133/16 135/5 141/7 149/23 162/8 163/15 169/21 169/25</p> <p>non [15] 9/6 9/14 38/17 57/24 63/6 64/9 73/21 79/11 97/13 106/6 110/14 120/3 127/8 132/9 182/23</p> <p>non-compliant [1] 182/23</p> <p>non-Covid [4] 9/6 79/11 120/3 127/8</p> <p>non-disabled [1] 132/9</p> <p>non-essential [3] 63/6 64/9 73/21</p> <p>non-immune [1] 38/17</p> <p>non-pharmaceutical [3] 9/14 106/6 110/14</p> <p>non-scientific [1] 97/13</p> <p>non-urgent [1] 57/24</p>	<p>none [4] 37/12 107/22 159/8 186/1</p> <p>nonetheless [4] 150/19 162/9 165/14 177/12</p> <p>nor [4] 150/6 183/20 183/21 194/5</p> <p>norm [1] 189/24</p> <p>normally [1] 161/5</p> <p>north [3] 55/2 78/9 88/22</p> <p>North Wales [1] 55/2</p> <p>North-East [1] 88/22</p> <p>north/south [1] 78/9</p> <p>northern [14] 14/22 15/9 25/12 30/7 48/16 72/6 73/24 74/5 74/12 74/19 87/8 131/23 188/1 198/1</p> <p>Northern Ireland [11] 14/22 15/9 25/12 30/7 72/6 74/5 74/12 74/19 131/23 188/1 198/1</p> <p>nose [1] 105/11</p> <p>not [211]</p> <p>notable [2] 78/23 159/10</p> <p>notably [2] 74/3 190/11</p> <p>note [12] 13/15 50/3 54/9 55/10 56/2 63/15 84/24 107/10 130/21 176/7 183/13 183/18</p> <p>noted [18] 32/1 32/2 32/5 33/10 33/15 43/3 44/24 45/11 45/16 46/20 52/3 52/8 54/12 63/11 80/5 128/20 149/16 169/16</p> <p>notes [2] 60/1 81/23</p> <p>nothing [3] 8/24 110/1 131/25</p> <p>notice [3] 2/19 147/10 159/21</p> <p>noticeable [1] 76/17</p> <p>notices [1] 140/1</p> <p>notifiable [1] 51/8</p> <p>Notification [1] 51/6</p> <p>notified [1] 141/11</p> <p>noting [3] 14/18 32/24 65/25</p> <p>notwithstanding [5] 66/13 104/3 104/18 119/18 156/11</p> <p>novel [10] 31/24 32/3 32/9 32/18 36/11 37/3 37/11 39/10 42/3 49/20</p> <p>November [9] 34/25 83/21 84/13 84/22 89/6 101/21 125/1 170/5 195/6</p> <p>November 2020 [2] 34/25 170/5</p>
--	---	--	--	--

N	objective [2] 54/7 191/6	159/7 159/9	186/6 186/9 186/10	opportunity [8] 71/22 93/5 164/16 173/18 184/12 186/4 186/8 186/12
November 2022 [1] 125/1	objectively [1] 54/20	office's [1] 145/19	ongoing [3] 76/20 95/3 100/24	opposed [5] 42/10 43/21 47/2 55/12 76/7
now [39] 3/4 3/8 3/11 8/13 9/17 11/21 13/15 13/24 30/22 30/25 32/19 36/22 37/18 37/21 52/24 67/16 85/19 86/15 92/15 95/16 98/22 117/22 118/20 124/2 131/23 134/18 142/24 151/2 157/10 160/24 175/1 179/4 180/4 180/8 180/18 180/23 181/9 187/7 188/2	objectives [3] 75/21 172/4 172/10	Officer [8] 10/25 17/10 32/17 34/21 122/3 132/18 147/19 190/19	online [5] 1/10 2/16 3/5 80/3 86/17	opposition [1] 189/25
NPI [1] 21/19	obligation [1] 8/10	officers [5] 31/7 36/8 178/4 178/23 180/9	only [31] 5/16 12/24 41/5 41/5 45/19 58/24 62/19 68/13 69/7 71/6 71/7 72/15 80/8 89/13 98/15 103/20 117/6 119/20 121/12 126/8 133/15 135/24 143/13 157/1 157/24 179/8 180/7 182/10 186/15 189/13 196/6	opt [1] 77/2
NPIs [16] 9/22 46/20 67/13 79/7 79/14 79/20 79/21 84/23 109/12 111/5 183/5 183/7 183/9 183/13 184/4 184/15	obliged [1] 30/5	official [7] 11/25 32/1 32/15 47/10 101/20 158/1 174/18	ONS [6] 12/10 14/21 15/17 18/10 24/18 58/14	optically [1] 69/20
nuanced [2] 174/3 181/12	obliging [1] 70/18	officials [13] 37/8 91/2 94/17 147/3 147/19 149/5 149/10 152/1 156/1 186/21 190/19 194/6 197/12	onset [3] 23/23 31/15 43/6	option [1] 184/11
number [58] 8/11 8/24 11/9 11/13 11/18 12/13 12/19 13/16 14/2 16/1 19/17 21/13 26/8 32/21 35/19 35/19 38/15 39/24 41/14 41/16 42/12 42/14 47/15 48/18 48/25 55/5 55/10 57/22 59/4 66/19 67/17 78/23 79/4 82/3 84/24 85/10 85/12 85/16 86/5 86/10 89/14 89/16 89/19 99/9 120/6 121/19 122/2 126/14 128/10 131/5 131/6 132/10 158/24 162/21 164/11 168/4 169/5 178/11	observation [2] 170/25 172/13	often [13] 8/16 79/1 119/8 128/20 140/21 146/7 149/17 157/21 159/22 160/15 164/14 178/24 182/19	onto [1] 100/19	options [2] 71/8 184/13
number 2 [1] 178/11	observations [4] 64/17 104/23 107/11 168/9	Ogbonna [1] 91/11	onwards [2] 12/7 136/13	or [127] 2/15 4/21 7/16 13/16 13/21 17/23 19/10 19/12 21/4 22/11 24/14 29/12 30/12 30/14 31/22 33/3 33/4 36/20 38/6 38/10 40/6 42/8 42/25 44/19 44/21 46/18 47/17 54/4 55/25 58/23 59/2 61/4 67/2 75/1 76/1 76/2 76/11 76/11 77/2 92/6 94/15 95/24 96/15 96/23 97/16 101/17 103/12 108/1 111/10 111/11 112/10 113/8 114/11 117/2 117/24 118/22 120/9 120/18 120/20 121/11 121/25 122/19 124/23 125/25 127/8 129/2 129/11 130/8 130/15 132/18 135/20 135/20 137/12 139/11 141/16 143/5 146/24 147/19 148/1 148/24 149/3 150/3 150/12 150/15 151/22 152/4 154/25 155/5 155/8 155/11 156/9 156/14 157/2 157/17 157/17 157/22 157/25 158/10 158/13 158/20 159/14 159/20 159/23 160/15 160/21 160/25 163/16 164/23 167/15 169/21 171/3 172/9 172/16 175/23 178/22 181/18 182/16 183/10 184/22 187/8 191/13 194/6 194/7 196/24 198/1 198/1 198/19
numbers [10] 8/4 34/11 47/10 47/12 47/17 55/7 61/16 79/12 123/25 143/11	obvious [7] 62/6 75/21 123/15 183/17 185/22 188/9 194/14	Okay [1] 145/3	open [19] 59/17 62/19 62/22 63/6 73/22 73/23 74/13 96/6 100/10 105/14 109/1 151/8 159/10 168/2 171/9 172/18 172/21 177/13 190/12	opened [1] 74/19
numerous [3] 92/2 130/6 169/2	obviously [2] 123/19 198/16	old [2] 39/8 117/25	opening [26] 1/5 3/14 3/20 66/16 74/11 74/15 80/7 130/18 130/19 150/12 150/12 151/5 151/9 161/9 162/1 162/12 167/17 173/10 174/25 175/17 178/12 187/15 188/20 194/3 199/3 199/5	operated [2] 48/4 177/1
nurse [1] 163/16	occasion [1] 160/2	older [20] 10/4 20/20 21/15 21/17 23/4 28/9 60/22 85/2 120/13 121/7 122/22 128/13 128/17 133/19 167/9 190/16 193/12 193/17 193/18 193/22	operate [2] 20/14 83/15	operates [1] 83/11
nurses [5] 64/22 109/2 163/2 163/3 163/20	occasioned [1] 144/7	old 89/11 89/14 89/23 90/1	operating [1] 179/13	operating [1] 179/13
nursing [6] 21/6 109/1 116/3 155/8 157/17 164/25	occasions [2] 169/2 182/19	one [51] 5/16 12/1 32/4 36/13 38/16 39/7 44/15 45/25 50/9 58/5 71/10 74/10 76/21 84/2 87/24 100/15 103/7 107/13 107/18 108/23 109/24 112/11 114/10 116/3 116/14 121/2 125/8 125/11 126/15 126/25 128/4 130/6 138/13 140/13 143/13 153/6 153/8 153/9 154/22 155/10 157/15 162/8 165/1 166/25 168/25 173/8 180/22 194/2 195/11 197/24 198/10	operational [3] 7/19 107/6 195/25	operation [2] 93/10 189/21
O	occurred [5] 12/7 12/11 38/19 96/22 179/10	one's [2] 121/14 121/15	operationalisation [1] 175/22	operationalising [1] 176/15
o'clock [2] 98/22 198/21	occurring [2] 12/5 37/21	one week [1] 195/11	operations [3] 51/19 149/23 190/10	operations [3] 51/19 149/23 190/10
O's [1] 79/3	October [24] 15/10 19/20 69/8 77/20 79/8 80/21 81/8 81/10 81/18 81/23 82/9 82/11 82/13 82/16 84/12 98/1 109/24 126/12 129/23 135/12 139/3 195/3 195/9 196/5	ones [7] 113/20 114/24 121/16 186/2	operative [1] 164/8	opined [4] 21/7 22/9 23/9 26/1

O	73/17 98/19 118/8 119/16 126/13 127/19 162/12 162/20 165/5 165/7 165/7 165/7 167/17 171/5 173/10 182/9 186/1 186/16 186/16	104/2 overall [8] 42/7 47/19 48/8 86/4 119/18 119/21 133/12 185/2 overarching [2] 146/15 176/6 overlap [1] 131/9 overlook [1] 133/23 overlooked [11] 118/19 122/16 125/2 127/13 127/13 130/2 130/8 137/4 175/24 182/6 183/1 overriding [1] 119/8 oversee [1] 91/6 oversights [1] 135/9 oversimplifying [1] 154/20 overtake [1] 53/24 overwhelm [1] 84/25 overwhelmed [4] 81/6 86/2 88/9 104/19 overwhelmingly [1] 143/11 owes [1] 8/3 own [20] 11/6 28/23 28/23 28/24 49/3 67/12 93/8 96/4 100/5 100/5 100/15 111/15 138/20 142/6 142/18 143/14 157/22 185/25 188/15 190/21 oxygen [1] 51/3	24/8 25/2 25/4 25/18 25/22 26/21 26/25 27/2 27/17 28/8 28/22 29/25 36/20 38/5 43/15 44/4 45/12 48/6 48/11 53/4 56/6 57/13 63/17 63/24 65/2 65/19 67/5 67/9 67/11 69/17 76/13 76/15 83/7 84/3 87/25 88/6 88/9 88/10 89/20 90/17 90/23 90/25 91/4 91/7 91/15 91/18 93/19 93/22 95/3 98/6 99/16 99/16 99/19 101/24 103/25 106/10 106/16 106/22 112/13 113/6 113/12 114/3 114/9 114/15 115/7 117/6 117/11 118/4 118/10 119/23 127/18 128/7 133/16 134/1 134/3 136/22 137/24 141/21 145/22 147/4 147/10 147/21 149/21 149/22 151/18 153/12 154/18 155/2 155/11 155/19 158/16 160/12 162/15 162/19 162/22 163/6 165/2 165/11 165/23 166/2 166/4 166/6 166/10 166/11 166/14 166/15 166/17 167/2 167/3 167/8 167/13 169/4 170/14 171/22 173/9 173/21 175/3 176/22 177/12 177/17 177/22 179/19 179/25 180/19 181/8 181/12 182/12 185/16 185/20 185/25 187/8 188/14 189/8 190/4 190/9 191/1 191/10 191/19 191/23 192/3 193/4 194/12 194/24 194/24 pandemics [2] 23/10 146/7 panic [1] 103/12 paper [3] 78/18 78/20 79/19 paragraph [9] 41/13 41/17 42/17 42/23 53/20 54/2 54/7 126/14 130/19 paragraph 1 [1] 41/13 paragraph 13 [1] 42/23 paragraph 3 [1] 54/2 paragraph 39 [1] 126/14 paragraph 4 [1] 54/7 paragraph 6 [1]	130/19 paragraph 7 [2] 41/17 42/17 paragraphs [4] 118/8 119/16 124/10 127/19 paragraphs 14 [1] 119/16 Paragraphs 34 [1] 124/10 paragraphs 41 [1] 127/19 paragraphs 5 [1] 118/8 paramount [1] 73/15 Parc [2] 153/8 153/18 parcels [1] 165/5 parents [1] 170/19 Paris [2] 145/17 145/22 parliamentary [1] 95/6 part [31] 4/20 4/22 24/5 27/8 27/17 27/21 38/25 43/8 58/5 58/17 71/20 72/8 83/4 90/20 91/21 118/1 123/13 132/15 134/16 137/21 139/17 140/14 147/12 151/12 157/4 161/11 162/22 172/16 187/21 188/14 196/22 Part 2 [1] 139/17 partial [2] 78/19 150/12 participant [1] 173/18 participants [6] 2/25 16/19 92/14 135/13 198/11 198/20 participate [1] 140/24 participated [1] 167/14 participation [1] 100/25 particular [20] 10/10 21/3 21/15 21/17 23/12 25/22 28/3 93/1 93/14 96/20 96/24 97/2 110/24 127/21 128/24 143/23 170/18 182/7 185/15 198/3 particularly [16] 14/6 21/5 22/17 23/3 57/9 62/22 72/16 100/3 100/7 129/25 133/14 145/23 152/10 169/13 183/14 189/5 parties [4] 137/6 189/18 189/25 190/15 partly [1] 137/23 partner [2] 136/6 174/11 partnering [1] 137/3
ordinate [1] 91/6 ordination [5] 40/10 66/22 97/21 103/7 105/4 Orford [12] 11/1 34/20 43/3 43/19 47/22 48/19 52/8 57/15 60/11 61/23 70/24 122/5 Organisation [1] 31/19 organisations [8] 10/2 28/8 130/21 131/19 135/15 155/16 168/7 175/21 organised [2] 137/10 159/5 orientation [1] 28/2 original [2] 72/7 149/18 Orthopaedic [1] 64/23 other [67] 5/3 5/24 7/8 12/18 16/22 21/11 25/25 31/8 35/13 38/17 41/2 44/9 46/15 46/18 54/6 57/4 57/11 66/21 66/25 67/21 70/7 73/1 73/3 75/3 75/9 76/20 79/25 81/2 90/11 95/21 98/13 108/12 111/19 117/1 118/5 119/23 121/6 124/12 126/18 127/1 128/4 136/3 136/6 137/6 140/23 152/13 158/9 164/5 164/10 166/21 176/1 181/16 186/20 187/10 188/6 189/18 190/1 190/7 191/1 191/7 191/14 192/25 194/5 194/6 197/11 197/21 198/20 others [23] 22/24 32/17 34/23 45/7 92/5 101/18 102/6 107/20 121/10 127/18 128/22 165/8 171/10 171/17 172/23 174/23 175/6 177/3 178/17 181/6 187/17 189/20 196/21 otherwise [5] 111/11 113/1 117/24 141/16 142/2 ought [14] 29/10 29/17 29/20 40/6 49/7 57/2 63/13 126/15 126/22 126/24 127/4 127/9 128/2 128/16 our [27] 1/12 30/11 44/19 44/20 44/21 64/21 66/10 73/16	ourselves [1] 44/18 out [40] 26/9 26/17 27/23 34/16 48/21 50/13 65/18 66/15 68/21 69/13 75/20 75/21 77/2 96/8 102/6 113/16 114/19 118/8 119/15 122/23 124/10 126/24 128/24 132/4 132/5 132/7 136/7 136/8 136/23 139/22 141/18 142/10 148/10 149/25 159/25 160/13 163/25 165/20 180/13 187/10 outbound [1] 35/4 outbreak [11] 31/10 35/16 35/24 36/12 36/19 38/12 47/2 52/18 153/12 158/5 191/11 outbreaks [6] 25/2 41/18 41/23 42/18 77/21 88/5 outcome [1] 137/2 outcomes [4] 75/2 138/3 138/8 166/24 outdoor [2] 64/11 74/15 outdoors [3] 74/4 74/6 94/11 outlets [1] 73/22 outlining [1] 37/5 outpatients [1] 57/24 outputs [1] 184/19 outset [5] 25/3 95/19 128/7 174/4 186/3 outside [6] 7/20 37/12 37/21 38/9 42/19 118/12 outskirts [1] 1/11 outstripping [1] 60/4 over [46] 2/15 4/11 6/12 8/13 8/19 13/1 15/4 15/13 16/3 28/5 35/22 46/7 51/12 52/2 54/22 58/7 59/19 60/6 60/23 65/2 65/7 67/5 68/12 72/24 73/18 78/20 81/16 83/9 84/15 84/21 89/17 91/14 104/2 120/4 129/3 131/7 135/16 143/7 152/18 154/17 161/4 161/13 174/8 181/14 186/24 197/9 over-reliance [1]	pace [1] 167/25 paced [1] 147/23 package [6] 60/20 65/14 79/14 80/12 84/14 84/16 packages [1] 135/23 Padua [1] 45/25 page [6] 60/6 60/6 60/7 73/8 73/9 199/2 page 2 [3] 60/6 60/7 73/8 paid [5] 22/11 143/5 158/14 165/4 165/5 pain [7] 113/19 114/23 120/16 120/18 121/15 163/17 186/6 painful [1] 143/12 pandemic [186] 2/7 3/3 3/18 4/1 4/9 5/12 5/15 5/18 5/22 6/1 6/5 6/10 6/12 6/16 7/4 7/10 10/2 10/9 11/12 11/22 12/20 16/1 16/4 16/9 16/13 17/13 17/15 17/20 18/1 19/12 20/5 20/22 21/14 21/22 22/20 22/22 22/25 23/8 23/23 23/25 24/2 24/6		

P	peaking [1] 12/7	84/23 119/25 129/3	plan [14] 35/2 50/12	policed [1] 92/21
partners [8] 106/4	peaks [1] 13/19	146/3 180/8 195/14	50/12 50/17 62/16	policies [12] 41/21
113/16 114/20 140/19	peers [1] 22/23	periods [2] 151/4	65/16 65/20 66/4	42/22 67/24 71/11
166/21 167/8 177/20	people [129] 2/1 2/11	158/4	66/15 73/17 77/4 77/4	92/18 92/20 103/19
182/2	4/17 4/23 8/4 13/13	Perm [1] 44/11	133/17 179/5	108/13 175/14 175/19
partnership [20]	15/1 15/14 15/16	permanent [3] 11/2	planned [3] 25/3 79/7	176/3 184/3
90/21 138/16 140/8	15/18 16/9 20/23 21/2	44/12 180/5	145/2	policy [23] 48/8
155/14 162/10 166/13	21/17 22/3 22/5 22/10	permit [1] 26/16	planning [23] 5/12	59/11 59/15 68/25
166/16 167/4 167/5	22/16 22/17 22/22	permitted [5] 73/22	19/4 19/12 38/23 44/2	75/21 76/21 83/12
168/1 168/12 170/13	23/3 23/3 23/4 23/4	74/4 74/6 126/18	44/8 47/18 51/17	102/12 102/20 103/17
171/10 173/1 173/2	24/19 26/25 28/10	181/14	57/14 81/1 81/4 105/3	103/21 103/22 111/8
175/10 175/25 184/16	28/11 29/22 30/23	persisted [1] 154/3	133/14 133/25 135/22	112/9 122/3 123/24
190/7 193/20	38/17 46/7 46/8 50/5	persistent [1] 20/17	137/4 140/21 165/11	140/20 155/18 176/16
parts [9] 63/20 73/1	50/6 51/1 52/12 52/20	person [10] 32/25	166/4 166/8 166/11	178/25 181/19 188/21
73/3 87/12 88/10	56/4 56/17 64/14 65/8	32/25 33/22 33/22	178/6 180/16	191/7
88/21 144/20 162/20	68/13 73/7 74/2 74/3	38/16 47/13 47/13	plans [3] 29/18 33/13	policymakers [1]
192/25	74/6 75/4 77/6 77/15	127/6 129/13 129/16	106/5	103/17
party [4] 76/6 112/13	81/14 86/16 91/18	personal [5] 76/10	plant [1] 164/8	policymaking [3]
112/15 189/21	94/8 95/12 98/10	80/1 86/6 127/3 186/4	plaster [1] 100/15	123/8 175/23 176/13
passages [1] 115/13	101/3 107/17 107/22	personalities [1]	plastic [1] 163/11	political [13] 3/17 5/4
passed [4] 18/21	114/4 115/8 116/12	138/3	play [6] 3/8 27/8 76/6	6/14 7/12 25/17 26/14
34/21 139/21 150/2	117/5 117/7 117/21	personality [1] 138/9	90/20 133/6 147/21	76/11 100/9 134/13
passenger [1] 46/4	117/23 117/25 122/24	persons [3] 146/12	played [5] 2/21 3/10	174/18 189/3 189/4
passengers [2] 46/1	123/1 123/23 123/25	148/4 190/16	83/4 91/24 162/21	189/23
46/6	124/3 124/3 124/18	perspective [5] 6/17	playing [1] 112/13	politically [3] 76/9
passing [1] 139/17	125/17 128/12 131/19	68/5 143/6 162/5	please [25] 2/17 2/18	111/10 144/3
past [1] 81/17	131/25 132/3 132/4	194/11	3/9 11/23 11/24 12/9	politicians [1] 133/3
patchwork [1]	132/7 132/9 132/13	persuade [1] 49/5	13/3 14/1 14/20 30/24	politicisation [1]
141/14	133/11 133/23 134/1	persuading [1] 139/2	33/20 41/10 41/11	76/13
path [1] 98/19	134/5 135/19 136/7	perturbed [1] 106/18	41/17 42/15 42/23	politics [4] 25/16
patient [4] 51/9 53/6	136/7 136/23 137/22	pervasive [1] 23/22	44/6 53/19 54/2 59/21	112/13 112/15 134/9
54/25 64/23	138/23 139/6 139/12	pharmaceutical [3]	59/25 64/19 72/21	pond [1] 103/15
patients [23] 13/5	139/19 140/4 140/8	9/14 106/6 110/14	73/8 197/19	pool [1] 181/3
13/8 13/11 13/17	141/21 142/12 143/4	phase [2] 53/11	plenty [1] 112/2	Poole [8] 2/21 3/13
13/19 13/21 31/14	144/12 144/17 144/19	53/13	plug [1] 112/22	31/2 98/21 123/11
32/3 36/15 39/16	147/7 153/25 154/10	phenomenon [1]	pm [5] 98/24 99/1	176/9 187/5 194/3
55/20 57/25 58/2 58/9	154/13 155/7 157/23	149/20	161/1 161/3 198/23	poor [2] 104/3 166/4
58/12 58/18 59/12	158/17 159/1 159/4	phone [1] 116/6	pneumonia [3] 31/10	poorer [2] 22/13
61/17 85/11 107/22	159/6 159/11 160/1	physical [4] 23/2	31/12 31/14	133/19
108/4 121/9 123/14	161/14 161/19 165/5	120/25 121/12 142/15	point [36] 27/9 30/8	poorest [1] 164/14
Patients Association	170/20 178/4 189/10	physiotherapy [1]	33/11 33/21 33/24	population [25]
[1] 121/9	192/23 192/25 193/4	120/20	34/2 45/14 52/8 67/4	14/24 15/5 15/21
pattern [3] 61/21	193/12 193/17 193/22	pick [1] 128/25	69/1 72/22 76/19	17/22 21/3 21/25
74/10 74/18	197/16	picks [2] 3/22 28/16	96/18 103/4 103/11	29/15 34/9 40/20 44/3
patterns [1] 50/8	people's [15] 10/4	picture [1] 181/12	119/13 121/14 126/6	44/5 47/20 50/23 53/2
pause [7] 2/17 3/4	120/13 121/7 122/22	piecemeal [1] 133/13	126/16 139/20 140/20	54/21 54/22 55/18
3/6 3/7 30/10 112/20	128/13 128/18 130/21	pillars [1] 65/21	142/24 147/13 147/24	97/2 98/11 133/19
115/22	131/18 133/7 135/15	pinny [1] 163/11	159/15 159/23 174/7	134/5 146/11 151/8
pay [4] 98/3 119/3	139/22 141/25 167/9	Placatory [1] 167/25	175/7 175/16 176/1	153/22 193/17
162/15 169/15	168/7 193/18	place [27] 21/20 33/7	179/22 182/7 182/15	populations [1] 20/8
payment [2] 170/3	per [10] 13/16 14/2	36/5 37/9 37/14 43/14	184/4 194/2 196/8	Port [2] 77/25 153/10
170/9	26/6 37/23 52/2 63/12	43/19 49/22 52/11	point 12 [1] 33/24	Port Talbot [1]
pacetime [1] 166/1	79/5 81/14 81/16	52/14 56/19 61/1	Point 13 [1] 34/2	153/10
peak [23] 12/4 12/5	87/18	65/12 65/15 73/4	point 7 [1] 33/21	portfolio [1] 137/16
12/21 12/24 13/7	perceived [1] 65/3	76/22 77/12 77/23	pointed [1] 169/2	pose [1] 66/19
13/10 13/12 14/4	perception [3]	88/5 110/11 112/12	points [11] 36/6 36/7	posed [9] 4/23 5/13
14/11 15/13 15/14	106/19 108/17 112/15	125/10 125/20 126/7	74/25 95/17 146/20	9/18 40/5 48/25 89/7
43/20 46/24 47/1 50/7	perhaps [4] 95/25	133/11 138/4 196/11	165/1 165/9 174/20	138/13 168/21 176/8
50/10 51/20 52/1 52/4	118/5 123/3 125/24	placed [6] 53/22	176/24 180/4 183/7	posing [1] 176/16
52/17 53/24 55/14	period [20] 3/19	106/9 132/12 137/2	polarisation [1]	position [12] 9/11
60/3	12/16 12/25 24/4	154/10 160/7	76/14	44/22 58/19 70/19
peaked [3] 14/14	40/11 65/2 65/7 66/6	places [2] 136/2	police [7] 178/19	70/21 72/19 112/11
14/17 61/25	66/11 78/22 79/7	154/5	180/24 184/16 184/20	142/9 142/11 174/3
	84/15 84/19 84/22	placing [1] 173/2	184/22 184/24 190/3	174/14 175/1

P	pre-eminent [1] 8/3	87/17 175/4 175/6	156/2	71/4 78/4 78/6 91/10
positions [2] 27/10 29/21	pre-existing [9] 9/4 10/6 19/6 19/10 19/18 23/2 29/16 191/14 192/21	179/21	proactively [4] 151/13 155/5 155/23 168/6	91/11 91/20 122/4 122/6 123/5 124/13 133/1 134/19 135/4 138/13 146/2 149/16 192/24 193/2
positive [11] 15/6 39/17 42/2 45/14 46/5 52/21 53/7 55/1 108/8 122/21 184/7	pre-pandemic [7] 20/5 20/22 21/22 22/20 23/8 23/25 24/2	pressures [1] 180/12	probability [2] 42/18 42/24	Professor Ailsa Henderson [1] 25/7
positives [1] 170/8	precarious [1] 169/18	prevail [1] 142/15	probably [4] 2/3 15/13 30/10 61/12	Professor Bécares [3] 22/19 22/21 22/24
positivity [2] 81/15 81/17	precautionary [3] 33/18 34/18 110/25	prevalence [4] 23/2 79/9 109/18 181/15	probe [1] 4/18	Professor Cairney [1] 134/19
possession [1] 101/14	precautions [1] 169/6	prevarication [1] 4/21	problem [9] 1/6 24/25 116/24 119/20 125/4 169/18 195/2 195/23 196/6	Professor Chris [1] 24/21
possibilities [2] 45/13 144/4	preceded [1] 24/4	prevent [2] 111/13 133/7	problematic [1] 137/13	Professor Clare Bambra [1] 18/3
possibility [8] 9/21 45/5 62/12 62/15 63/1 109/6 154/17 195/22	precedence [1] 128/5	prevented [2] 35/15 120/9	problems [9] 118/2 120/16 120/18 126/9 127/11 127/23 129/7 163/7 196/4	Professor Daniel [1] 25/15
possible [8] 1/18 1/19 43/3 45/20 55/13 64/11 80/25 166/24	precious [1] 106/1	preventing [1] 88/16	procedural [1] 122/18	Professor David [1] 23/24
post [1] 145/15	precise [2] 135/3 187/18	prevention [2] 8/8 43/25	proceedings [3] 1/3 30/11 185/10	Professor David Feldman [1] 135/4
postponed [1] 56/10	predecessors [1] 2/13	previous [11] 15/12 19/16 27/23 50/21 81/25 85/18 88/14 89/17 134/22 154/16 197/2	process [20] 4/20 7/18 67/2 83/14 97/12 138/10 147/13 147/14 147/17 147/23 151/12 151/21 152/24 157/5 162/7 162/9 164/8 174/9 175/5 180/22	Professor Debbie Foster's [1] 192/24
potential [11] 10/15 17/20 34/11 44/13 70/1 79/9 125/2 147/15 150/21 177/23 183/23	predict [1] 47/16	price [2] 165/4 165/4	processed [1] 165/6	Professor Foster [1] 193/2
potentially [5] 46/22 54/5 108/3 124/18 147/25	predicted [2] 51/20 51/22	primarily [1] 14/13	processes [11] 19/13 20/12 92/8 147/2 149/13 150/4 151/2 155/4 159/18 165/17 168/9	Professor Gravenor [1] 78/6
poverty [1] 22/6	predictions [1] 61/16	prime [15] 49/10 52/13 52/15 64/5 66/8 66/14 67/18 69/11 82/1 84/7 89/6 111/24 151/14 171/23 194/17	produced [5] 20/23 54/16 106/5 116/20 128/8	Professor Hale [3] 25/21 26/1 26/5
power [3] 134/10 143/17 146/25	predominant [2] 6/5 6/13	Prime Minister [10] 49/10 64/5 66/8 66/14 67/18 84/7 89/6 111/24 171/23 194/17	producing [1] 128/15	Professor Henderson [2] 25/20 71/4
powerful [2] 101/9 193/5	predominantly [1] 71/5	Prime Ministerial [1] 69/11	product [2] 138/24 182/24	Professor Holland's [1] 149/16
powerfully [1] 162/17	prefer [1] 127/6	Princess [2] 46/2 46/3	productive [1] 189/13	Professor Ian Diamond [1] 15/23
powers [11] 49/2 63/16 63/20 64/25 68/1 99/18 134/18 175/9 184/18 188/15 188/16	pregnant [1] 170/19	Principality [1] 56/20	profession [1] 180/12	Professor James Nazroo [1] 20/4
PPE [11] 7/7 59/5 101/7 106/7 126/20 127/16 127/16 127/24 163/8 182/15 182/17	preliminary [1] 19/16	principle [6] 82/10 82/12 83/22 85/21 155/14 195/7	professional [2] 132/21 172/18	Professor John Watkins [1] 122/4
practical [5] 35/14 70/17 153/3 154/3 195/22	prematurely [1] 53/1	principles [6] 65/22 145/17 145/22 148/10 148/25 150/6	professionals [2] 152/14 158/8	Professor Keshav Singhal [1] 91/10
Practically [1] 154/8	premium [1] 137/2	prior [20] 5/16 17/2 17/12 22/22 23/11 23/23 31/15 34/1 85/9 85/19 86/13 89/18 108/1 123/10 123/23 125/2 126/19 137/23 151/9 179/19	professor [46] 15/23 18/3 20/4 20/4 20/21 21/2 21/13 21/21 21/21 22/2 22/19 22/21 22/24 23/24 24/1 24/8 24/21 25/7 25/7 25/11 25/15 25/15 25/17 25/20 25/21 26/1 26/5 32/12	Professor Laia Bécares [1] 20/4
powerfully [1] 162/17	preparation [1] 166/11	principles [6] 65/22 145/17 145/22 148/10 148/25 150/6	productive [1] 189/13	Professor Michael Gravenor [2] 78/4 122/6
powers [11] 49/2 63/16 63/20 64/25 68/1 99/18 134/18 175/9 184/18 188/15 188/16	preparations [4] 37/9 57/21 177/18 177/21	prior [20] 5/16 17/2 17/12 22/22 23/11 23/23 31/15 34/1 85/9 85/19 86/13 89/18 108/1 123/10 123/23 125/2 126/19 137/23 151/9 179/19	profession [1] 180/12	Professor Nick [1] 21/21
PPE [11] 7/7 59/5 101/7 106/7 126/20 127/16 127/16 127/24 163/8 182/15 182/17	prepare [7] 38/25 49/19 53/14 88/15 105/12 106/2 183/21	priorities [1] 48/9	professional [2] 132/21 172/18	professor of [1] 25/15
practical [5] 35/14 70/17 153/3 154/3 195/22	prepared [6] 49/21 70/6 137/23 174/22 177/8 178/4	prioritise [2] 56/5 57/13	professionals [2] 152/14 158/8	Professor Sally Holland [1] 146/2
Practically [1] 154/8	preparedness [11] 5/8 16/24 17/1 17/25 25/1 40/13 44/19 101/4 134/1 165/18 173/21	prioritised [1] 120/4	professor [46] 15/23 18/3 20/4 20/4 20/21 21/2 21/13 21/21 21/21 22/2 22/19 22/21 22/24 23/24 24/1 24/8 24/21 25/7 25/7 25/11 25/15 25/15 25/17 25/20 25/21 26/1 26/5 32/12	Professor Shakespeare [1] 22/2
practice [9] 57/11 140/18 147/8 148/11 148/21 151/11 152/16 159/13 184/16	preparing [1] 131/23	privy [1] 177/22	proactive [2] 97/16	Professor Thomas Shakespeare [1]
practices [1] 132/23	present [6] 3/4 15/25 16/10 34/17 37/20 137/20	proactive [2] 97/16		
pre [18] 8/3 9/4 10/6 19/6 19/10 19/18 20/5 20/22 21/22 22/20 23/2 23/8 23/25 24/2 29/16 84/23 191/14 192/21	presented [1] 23/21			
pre-Christmas [1] 84/23	presenting [1] 31/14			
	preserved [1] 156/9			
	press [8] 2/17 3/5 49/15 64/13 76/7 101/21 159/2 163/19			
	pressed [2] 99/23 142/21			
	pressing [1] 185/1			
	pressure [5] 33/8			

P	proposals [1] 156/25	157/23 169/15 177/9	98/5 110/6 110/11	raised [13] 34/7
Professor Thomas Shakespeare... [1] 21/21	propose [5] 16/14 20/1 26/23 28/14 90/11	prudence [1] 106/13	125/10 143/7 159/25	49/12 55/22 103/6
Professor Watkins [1] 124/13	proposed [5] 156/16 156/19 188/11 196/16 197/4	Prynhawn [1] 99/6	176/1 187/22 196/11 196/24	107/25 120/23 121/6
Professor Wincott [3] 25/17 123/5 138/13	proposition [1] 22/10	Prynhawn da [1] 99/6	puts [1] 18/23	127/6 130/3 151/23
Professors [6] 19/2 20/7 21/23 22/9 27/24 164/19	prospects [1] 9/4	public [98] 9/8 10/16 10/22 10/23 11/20	putting [3] 37/8 77/12 144/9	169/23 181/6 187/17
profile [4] 17/21 54/21 97/3 157/9	protect [11] 5/1 49/23 60/23 64/14 64/15 65/8 72/3 133/20 135/19 143/4 179/3	16/19 18/23 19/9 19/21 28/25 29/17 31/8 31/11 34/6 35/1 35/2 35/4 35/8 37/5 39/4 40/19 40/22 42/2 48/20 49/23 51/18 52/9 54/16 54/19 57/18 61/10 63/16 65/23 67/7 68/9 68/16 72/16 72/19 73/15 75/18 76/8 76/14 77/11 77/14 81/18 82/7 86/9 86/11 86/22 93/8 94/10 94/13 95/6 95/9 98/4 104/23 109/11 111/6 111/14 112/15 122/5 126/1 134/16 144/7 147/9 151/17 151/18 151/19 151/22 151/25 151/25 152/14 152/25 154/1 154/18 155/16 155/21 157/19 158/9 158/9 160/10 165/10 169/15 173/2 177/4 179/8 180/6 180/13 180/14 181/4 181/21 181/21 182/11 182/25 189/6 195/24 196/9 196/20	puzzles [1] 142/4	raises [1] 130/8
profiles [5] 29/16 153/24 155/6 157/13 158/6	protected [6] 19/19 28/1 114/5 115/9 159/14 192/1	112/15 122/5 126/1 134/16 144/7 147/9 151/17 151/18 151/19 151/22 151/25 151/25 152/14 152/25 154/1 154/18 155/16 155/21 157/19 158/9 158/9 160/10 165/10 169/15 173/2 177/4 179/8 180/6 180/13 180/14 181/4 181/21 181/21 182/11 182/25 189/6 195/24 196/9 196/20	Q	range [9] 10/21 35/21 45/1 106/6 135/8 155/24 161/14 170/17 184/7
profit [1] 143/7	protecting [4] 4/16 139/19 146/14 178/3	109/11 111/6 111/14 112/15 122/5 126/1 134/16 144/7 147/9 151/17 151/18 151/19 151/22 151/25 151/25 152/14 152/25 154/1 154/18 155/16 155/21 157/19 158/9 158/9 160/10 165/10 169/15 173/2 177/4 179/8 180/6 180/13 180/14 181/4 181/21 181/21 182/11 182/25 189/6 195/24 196/9 196/20	quad [1] 40/24	rapid [4] 38/7 88/21 90/4 108/16
profound [3] 120/25 165/1 165/18	protection [15] 8/2 51/6 60/9 64/21 75/15 77/22 141/20 142/2 177/4 179/5 180/10 180/13 180/14 181/22 182/25	112/15 122/5 126/1 134/16 144/7 147/9 151/17 151/18 151/19 151/22 151/25 151/25 152/14 152/25 154/1 154/18 155/16 155/21 157/19 158/9 158/9 160/10 165/10 169/15 173/2 177/4 179/8 180/6 180/13 180/14 181/4 181/21 181/21 182/11 182/25 189/6 195/24 196/9 196/20	qualification [1] 174/7	rapidly [3] 44/11 78/25 89/11
profoundly [2] 132/1 144/21	protection [15] 8/2 51/6 60/9 64/21 75/15 77/22 141/20 142/2 177/4 179/5 180/10 180/13 180/14 181/22 182/25	112/15 122/5 126/1 134/16 144/7 147/9 151/17 151/18 151/19 151/22 151/25 151/25 152/14 152/25 154/1 154/18 155/16 155/21 157/19 158/9 158/9 160/10 165/10 169/15 173/2 177/4 179/8 180/6 180/13 180/14 181/4 181/21 181/21 182/11 182/25 189/6 195/24 196/9 196/20	quarantine [2] 35/12 60/8	rate [16] 22/4 26/6 33/2 37/25 38/1 42/8 44/25 47/19 51/22 51/23 51/24 79/15 81/19 81/22 118/13 164/9
programme [1] 180/25	protecting [4] 4/16 139/19 146/14 178/3	109/11 111/6 111/14 112/15 122/5 126/1 134/16 144/7 147/9 151/17 151/18 151/19 151/22 151/25 151/25 152/14 152/25 154/1 154/18 155/16 155/21 157/19 158/9 158/9 160/10 165/10 169/15 173/2 177/4 179/8 180/6 180/13 180/14 181/4 181/21 181/21 182/11 182/25 189/6 195/24 196/9 196/20	quarantined [1] 46/3	rates [12] 16/3 76/17 85/16 85/18 85/20 85/23 86/15 87/17 90/5 105/21 123/17 164/7
programmes [1] 195/1	protection [15] 8/2 51/6 60/9 64/21 75/15 77/22 141/20 142/2 177/4 179/5 180/10 180/13 180/14 181/22 182/25	109/11 111/6 111/14 112/15 122/5 126/1 134/16 144/7 147/9 151/17 151/18 151/19 151/22 151/25 151/25 152/14 152/25 154/1 154/18 155/16 155/21 157/19 158/9 158/9 160/10 165/10 169/15 173/2 177/4 179/8 180/6 180/13 180/14 181/4 181/21 181/21 182/11 182/25 189/6 195/24 196/9 196/20	quarter [3] 21/10 30/12 188/2	rather [11] 39/3 55/16 63/18 67/9 80/21 139/9 143/15 147/25 156/22 168/15 189/24
progressed [4] 28/22 67/11 171/22 178/10	protections [2] 21/20 156/17	109/11 111/6 111/14 112/15 122/5 126/1 134/16 144/7 147/9 151/17 151/18 151/19 151/22 151/25 151/25 152/14 152/25 154/1 154/18 155/16 155/21 157/19 158/9 158/9 160/10 165/10 169/15 173/2 177/4 179/8 180/6 180/13 180/14 181/4 181/21 181/21 182/11 182/25 189/6 195/24 196/9 196/20	question [14] 5/2 5/13 5/16 8/20 8/21 112/7 127/5 127/21 134/21 138/13 138/15 147/15 193/23 196/15	ratio [1] 132/4
progressive [1] 142/3	protective [1] 77/13	109/11 111/6 111/14 112/15 122/5 126/1 134/16 144/7 147/9 151/17 151/18 151/19 151/22 151/25 151/25 152/14 152/25 154/1 154/18 155/16 155/21 157/19 158/9 158/9 160/10 165/10 169/15 173/2 177/4 179/8 180/6 180/13 180/14 181/4 181/21 181/21 182/11 182/25 189/6 195/24 196/9 196/20	questionable [1] 101/19	rationale [3] 110/25 150/15 150/22
prohibit [1] 56/7	protocol [1] 58/2	109/11 111/6 111/14 112/15 122/5 126/1 134/16 144/7 147/9 151/17 151/18 151/19 151/22 151/25 151/25 152/14 152/25 154/1 154/18 155/16 155/21 157/19 158/9 158/9 160/10 165/10 169/15 173/2 177/4 179/8 180/6 180/13 180/14 181/4 181/21 181/21 182/11 182/25 189/6 195/24 196/9 196/20	questioning [1] 134/23	Ray [1] 91/9
project [1] 27/7	prove [1] 95/24	109/11 111/6 111/14 112/15 122/5 126/1 134/16 144/7 147/9 151/17 151/18 151/19 151/22 151/25 151/25 152/14 152/25 154/1 154/18 155/16 155/21 157/19 158/9 158/9 160/10 165/10 169/15 173/2 177/4 179/8 180/6 180/13 180/14 181/4 181/21 181/21 182/11 182/25 189/6 195/24 196/9 196/20	questions [21] 29/1 29/7 39/24 48/25 66/20 76/21 94/20 103/18 129/18 130/9 131/1 148/22 176/7 176/8 176/8 176/14 186/11 187/9 187/17 187/21 197/16	re [15] 6/25 63/6 66/16 73/22 73/23 74/11 74/13 74/19 97/25 102/23 151/5 151/8 151/9 178/12 185/23
proliferated [1] 140/1	proved [2] 94/16 135/25	109/11 111/6 111/14 112/15 122/5 126/1 134/16 144/7 147/9 151/17 151/18 151/19 151/22 151/25 151/25 152/14 152/25 154/1 154/18 155/16 155/21 157/19 158/9 158/9 160/10 165/10 169/15 173/2 177/4 179/8 180/6 180/13 180/14 181/4 181/21 181/21 182/11 182/25 189/6 195/24 196/9 196/20	quick [2] 166/6 166/7	re-create [1] 102/23
prolonged [2] 111/20 121/4	proverb [2] 113/25 115/4	109/11 111/6 111/14 112/15 122/5 126/1 134/16 144/7 147/9 151/17 151/18 151/19 151/22 151/25 151/25 152/14 152/25 154/1 154/18 155/16 155/21 157/19 158/9 158/9 160/10 165/10 169/15 173/2 177/4 179/8 180/6 180/13 180/14 181/4 181/21 181/21 182/11 182/25 189/6 195/24 196/9 196/20	quicker [1] 171/10	re-emergence [1] 97/25
prominence [1] 140/2	provide [21] 3/24 16/7 25/8 47/24 78/24 79/21 92/9 108/7 108/22 117/2 120/19 120/21 122/21 122/24 123/1 154/4 160/7 161/18 190/11 192/22 197/14	109/11 111/6 111/14 112/15 122/5 126/1 134/16 144/7 147/9 151/17 151/18 151/19 151/22 151/25 151/25 152/14 152/25 154/1 154/18 155/16 155/21 157/19 158/9 158/9 160/10 165/10 169/15 173/2 177/4 179/8 180/6 180/13 180/14 181/4 181/21 181/21 182/11 182/25 189/6 195/24 196/9 196/20	quickly [6] 36/7 44/23 55/7 69/2 104/4 140/7	re-open [5] 63/6 73/22 73/23 74/13 151/8
prominent [2] 92/3 192/6	provided [32] 1/13 11/10 20/21 22/19 24/8 25/11 29/5 33/12 38/22 42/6 47/25 50/3 51/18 52/23 53/7 53/16 55/4 70/11 75/14 84/7 92/22 93/4 93/11 126/20 126/21 129/24 174/2 183/23 184/16 184/19 195/23 197/8	109/11 111/6 111/14 112/15 122/5 126/1 134/16 144/7 147/9 151/17 151/18 151/19 151/22 151/25 151/25 152/14 152/25 154/1 154/18 155/16 155/21 157/19 158/9 158/9 160/10 165/10 169/15 173/2 177/4 179/8 180/6 180/13 180/14 181/4 181/21 181/21 182/11 182/25 189/6 195/24 196/9 196/20	quite [3] 109/1 180/4 195/18	re-opened [1] 74/19
promise [1] 1/24	public's [1] 93/25	109/11 111/6 111/14 112/15 122/5 126/1 134/16 144/7 147/9 151/17 151/18 151/19 151/22 151/25 151/25 152/14 152/25 154/1 154/18 155/16 155/21 157/19 158/9 158/9 160/10 165/10 169/15 173/2 177/4 179/8 180/6 180/13 180/14 181/4 181/21 181/21 182/11 182/25 189/6 195/24 196/9 196/20	quote [1] 39/20	re-opening [5] 66/16 74/11 151/5 151/9 178/12
promote [1] 149/10	public-facing [1] 151/18	109/11 111/6 111/14 112/15 122/5 126/1 134/16 144/7 147/9 151/17 151/18 151/19 151/22 151/25 151/25 152/14 152/25 154/1 154/18 155/16 155/21 157/19 158/9 158/9 160/10 165/10 169/15 173/2 177/4 179/8 180/6 180/13 180/14 181/4 181/21 181/21 182/11 182/25 189/6 195/24 196/9 196/20	R	re-state [1] 185/23
promotes [1] 191/6	publication [1] 190/23	109/11 111/6 111/14 112/15 122/5 126/1 134/16 144/7 147/9 151/17 151/18 151/19 151/22 151/25 151/25 152/14 152/25 154/1 154/18 155/16 155/21 157/19 158/9 158/9 160/10 165/10 169/15 173/2 177/4 179/8 180/6 180/13 180/14 181/4 181/21 181/21 182/11 182/25 189/6 195/24 196/9 196/20	R number [3] 35/19 82/3 86/10	reablement [1] 163/20
prompt [2] 113/24 115/3	publicised [1] 93/24	109/11 111/6 111/14 112/15 122/5 126/1 134/16 144/7 147/9 151/17 151/18 151/19 151/22 151/25 151/25 152/14 152/25 154/1 154/18 155/16 155/21 157/19 158/9 158/9 160/10 165/10 169/15 173/2 177/4 179/8 180/6 180/13 180/14 181/4 181/21 181/21 182/11 182/25 189/6 195/24 196/9 196/20	R rate [1] 79/15	reach [2] 160/13 182/10
prompted [3] 44/8 56/11 157/5	publicly [2] 39/15 68/9	109/11 111/6 111/14 112/15 122/5 126/1 134/16 144/7 147/9 151/17 151/18 151/19 151/22 151/25 151/25 152/14 152/25 154/1 154/18 155/16 155/21 157/19 158/9 158/9 160/10 165/10 169/15 173/2 177/4 179/8 180/6 180/13 180/14 181/4 181/21 181/21 182/11 182/25 189/6 195/24 196/9 196/20	race [3] 10/3 20/5 142/8	reached [6] 33/3 36/6 53/24 84/14 136/7 142/9
prompting [1] 68/14	published [9] 15/17 32/18 36/11 38/12 50/12 59/18 61/8 77/3 78/18	109/11 111/6 111/14 112/15 122/5 126/1 134/16 144/7 147/9 151/17 151/18 151/19 151/22 151/25 151/25 152/14 152/25 154/1 154/18 155/16 155/21 157/19 158/9 158/9 160/10 165/10 169/15 173/2 177/4 179/8 180/6 180/13 180/14 181/4 181/21 181/21 182/11 182/25 189/6 195/24 196/9 196/20	Rachael [1] 24/22	reaching [6] 12/22 30/5 64/4 79/10 95/22 167/11
pronounced [3] 20/20 134/9 169/18	pulled [2] 135/7 156/24	109/11 111/6 111/14 112/15 122/5 126/1 134/16 144/7 147/9 151/17 151/18 151/19 151/22 151/25 151/25 152/14 152/25 154/1 154/18 155/16 155/21 157/19 158/9 158/9 160/10 165/10 169/15 173/2 177/4 179/8 180/6 180/13 180/14 181/4 181/21 181/21 182/11 182/25 189/6 195/24 196/9 196/20	racialisation [1] 20/12	reaction [1] 18/6
proper [8] 2/19 4/19 59/6 67/2 74/22 117/17 138/5 144/9	punishing [1] 95/13	109/11 111/6 111/14 112/15 122/5 126/1 134/16 144/7 147/9 151/17 151/18 151/19 151/22 151/25 151/25 152/14 152/25 154/1 154/18 155/16 155/21 157/19 158/9 158/9 160/10 165/10 169/15 173/2 177/4 179/8 180/6 180/13 180/14 181/4 181/21 181/21 182/11 182/25 189/6 195/24 196/9 196/20	radical [1] 143/1	
properly [16] 19/5 27/16 39/25 63/2 67/25 75/18 96/15 97/8 116/25 121/11 125/5 125/16 129/11 141/16 142/17 160/18	purpose [6] 3/20 43/14 47/23 100/13 166/21 168/3	109/11 111/6 111/14 112/15 122/5 126/1 134/16 144/7 147/9 151/17 151/18 151/19 151/22 151/25 151/25 152/14 152/25 154/1 154/18 155/16 155/21 157/19 158/9 158/9 160/10 165/10 169/15 173/2 177/4 179/8 180/6 180/13 180/14 181/4 181/21 181/21 182/11 182/25 189/6 195/24 196/9 196/20	radically [1] 190/10	
proportion [8] 14/24 41/19 42/20 119/18 119/21 124/18 193/12 193/17	purposes [1] 134/1	109/11 111/6 111/14 112/15 122/5 126/1 134/16 144/7 147/9 151		

R	recently [1] 116/10	reform [1] 196/17	relationships [6] 137/5 138/9 167/22 181/3 189/6 189/11	169/20 169/21 180/14 192/16 193/3 193/5
read [2] 48/21 103/20	receptive [1] 53/2	refused [1] 100/10	relative [1] 126/19	report's [1] 193/9
readily [3] 67/5 122/13 175/5	recognise [4] 175/2 186/8 186/12 194/19	refute [1] 110/5	relatively [2] 40/12 62/12	reported [30] 14/2 15/6 21/24 21/25 22/21 22/22 22/24 24/1 24/20 25/21 26/5 31/23 32/21 32/22 33/4 36/9 36/13 37/12 47/9 48/16 49/16 51/19 61/13 63/11 85/18 86/15 89/16 89/21 105/8 169/7
reading [3] 115/18 174/23 193/5	recognised [5] 109/7 116/15 123/20 124/15 187/5	Reg [1] 44/8	relax [1] 70/16	reporting [3] 14/6 15/3 33/5
reads [2] 41/13 64/20	recognises [3] 95/19 146/6 175/8	Reg Kilpatrick [1] 44/8	relaxation [4] 84/16 85/9 110/16 126/6	reports [3] 19/22 25/6 46/8
ready [4] 37/6 37/22 133/20 187/13	recognising [2] 139/5 158/10	regard [16] 25/13 50/16 59/10 65/1 107/12 146/22 148/6 148/10 148/17 149/1 149/7 150/6 156/16 157/16 158/14 191/16	relaxations [1] 84/15	represent [3] 115/16 161/13 173/16
reaffirmed [1] 193/7	recognition [4] 75/13 124/4 126/9 174/10	regarding [6] 3/25 24/2 34/10 109/18 163/19 164/7	relayed [1] 177/25	representative [6] 9/24 14/25 34/17 37/19 41/8 174/1
real [9] 28/8 39/1 97/14 103/24 129/7 133/8 141/15 156/4 166/8	recollections [1] 8/1	regardless [1] 59/13	released [1] 64/24	representatives [7] 41/3 69/10 71/1 71/2 135/9 167/7 190/1
realistic [4] 42/18 42/24 45/5 45/13	recommend [1] 31/20	regards [2] 21/15 24/7	relevance [1] 19/24	represented [5] 36/3 38/23 67/19 68/17 72/7
realistically [1] 70/20	recommendation [1] 60/11	regime [3] 153/18 181/9 183/3	relevant [12] 7/3 19/9 19/14 20/2 20/13 20/25 92/9 139/19 148/22 149/19 179/15 190/4	represents [2] 8/15 161/16
realities [1] 189/3	recommendations [11] 136/24 140/19 180/15 192/16 193/7 193/10 196/15 196/16 196/23 197/1 197/5	regimes [1] 101/7	reliance [1] 104/2	reproduction [5] 35/19 37/25 38/15 81/19 81/22
reality [6] 3/25 6/8 11/22 113/17 114/21 144/19	recommended [4] 31/13 51/10 63/15 109/19	region [2] 36/10 51/4	relied [1] 66/3	reproductive [1] 23/13
really [7] 103/8 109/3 116/13 118/4 121/18 129/2 142/19	record [8] 33/21 38/25 81/24 89/10 89/18 148/22 148/23 149/11	regional [1] 37/4	relying [2] 88/3 137/7	request [4] 50/1 83/24 195/16 197/6
reason [9] 96/20 105/24 111/5 111/7 111/9 124/2 188/25 189/24 194/1	recorded [3] 60/18 61/14 121/1	register [2] 17/13 17/16	remain [5] 65/14 67/10 73/4 134/16 186/17	requests [3] 68/15 103/10 128/10
reasonable [14] 38/4 38/22 39/1 44/19 50/4 51/21 53/15 53/23 53/25 57/16 61/2 74/22 87/16 93/5	recording [3] 59/23 64/17 198/2	registered [1] 99/9	remained [5] 45/13 53/11 75/15 119/24 145/23	require [2] 50/25 51/2
reasonableness [1] 48/10	records [1] 101/23	regular [9] 43/5 49/14 69/24 111/22 112/2 136/9 182/9 184/25 194/15	remaining [2] 50/24 88/21	required [12] 38/8 85/11 95/21 105/12 106/2 108/1 146/22 169/13 173/6 180/18 182/18 191/16
reasonably [2] 12/19 93/23	recovery [6] 33/4 65/19 66/1 66/6 66/8 75/22	regularly [6] 90/23 91/14 101/21 102/12 111/25 190/4	remains [5] 24/24 100/8 142/14 160/16 196/6	reproduction [5] 35/19 37/25 38/15 81/19 81/22
reasoned [1] 96/7	recur [1] 182/20	regulations [13] 28/24 51/7 72/25 73/4 94/21 95/1 95/8 169/9 178/9 178/11 178/24 180/11 182/14	remarks [4] 1/5 174/25 175/17 199/3	reproductive [1] 23/13
reasons [11] 7/16 48/1 48/10 59/9 65/2 123/16 125/12 143/23 149/11 170/5 187/11	redistribution [1] 142/24	rehearse [1] 25/13	remedy [1] 137/5	request [4] 50/1 83/24 195/16 197/6
reassessed [1] 57/16	reduce [8] 23/6 51/16 54/13 77/17 79/9 82/2 85/10 166/9	reimburse [1] 195/15	remember [2] 2/6 2/8	requests [3] 68/15 103/10 128/10
reassured [1] 188/8	reduced [1] 178/14	reinfections [1] 14/19	remembering [1] 164/4	require [2] 50/25 51/2
reassuring [1] 160/1	reducing [1] 54/15	reinforced [2] 57/11 194/24	remind [2] 8/1 8/15	required [12] 38/8 85/11 95/21 105/12 106/2 108/1 146/22 169/13 173/6 180/18 182/18 191/16
Rebecca [1] 137/16	reduction [4] 46/17 46/19 61/2 85/9	reiterated [1] 80/16	reminded [1] 101/22	requirement [2] 64/10 168/14
Rebecca Evans [1] 137/16	reference [3] 56/17 71/5 119/13	reiterating [1] 77/15	reminder [1] 162/18	requirements [3] 50/19 70/16 196/10
recall [1] 197/2	referred [3] 10/11 27/25 62/15	relate [1] 156/16	reminding [1] 102/5	requires [5] 148/5 148/15 149/8 166/6 187/1
receipt [2] 28/9 152/17	referring [1] 116/21	related [6] 9/11 13/23 22/6 54/13 60/18 80/11	reminds [2] 2/14 175/14	requiring [6] 32/10 33/11 51/1 148/11 157/25 181/7
receive [2] 66/24 93/5	reflect [6] 109/14 113/11 114/14 132/13 157/12 189/2	relation [8] 3/18 20/10 24/22 66/20 106/22 157/11 185/1 197/20	remote [1] 184/13	research [3] 38/14 50/14 150/1
received [19] 5/4 5/22 28/6 29/11 47/14 48/20 78/3 82/21 84/8 85/25 91/13 92/12 92/17 116/6 118/17 180/7 183/20 193/25 198/18	reflected [5] 33/8 146/17 149/18 156/5 189/18	relating [7] 5/24 10/1 15/25 25/22 26/15 101/23 156/20	reminded [1] 101/22	researched [1] 20/18
receiving [2] 117/23 118/11	reflecting [2] 158/20 188/12	relations [9] 6/20 6/24 111/18 112/8 134/7 135/7 135/18 137/7 196/17	reminders [1] 162/18	reserved [1] 153/1
recent [1] 195/20	Reflection [1] 2/5	relationship [3] 140/12 143/17 145/20	reminding [1] 102/5	resident [1] 163/17
	reflective [3] 113/21 114/25 171/13		reminds [2] 2/14 175/14	residential [3] 108/2 155/8 163/21
			reminders [2] 2/14 175/14	residents [7] 21/7
			remind [2] 8/1 8/15	
			reminded [1] 101/22	
			reminder [1] 162/18	
			reminding [1] 102/5	
			reminds [2] 2/14 175/14	
			remote [1] 184/13	
			removed [1] 149/17	
			repatriation [1] 37/9	
			repeat [3] 4/2 158/4 197/5	
			repeated [2] 100/9 111/13	
			repeatedly [4] 62/14 169/7 169/23 194/13	
			repetition [1] 16/18	
			replaced [1] 69/3	
			report [31] 19/18 20/24 21/12 24/23 32/1 32/16 32/19 34/13 35/17 37/12 46/12 46/20 50/21 91/17 91/19 122/23 125/1 128/20 136/23 136/24 142/10 165/13 166/3 168/17 169/19	

R	23/20 54/23 133/16 188/15	48/16 59/16 63/9 72/1 84/13	23/18 27/23 34/9 36/16 36/25 39/2 39/22 55/22 57/10 94/24 107/8 107/13 107/14 109/10 111/4 111/12 124/5 124/6 124/16 125/3 126/7 126/7 126/8 126/23 126/25 127/8 127/8 136/2 153/24 155/6 157/8 157/13 157/18 158/6 164/22 168/19 168/21 169/8 169/14 192/1 192/18 192/19	S
residents... [6] 108/11 116/16 118/11 118/14 121/5 125/14	responsibility [7] 71/24 83/7 147/6 152/7 176/4 182/23 198/5	reveal [1] 196/21 revealer [1] 144/17 reversal [1] 124/3 reverse [2] 80/14 83/15	sacrifice [2] 162/2 162/14	sadly [2] 186/6 186/8
resilience [8] 5/8 17/2 98/20 134/6 146/18 165/10 165/19 173/21	responsible [3] 14/12 129/14 129/16	reversion [1] 139/14 reverting [1] 154/17 review [4] 90/3 146/21 147/13 147/17 178/2 178/3	sadness [1] 186/7	safe [2] 73/14 77/16
resisted [1] 143/8	rest [7] 110/23 130/1 137/14 139/7 140/9 141/3 193/13	reviewed [3] 64/7 178/2 178/3	safeguarding [1] 7/22	safeguards [1] 156/17
resolution [1] 59/7	restaurants [2] 74/12 80/1	reviews [1] 178/9	safely [1] 154/1	safely [1] 154/1
resolved [2] 1/7 182/11	restricting [1] 43/23	revisit [1] 131/2	safer [1] 87/5	safety [8] 75/4 98/20 167/19 168/11 168/23 169/1 169/3 189/16
resource [4] 177/8 178/2 178/16 180/16	restriction [1] 127/1	Rhondda [1] 77/23	SAGE [48] 11/14 29/13 33/18 33/20 34/18 37/18 37/20 37/24 38/5 38/7 41/1 41/9 42/1 43/2 43/18 44/2 44/7 46/11 46/24 47/18 47/25 48/3 48/21 50/21 51/10 51/14 55/7 62/13 62/14 70/24 70/24 71/1 71/6 71/9 76/2 79/18 79/21 80/5 82/7 93/4 97/15 102/23 106/24 109/19 135/10 138/21 138/24 143/9	
resourced [1] 179/24	restrictions [57] 26/8 28/24 31/22 43/24 54/12 64/11 65/14 65/22 72/11 73/18 74/1 74/19 75/10 76/22 80/18 81/20 82/20 84/18 85/7 85/10 85/13 85/22 86/12 86/23 86/25 87/1 87/13 87/21 88/23 88/25 90/6 90/8 95/5 95/12 110/8 110/17 116/22 117/14 117/19 119/6 119/11 119/14 120/5 120/8 120/20 120/25 121/13 121/20 125/19 125/20 125/22 125/24 178/5 178/12 183/25 191/25 195/1	right [20] 5/13 29/5 57/7 58/2 63/6 73/12 76/7 82/8 96/12 99/17 103/18 116/15 117/1 131/14 142/6 147/25 160/24 161/5 196/24 197/25	Rob [2] 34/20 122/5	
resources [7] 17/22 55/19 97/11 134/8 140/5 141/24 179/15	respect [8] 68/3 103/5 103/6 107/16 107/24 108/22 151/7 172/24	right-wing [1] 76/7	Robert [1] 11/1	
respect [8] 68/3 103/5 103/6 107/16 107/24 108/22 151/7 172/24	respected [2] 145/13 193/21	rightly [5] 168/8 186/11 187/5 190/25 197/16	Robinson [3] 23/24 24/1 24/8	
respectfully [1] 117/4	respectively [3] 74/9 74/16 74/17	rights [57] 10/3 115/14 115/17 116/17 116/20 121/8 130/17 130/23 131/16 131/18 133/22 134/14 134/20 135/2 135/3 135/14 139/6 139/22 142/1 142/22 142/23 145/13 145/16 146/6 146/7 146/14 146/16 146/23 147/16 147/22 148/3 148/4 148/6 149/3 150/3 150/21 150/23 151/1 151/10 151/13 152/22 153/15 154/2 154/24 155/12 157/6 157/16 158/7 158/15 160/17 167/18 187/16 189/15 191/17 193/9 199/12 199/15	robust [5] 49/22 101/22 103/19 185/4 189/14	
resource [4] 177/8 178/2 178/16 180/16	restrictive [2] 52/25 152/20	rights-based [1] 154/24	Robustly [1] 111/2	
resourced [1] 179/24	result [10] 71/7 71/9 87/9 95/5 118/6 123/25 134/6 147/17 167/17 179/23	ring [1] 101/17	role [13] 5/10 20/6 48/7 65/3 91/24 94/2 133/6 145/19 147/21 152/15 178/20 182/4 182/24	
resources [7] 17/22 55/19 97/11 134/8 140/5 141/24 179/15	resultant [1] 155/4	ripped [1] 163/15	roles [3] 23/16 92/5 181/22	
respect [8] 68/3 103/5 103/6 107/16 107/24 108/22 151/7 172/24	resulted [3] 6/11 171/19 177/15	rise [6] 46/23 80/12 80/14 81/11 84/24 85/17	rolling [1] 180/25	
respected [2] 145/13 193/21	resulting [1] 152/5	risen [1] 32/22	room [5] 2/18 2/20 3/5 107/21 173/4	
respectfully [1] 117/4	results [3] 14/21 15/8 127/15	Rishi [1] 195/9	root [1] 142/10	
respectively [3] 74/9 74/16 74/17	resume [3] 3/11 46/23 89/1	Rishi Sunak [1] 195/9	Ros [1] 116/9	
respiratory [6] 21/5 22/14 39/19 40/21 64/24 132/14	Resuscitate [1] 140/1	rising [2] 78/25 89/23	rose [1] 48/19	
respond [5] 67/8 88/15 90/25 95/23 128/14	retail [2] 64/10 73/22	risk [56] 9/12 9/19 9/20 10/7 17/13 17/15 17/16 19/4 19/13 21/3 21/8 21/17 21/18 23/6	route [1] 59/6	
responded [3] 77/21 121/11 129/12	retain [1] 101/22		row [1] 155/1	
responding [5] 63/17 83/7 103/11 124/21 188/13	retained [1] 75/9		rugby [6] 52/11 56/18 56/21 56/23 57/3 105/20	
response [66] 5/5 5/8 5/21 7/4 7/6 8/5 10/24 11/11 17/2 18/1 21/14 26/2 26/5 29/8 35/2 47/6 48/6 50/1 50/2 51/18 54/6 56/5 57/13 57/15 63/23 65/23 67/10 75/4 76/15 88/13 91/4 91/7 93/17 99/16 99/19 101/4 104/6 104/8 104/17 105/3 105/10 105/24 105/25 113/5 114/8 118/6 119/12 136/22 146/13 155/23 162/22 166/6 166/6 166/7 166/14 166/15 167/1 169/24 170/16 177/20 177/23 177/24 189/12 191/1 193/14 194/23	retention [4] 83/20 84/11 92/18 195/14		rule [7] 28/6 68/18 75/9 75/12 75/14 75/15 157/25	
responded [3] 77/21 121/11 129/12	Retrofitting [1] 149/19		Rule 9 [1] 28/6	
responding [5] 63/17 83/7 103/11 124/21 188/13	retrospectively [1] 78/8		ruled [1] 34/16	
response [66] 5/5 5/8 5/21 7/4 7/6 8/5 10/24 11/11 17/2 18/1 21/14 26/2 26/5 29/8 35/2 47/6 48/6 50/1 50/2 51/18 54/6 56/5 57/13 57/15 63/23 65/23 67/10 75/4 76/15 88/13 91/4 91/7 93/17 99/16 99/19 101/4 104/6 104/8 104/17 105/3 105/10 105/24 105/25 113/5 114/8 118/6 119/12 136/22 146/13 155/23 162/22 166/6 166/6 166/7 166/14 166/15 167/1 169/24 170/16 177/20 177/23 177/24 189/12 191/1 193/14 194/23	return [4] 9/17 30/16 48/12 98/22		rules [7] 73/10 74/2 94/11 94/16 95/14 102/14 152/19	
responses [2] 26/19 28/7	returned [1] 77/6		run [3] 6/25 37/23 144/10	
responsibilities [4]	returning [6] 48/14		runaway [1] 8/7	

S				
Save... [1] 72/4	105/6 105/14 106/25	129/21 130/7 140/23	127/24	45/20 117/12 137/12
saved [1] 172/5	109/14 110/9 122/5	153/6 155/16 155/21	separate [1] 74/24	142/25
saving [8] 88/17 98/8	124/16 124/25 138/20	157/11 158/9 163/12	Separately [1]	severe [9] 13/14 14/7
171/20 171/20 171/24	143/8 150/18 159/15	167/8 167/15 181/4	170/13	34/4 38/10 53/21
171/25 172/8 172/9	159/17 159/21 190/20	190/15	September [19] 12/8	117/14 119/14 120/5
saw [5] 15/12 65/10	scientists [7] 31/6	sectors [10] 16/4	13/23 14/11 15/10	127/7
101/3 108/21 171/25	31/9 37/14 41/2 59/18	27/14 54/6 161/14	69/5 77/8 77/18 77/20	severely [3] 9/8 32/4
say [23] 11/21 26/23	98/6 139/1	162/21 164/5 164/7	78/17 79/3 79/12	169/3
38/16 42/9 57/7 83/16	scope [8] 3/21 4/13	164/21 182/22 191/25	79/18 80/15 82/22	severity [2] 42/7
96/8 101/15 116/10	7/20 20/2 27/22 111/3	secure [3] 153/9	97/25 109/19 115/21	130/11
119/13 121/18 123/15	149/14 183/13	154/4 154/5	116/1 139/3	sex [1] 28/1
124/5 124/19 126/23	Scotland [27] 14/22	see [20] 4/18 13/18	September 2020 [1]	sexual [2] 23/13 28/2
127/9 138/9 143/22	15/10 22/4 25/12 30/7	22/7 26/19 30/16	14/11	Shadow [4] 90/20
151/24 152/1 173/7	30/23 56/19 56/24	41/12 44/7 50/5 50/9	September 2022 [1]	167/5 190/7 193/19
181/5 197/22	57/3 68/3 68/19 72/6	52/1 53/20 87/12 97/6	13/23	Shakespeare [4]
saying [3] 37/1	73/24 74/14 74/20	110/24 116/2 116/7	series [2] 36/5 130/2	21/21 21/23 22/2 22/9
106/12 134/19	85/20 87/8 89/5	131/11 163/2 174/19	serious [7] 9/21 63/2	shall [12] 1/15 2/10
says [2] 116/1	105/20 131/22 131/23	176/25	79/14 95/22 120/7	2/23 3/1 3/4 3/11
180/23	133/18 134/19 138/19	seek [11] 7/1 29/20	123/7 192/9	30/16 67/14 98/22
scale [7] 18/16 79/15	142/21 188/1 198/1	49/5 49/8 55/11 66/24	seriously [3] 9/5 40/6	160/24 198/16 198/17
97/11 138/16 155/21	Scottish [8] 56/2	93/5 94/9 98/15	134/5	Shan [1] 44/12
159/3 194/20	56/23 74/7 85/4	102/13 111/13	seriousness [1]	Shan Morgan [1]
scaled [1] 179/6	136/19 137/9 162/5	seeking [5] 43/21	44/13	44/12
scaling [1] 137/5	162/6	52/17 100/18 152/4	servants [6] 5/24	shape [2] 54/4 55/12
scenario [15] 38/4	Scottish TUC [1]	168/3	26/13 98/4 133/2	share [1] 170/21
38/22 39/1 50/5 51/22	162/5	seeks [1] 100/17	136/7 187/12	shared [12] 34/19
51/24 53/15 53/23	scratch [1] 135/22	seemed [1] 70/12	serve [3] 106/17	35/17 36/7 44/5 44/10
54/1 57/16 61/2 81/1	screen [8] 11/23	seemingly [2] 105/6	137/14 189/11	86/6 113/17 114/21
81/4 86/7 87/16	33/20 41/10 42/15	137/13	service [5] 11/3	141/16 166/20 166/23
scenarios [1] 96/21	44/6 53/19 59/21	seen [10] 14/4 44/25	153/17 164/10 164/18	181/13
Schedule [1] 139/18	72/21	81/16 117/8 139/14	180/1	sharing [5] 141/13
Schedule 12 [1]	scripted [1] 68/22	141/22 155/3 167/23	17/9 17/17 23/12 36/4	156/2 159/1 174/9
139/18	scrutinise [3] 99/15	171/8 171/24	80/2 98/12 105/2	181/23
scheme [18] 75/21	109/4 152/4	self [11] 24/20 34/15	134/25 138/6 139/14	sharp [2] 118/4 192/2
76/4 76/16 76/23 77/1	scrutinised [1]	35/20 54/14 55/24	141/25 165/10 165/19	shattered [1] 99/12
77/2 83/19 83/20	159/24	60/21 95/13 158/2	165/25 180/13 183/1	Shavanah [2] 161/25
83/24 84/12 149/4	scrutinising [1]	169/13 169/17 169/22	set [19] 27/23 47/21	166/22
149/8 170/3 195/4	145/24	self-isolate [2] 158/2	48/2 50/12 66/15	Shavanah Taj [2]
195/4 195/11 195/14	scrutiny [12] 7/5 95/6	169/13	90/21 91/8 118/8	161/25 166/22
195/16	100/11 101/18 102/19	self-isolation [6]	119/15 124/10 128/24	she [6] 23/1 23/20
school [13] 25/16	104/7 107/12 185/16	54/14 55/24 60/21	136/25 138/19 148/10	116/1 147/24 158/22
41/4 43/22 45/17	185/18 187/1 187/6	95/13 169/17 169/22	155/25 168/16 171/4	193/21
46/18 48/17 62/6	197/12	self-reported [1]	180/13 187/10	shed [1] 92/8
62/23 63/8 149/23	season [1] 43/6	24/20	sets [1] 100/2	shelves [1] 165/7
151/3 151/4 184/8	seasonal [1] 50/9	self-sustaining [2]	setting [5] 50/2 108/2	shielding [4] 7/7
school-aged [1]	second [17] 3/24	34/15 35/20	149/25 154/9 154/11	60/22 135/23 139/15
62/23	12/5 12/25 13/1 13/10	send [3] 56/12 56/14	153/7 153/11 153/25	shine [3] 100/21
schools [16] 46/13	14/11 15/13 34/13	182/2	155/3 157/8 157/21	161/19 190/25
62/3 62/9 62/13 62/17	55/14 106/17 121/23	Senedd [5] 102/11	158/1 164/17	ship [4] 46/1 46/6
62/20 62/22 63/2 63/4	134/2 139/4 142/13	134/18 137/15 189/22	settlement [5] 6/9	106/13 106/15
66/16 80/7 86/17 89/1	144/11 165/11 174/22	189/25	154/21 155/2 170/7	shocking [4] 8/13
150/13 150/13 151/10	secondary [1] 86/17	senior [12] 5/23	189/3	99/24 132/5 162/24
science [5] 11/20	secondly [4] 118/23	10/22 26/13 40/24	settlements [1]	shopping [1] 63/7
102/22 103/17 110/19	123/18 130/13 176/12	102/3 102/7 155/25	187/25	shops [1] 63/6
133/1	secondments [1]	186/21 187/11 190/18	187/25	short [11] 30/19
scientific [36] 5/4	180/25	194/6 197/12	seven [8] 18/18 32/4	80/10 81/5 98/25
6/15 10/21 11/1 11/6	secretary [7] 11/3	sense [3] 126/6	46/14 55/24 61/22	129/3 147/10 157/16
11/10 11/10 26/14	35/10 36/1 44/12	141/15 166/20	79/6 80/10 132/4	159/21 161/2 174/12
31/25 32/16 33/17	65/24 161/23 161/25	sensible [2] 1		

S	100/23 111/3 117/6 134/12 169/5 175/11 176/10 179/21 181/7 182/8 184/5 189/7 196/3 significantly [4] 30/1 85/20 85/23 176/22 signs [1] 28/19 silos [1] 112/10 similar [5] 38/5 55/9 74/10 121/6 174/14 similarities [1] 184/17 similarly [5] 108/10 108/21 120/1 129/4 130/21 Simon [1] 65/25 Simon Hart [1] 65/25 simple [4] 8/6 142/11 165/24 166/5 simply [5] 67/25 73/20 97/17 101/18 102/24 since [10] 15/21 38/19 89/9 89/19 137/17 139/7 187/8 191/2 191/15 197/7 sincere [1] 186/5 Singh [1] 91/9 Singhal [1] 91/10 single [6] 89/19 96/12 121/2 129/13 129/16 196/8 singles [1] 139/21 Sir [3] 10/25 18/3 34/22 Sir Frank Atherton [2] 10/25 34/22 Sir Michael Marmot [1] 18/3 situation [7] 37/11 39/3 51/25 55/4 70/22 79/13 169/11 six [10] 32/22 52/11 52/24 56/18 74/6 116/4 132/5 137/16 157/25 179/1 six months [1] 116/4 Six Nations [2] 52/11 56/18 six years [1] 137/16 sixth [4] 43/2 70/25 72/22 128/6 size [6] 130/10 137/17 155/10 155/20 157/15 189/4 skill [1] 140/16 slightly [3] 12/24 30/21 30/22 slogan [1] 72/7 slow [4] 90/2 104/17 105/10 105/18 slower [3] 26/3 108/12 128/14	slowing [2] 41/6 46/22 small [7] 89/14 103/14 119/21 138/11 155/7 157/20 190/14 smaller [5] 12/6 18/16 20/8 87/4 153/25 so [67] 2/15 3/4 4/13 4/17 5/22 12/16 16/11 16/13 24/13 29/6 30/12 30/14 30/24 31/4 42/8 44/11 63/7 79/1 80/8 85/7 94/12 95/7 98/17 98/17 99/11 104/15 105/18 113/22 114/3 115/1 115/7 119/2 121/18 122/12 124/22 127/5 127/24 128/9 131/1 133/8 134/15 135/4 139/12 139/23 146/24 153/18 160/16 162/16 162/19 163/22 175/11 178/10 180/18 180/19 181/18 181/20 184/5 185/21 186/1 187/8 188/2 191/18 193/13 194/19 198/1 198/14 198/21 so-called [1] 139/12 social [61] 7/17 10/20 17/9 17/17 18/21 18/25 19/10 35/11 36/4 46/16 51/12 53/18 57/11 57/20 58/10 59/19 61/1 75/7 87/17 90/21 94/11 95/12 98/5 105/2 106/8 123/6 127/23 128/2 132/25 133/1 133/5 134/24 137/3 138/16 139/8 142/3 152/12 155/14 156/16 163/4 163/10 163/18 164/25 165/25 166/16 167/4 167/5 168/12 168/13 168/22 170/13 173/1 173/2 177/9 184/5 184/7 190/7 192/18 193/8 193/11 193/19 social care [12] 7/17 58/10 87/17 123/6 127/23 128/2 156/16 163/4 163/10 163/18 165/25 168/22 socialising [1] 77/7 societal [6] 9/2 9/5 9/19 19/5 97/14 139/9 society [18] 6/10 16/4 19/20 23/23 25/15 27/5 27/10 27/14 121/9 125/15	136/20 142/16 144/20 162/20 164/15 186/16 191/7 191/25 socio [1] 18/8 socio-spatial [1] 18/8 socioeconomic [7] 17/23 22/12 24/5 142/23 164/14 191/4 192/13 solely [5] 100/4 140/14 179/8 195/23 196/12 solution [1] 85/5 some [73] 1/22 3/2 3/24 4/10 11/13 16/14 16/18 19/2 19/14 28/12 28/13 30/2 32/7 32/20 45/4 51/1 53/10 57/10 68/7 68/23 70/5 70/8 73/19 73/25 84/21 87/18 87/19 90/11 92/9 95/4 95/4 95/15 95/17 101/10 101/15 103/11 113/3 113/4 113/4 114/6 114/7 114/7 115/18 118/20 122/20 122/24 126/2 126/17 130/8 131/10 143/2 149/23 168/12 168/23 170/8 170/25 171/3 171/8 171/25 172/7 172/13 175/10 178/7 180/4 180/7 181/6 182/19 183/18 184/14 191/14 197/23 198/4 198/5 someone [1] 55/24 something [7] 11/21 26/23 76/24 128/2 139/22 181/5 197/22 sometimes [2] 150/14 185/17 somewhat [4] 113/13 114/16 137/4 177/2 somewhere [1] 51/4 sooner [3] 105/15 177/3 179/13 sores [1] 120/16 sorry [2] 30/21 148/7 sort [2] 158/5 171/3 sort of [2] 158/5 171/3 sought [6] 16/7 112/8 139/8 140/22 156/22 171/18 sound [1] 111/9 source [1] 130/1 sources [1] 34/11 soured [1] 134/7 south [3] 47/12 61/19 78/9 South Korea [1] 47/12 sovereign [1] 135/16	sown [1] 141/14 Spain [1] 59/17 spatial [1] 18/8 speak [1] 158/22 speaking [1] 22/3 special [6] 100/12 102/3 102/5 102/8 106/11 106/17 specialist [3] 19/3 32/11 97/13 specific [20] 6/23 17/7 17/14 28/7 31/20 37/22 38/6 57/1 100/11 103/11 118/20 123/2 123/9 125/8 125/18 158/14 167/15 179/1 182/3 191/19 specifically [5] 29/15 54/21 94/8 153/7 157/10 specifics [2] 120/12 129/4 speed [3] 26/2 29/3 105/12 speedily [2] 114/2 115/6 speedy [1] 96/8 spend [1] 127/6 spending [2] 84/9 121/14 SPI [13] 11/14 11/14 37/13 41/12 42/12 44/24 45/16 62/14 76/2 76/2 79/3 79/6 104/2 SPI-B [2] 11/14 76/2 SPI-M [3] 11/14 76/2 104/2 SPI-M-O [7] 37/13 41/12 42/12 44/24 45/16 62/14 79/6 SPI-M-O's [1] 79/3 spirit [1] 112/17 spoken [3] 106/12 113/25 115/4 spokesman [1] 101/20 sponsored [1] 193/11 spotlight [1] 100/21 spread [15] 7/10 24/15 36/17 39/25 43/21 53/3 55/13 55/18 61/25 67/23 85/2 97/7 101/6 108/16 181/15 spreading [3] 39/20 49/9 93/20 spring [3] 73/19 88/25 90/7 St [1] 2/4 stability [2] 189/4 189/5 stable [1] 89/22
----------	--	---	--	---

S	36/18 38/17 104/20	storm [1] 106/16	subject [6] 76/1	144/12 163/4 179/20
stacked [2] 97/1 165/7	statement [21] 3/14 3/20 31/20 35/6 37/1 37/5 41/12 52/20 57/18 69/17 107/4 140/11 141/10 161/9 163/9 173/10 174/20 174/22 185/24 188/8 199/5	story [3] 27/7 168/4 179/18	78/16 79/1 165/12 165/13 187/19	suffering [11] 2/12 24/19 61/17 98/17 113/19 114/23 120/18 133/8 186/13 191/13 192/8
Stadium [2] 52/11 56/20	statements [9] 11/12 120/14 126/1 132/20 174/23 186/22 187/15 187/23 197/8	straddle [1] 154/6	subjected [1] 180/2	sufficiency [1] 107/5
staff [16] 1/17 13/16 59/4 101/21 108/11 109/1 121/2 126/21 154/9 163/23 163/24 168/20 168/22 168/22 172/6 195/13	states [5] 104/24 107/4 107/19 108/24 109/8	straightforward [4] 134/15 154/25 196/15 197/1	subjects [1] 141/19	sufficient [9] 29/3 97/23 118/23 119/3 122/25 127/16 128/7 148/18 169/6
stage [16] 27/6 28/17 40/12 47/7 56/7 62/12 109/8 109/10 111/1 120/24 122/14 131/21 157/7 168/14 176/10 197/24	stating [8] 34/8 44/9 48/20 56/13 66/2 66/9 84/8 86/3	strain [1] 87/9	submission [2] 162/1 176/17	sufficiently [3] 96/8 96/8 135/3
staged [1] 74/14	statistician [2] 15/23 15/24	straits [1] 179/17	submitted [4] 172/20 177/12 181/17 192/16	suggest [6] 20/14 58/14 71/17 72/14 150/17 180/16
stages [1] 106/22	statisticians [1] 132/10	strategic [14] 5/5 5/21 7/4 10/13 17/25 34/25 40/9 50/13 63/23 93/17 96/13 97/20 104/23 105/4	submit [1] 117/4	suggested [8] 51/4 61/20 61/23 67/18 80/9 103/13 140/4 171/17
stake [1] 112/14	statistics [1] 118/7	strategies [4] 24/14 28/23 49/4 65/9	submits [1] 175/18	suggesting [1] 198/3
stakeholders [13] 117/18 121/7 122/1 122/19 123/5 125/6 125/25 127/12 128/11 129/10 168/4 172/22 181/17	status [2] 17/23 54/22	strategy [14] 47/1 47/3 48/9 53/12 55/11 55/17 65/1 69/13 72/8 78/15 88/6 93/1 97/16 174/16	submitted [4] 172/20 177/12 181/17 192/16	suggestion [2] 110/5 195/20
stance [1] 135/15	statutory [1] 139/19	streaming [1] 3/12	suboptimal [1] 176/1	suggests [23] 39/12 40/16 43/9 48/23 62/16 63/19 68/6 70/20 71/12 103/8 103/22 104/1 104/16 104/20 105/9 105/24 112/1 113/14 113/18 114/18 114/22 127/22 188/21
stand [2] 183/6 187/13	stay [11] 60/23 64/6 64/10 64/14 68/10 68/10 72/3 72/4 72/12 73/3 183/24	strengthen [1] 146/18	subsequent [5] 25/6 77/21 79/9 88/15 193/5	suitable [2] 96/9 155/11
standard [3] 171/5 182/25 188/5	stay-at-home [2] 64/6 73/3	strengthened [3] 61/15 167/4 173/8	subsequently [1] 179/10	suite [1] 86/11
standards [4] 94/16 100/5 145/9 182/18	staying [1] 94/12	stretched [1] 85/1	substance [3] 4/4 189/1 190/23	summarise [5] 4/2 16/14 20/1 26/16 118/21
standing [2] 40/14 138/12	steady [1] 77/5	strict [1] 79/7	substandard [1] 182/17	summarised [2] 28/12 124/8
Star [1] 91/6	steered [1] 106/15	stricter [1] 60/20	substantial [1] 46/21	summarising [1] 50/22
Star Chamber [1] 91/6	stenographer [1] 30/13	strikes [2] 114/3 115/7	substantive [5] 1/20 73/25 75/1 162/13 182/13	summary [5] 16/6 16/10 54/17 79/19 85/16
stark [5] 3/25 11/22 64/17 107/18 108/19	step [3] 63/1 95/24 108/7	stringency [3] 26/1 26/7 26/9	substitute [2] 96/3 194/7	summer [7] 52/18 73/19 77/5 82/20 132/2 151/9 176/11
starker [1] 80/22	step-down [1] 108/7	stringent [2] 80/13 125/20	success [2] 175/20 176/5	Sunak [2] 84/7 195/9
start [20] 3/2 15/3 83/20 83/24 85/19 89/19 93/18 103/25 115/18 117/3 123/24 135/21 147/20 191/2 191/9 195/5 195/10 197/2 197/7 197/12	Stephanie [1] 15/24	strong [2] 22/6 78/21	successor [1] 83/19	Sunak's [2] 195/20 196/1
started [7] 15/19 30/9 67/12 80/12 117/9 136/11 187/8	Stephanie Howarth [1] 15/24	stronger [1] 109/9	such [56] 5/12 7/17 7/19 8/20 10/2 10/19 11/14 24/20 25/2 28/1 29/13 48/10 48/25 54/23 57/4 57/8 57/23 77/12 81/2 85/13 89/4 90/17 91/23 91/25 92/15 93/4 95/13 96/22 97/13 101/12 110/21 111/1 120/8 130/10 134/24 136/11 137/18 147/24 149/23 151/3 151/8 155/16 157/3 159/2 164/23 165/21 166/10 174/15 177/24 178/9 178/17 180/20 181/6 184/8 190/1 190/19	summarised [2] 28/12 124/8
starting [3] 37/8 67/4 133/11	steps [5] 44/20 66/10 81/2 93/25 107/2	strongly [1] 69/1	structural [4] 10/6 19/19 20/6 20/22	summary [5] 16/6 16/10 54/17 79/19 85/16
startling [1] 141/7	Stereophonics [2] 57/5 105/20	struck [2] 91/1 95/11	structure [3] 69/23 111/22 131/8	summer [7] 52/18 73/19 77/5 82/20 132/2 151/9 176/11
starvation [1] 116/11	sticking [2] 72/10 100/15	stringency [3] 26/1 26/7 26/9	structures [14] 5/9 6/18 6/19 17/2 19/3 28/20 29/17 90/15 90/24 93/4 136/11 136/14 167/3 189/5	Sunak [2] 84/7 195/9
state [20] 5/7 17/1 35/10 36/1 42/16 45/1 65/24 133/6 134/12 135/16 138/11 140/12 142/3 142/15 144/8 146/15 148/15 175/1 185/23 194/18	still [13] 1/6 40/17 47/7 47/16 76/22 81/10 89/21 99/13 116/23 132/5 140/10 140/20 179/7	stringent [2] 80/13 125/20	struggle [1] 166/1	Sunak's [2] 195/20 196/1
stated [5] 28/16 32/5	stimulating [1] 75/22	strong [2] 22/6 78/21	struggled [1] 103/13	Sunday [1] 2/6
	stocks [1] 43/16	stronger [1] 109/9	student [1] 39/8	supplement [3] 19/22 25/19 100/13
	stolen [1] 186/10	strongly [1] 69/1	study [2] 136/22 169/15	supplemental [1] 194/8
	stop [3] 55/16 90/9 139/4	struck [2] 91/1 95/11	sub [1] 91/10	supplementary [1] 163/9
	stopped [2] 144/2 158/4	structural [4] 10/6 19/19 20/6 20/22	sub-groups [1] 91/10	supplementing [1] 198/18
	stories [2] 162/16 162/19	structure [3] 69/23 111/22 131/8	subcommittees [1] 71/2	supply [2] 53/24 182/17
		structures [14] 5/9 6/18 6/19 17/2 19/3 28/20 29/17 90/15 90/24 93/4 136/11 136/14 167/3 189/5	subgroup [3] 103/7 192/14 192/17	support [24] 7/8 40/23 51/3 75/22 77/1
		struggled [1] 103/13	subgroups [2] 102/22 192/13	

S	switched [2] 55/17 139/23	26/12 27/16 29/10 29/23 31/17 40/6 59/10 62/3 62/20 66/10 67/1 70/12 71/23 82/20 86/16 87/21 88/19 94/1 96/9 101/23 107/2 107/16 108/11 109/9 126/3 126/22 127/4 127/9 127/14 132/7 133/15 137/19 142/19 148/17 149/20 156/13 167/20 171/3 196/11	23/19 23/20 71/7 71/9 tendency [1] 112/10 tenet [1] 145/18 tenor [2] 113/7 114/10 tension [1] 172/4 tenth [1] 46/11 term [5] 9/21 25/1 78/20 78/22 79/8 terms [10] 9/2 9/7 24/10 55/10 67/12 94/25 129/5 138/23 139/5 178/20 terrible [4] 8/14 95/23 132/4 165/21 test [12] 7/7 37/22 42/2 42/4 58/13 81/15 81/17 108/6 124/3 126/19 170/2 179/3 tested [8] 33/4 39/17 46/5 52/21 53/6 55/1 107/23 108/8 testimonies [1] 8/14 testimony [2] 25/6 101/9 testing [21] 37/7 43/5 55/19 58/19 58/21 58/25 59/2 59/12 77/13 93/18 101/7 107/18 108/10 108/23 110/16 110/21 123/11 123/23 125/2 129/24 136/3 tests [3] 15/7 37/23 108/1 text [4] 92/2 92/6 101/12 102/1 than [58] 12/23 13/2 13/21 15/2 15/6 18/10 22/5 22/23 26/3 32/14 32/15 39/3 41/15 42/13 46/18 52/7 55/16 56/4 58/11 59/14 60/9 63/18 67/9 70/10 71/1 75/3 81/14 81/16 85/19 87/18 108/9 108/12 110/22 116/12 118/5 118/14 119/23 128/16 132/1 132/9 133/17 136/3 136/6 139/7 139/10 140/9 143/15 147/25 156/22 168/15 169/25 170/4 183/9 186/1 188/2 189/24 193/13 197/8 thank [27] 1/8 3/8 3/11 31/3 98/21 99/5 115/10 115/11 131/4 131/12 131/20 131/21 144/23 144/24 160/23 163/1 173/11 173/15 185/7 185/9 185/13 197/17 197/18 198/9	198/10 198/14 198/21 thank you [14] 3/8 3/11 31/3 99/5 144/23 173/15 185/7 185/13 197/17 197/18 198/9 198/10 198/14 198/21 thankful [1] 143/21 thanks [2] 98/3 115/23 that [723] that's [13] 116/18 117/22 118/7 119/15 121/25 123/4 124/12 124/25 125/14 130/18 144/8 173/10 181/20 their [83] 1/17 2/6 2/11 6/7 6/14 8/17 8/17 8/18 10/5 16/6 18/7 19/6 19/12 19/22 19/24 20/1 21/6 22/15 22/23 23/6 24/23 26/19 26/25 32/16 67/12 67/25 86/1 93/1 98/5 113/20 114/24 116/17 120/14 126/19 127/6 132/21 138/11 143/4 145/12 148/8 148/12 149/11 150/23 151/1 152/15 153/13 154/10 157/2 157/22 158/3 158/3 158/6 158/6 158/23 159/1 159/12 159/18 160/6 160/13 160/14 160/17 162/16 162/22 164/22 167/20 170/21 175/20 175/21 176/4 176/5 179/22 180/15 182/25 185/5 186/7 186/10 187/3 187/11 187/15 188/15 188/17 191/17 193/14 them [31] 5/1 9/14 11/13 13/9 26/20 28/25 30/15 62/18 88/4 88/9 92/21 95/13 103/12 119/20 126/16 128/25 131/2 133/20 136/3 141/11 151/6 152/2 153/19 160/13 160/19 164/1 182/3 184/12 187/23 188/11 198/16 theme [3] 48/12 179/16 181/24 themes [3] 26/17 28/12 117/12 themselves [2] 102/5 159/24 then [27] 8/4 12/14 33/24 41/17 41/20 42/21 42/23 48/14 50/9 52/12 54/7 60/11 64/5 66/4 69/3 74/20
support... [19] 83/8 83/19 84/11 120/10 121/15 129/21 143/3 149/6 154/13 156/17 156/21 159/9 160/15 163/14 169/13 170/3 170/11 195/4 196/1 supported [7] 11/8 22/10 76/4 82/6 113/13 114/16 118/7 supporter [1] 117/1 supporting [1] 180/10 supportive [1] 167/3 suppress [2] 43/21 55/12 suppression [2] 47/2 49/3 sure [6] 1/15 2/18 94/5 131/5 131/10 185/19 surely [2] 183/13 183/16 surge [1] 61/17 surgery [1] 140/3 surgical [1] 57/24 surrounding [2] 37/10 76/14 surveillance [3] 15/4 25/3 183/3 survey [4] 14/21 15/19 125/15 170/21 surveys [1] 159/4 survival [1] 140/6 susceptibility [1] 24/10 susceptible [1] 24/11 suspect [1] 30/10 suspected [1] 125/14 suspended [2] 35/5 139/18 suspension [4] 57/23 58/1 141/25 156/16 suspiciously [1] 102/4 sustainable [2] 33/23 54/6 sustained [11] 36/20 38/9 41/23 42/25 45/3 45/5 45/8 45/20 47/13 159/14 193/25 sustaining [2] 34/15 35/20 Swansea [2] 77/24 78/4 Swansea's [1] 48/17 sweeping [1] 6/9 swifter [2] 49/6 176/20 swiftly [2] 153/18 192/20 swing [1] 60/16	sympathies [1] 186/4 symptom [1] 167/24 symptomatic [4] 42/8 50/6 108/4 124/19 symptoms [10] 15/1 31/16 34/1 34/4 46/9 50/24 54/14 58/25 59/14 64/24 syndrome [1] 24/17 system [9] 33/10 33/11 86/2 133/12 133/12 135/6 137/10 157/25 196/8 system-wide [1] 33/11 systematically [2] 19/9 174/17 systemic [1] 101/5 systemically [1] 102/4 systems [12] 17/4 17/6 29/12 41/22 88/3 92/24 93/3 93/9 93/10 93/20 127/23 178/3	26/12 27/16 29/10 29/23 31/17 40/6 59/10 62/3 62/20 66/10 67/1 70/12 71/23 82/20 86/16 87/21 88/19 94/1 96/9 101/23 107/2 107/16 108/11 109/9 126/3 126/22 127/4 127/9 127/14 132/7 133/15 137/19 142/19 148/17 149/20 156/13 167/20 171/3 196/11 takes [2] 130/6 151/13 taking [4] 14/25 148/13 148/14 155/5 Talbot [2] 77/25 153/10 tale [1] 76/12 targeted [3] 21/20 77/14 109/12 task [1] 95/18 tasked [1] 175/21 taskforce [4] 10/3 89/16 136/25 193/9 tasks [1] 179/25 Taylor [3] 23/24 24/1 24/8 Taylor-Robinson [1] 23/24 teachers [1] 98/12 teaching [3] 80/2 80/3 89/2 team [13] 1/16 1/16 38/13 42/5 78/5 78/17 131/20 147/14 150/9 152/9 159/19 173/23 181/2 teams [4] 41/4 103/21 131/21 143/22 tears [1] 164/4 technical [10] 11/6 11/7 11/8 11/10 40/18 47/24 53/17 97/7 132/18 138/24 teenagers [1] 157/22 teeth [1] 100/14 televised [1] 159/2 television [1] 116/10 tell [2] 30/24 133/9 telling [1] 104/24 tells [2] 16/8 140/11 temperature [1] 55/25 template [1] 149/25 temporal [1] 84/10 temporary [1] 180/7 ten [6] 15/6 32/15 42/13 45/24 132/4 132/5 ten-fold [1] 15/6 tend [1] 22/4 tended [5] 22/11		
T	tabletop [2] 43/7 49/24 TAC [25] 11/9 47/21 47/23 48/7 50/3 50/8 59/23 60/25 63/11 79/12 79/21 80/16 80/21 81/9 81/10 82/7 85/6 85/7 93/9 97/15 102/22 103/2 103/5 109/22 141/13 TAC's [2] 79/16 80/22 tackle [2] 77/5 119/6 tackled [1] 77/10 Taf [1] 77/23 TAG [15] 11/8 11/9 11/18 47/22 47/23 48/7 93/9 97/15 102/22 103/2 103/5 103/8 122/9 141/13 143/9 TAG's [1] 122/3 tailored [1] 99/20 Taj [2] 161/25 166/22 take [26] 13/17 17/13 30/6 30/12 40/8 49/6 56/19 77/15 82/15 82/25 96/7 117/16 117/17 121/25 122/18 124/23 125/6 144/25 152/2 152/7 153/14 160/24 169/6 186/3 186/12 195/8 taken [45] 4/15 7/12 7/16 7/16 10/9 16/12	26/12 27/16 29/10 29/23 31/17 40/6 59/10 62/3 62/20 66/10 67/1 70/12 71/23 82/20 86/16 87/21 88/19 94/1 96/9 101/23 107/2 107/16 108/11 109/9 126/3 126/22 127/4 127/9 127/14 132/7 133/15 137/19 142/19 148/17 149/20 156/13 167/20 171/3 196/11 takes [2] 130/6 151/13 taking [4] 14/25 148/13 148/14 155/5 Talbot [2] 77/25 153/10 tale [1] 76/12 targeted [3] 21/20 77/14 109/12 task [1] 95/18 tasked [1] 175/21 taskforce [4] 10/3 89/16 136/25 193/9 tasks [1] 179/25 Taylor [3] 23/24 24/1 24/8 Taylor-Robinson [1] 23/24 teachers [1] 98/12 teaching [3] 80/2 80/3 89/2 team [13] 1/16 1/16 38/13 42/5 78/5 78/17 131/20 147/14 150/9 152/9 159/19 173/23 181/2 teams [4] 41/4 103/21 131/21 143/22 tears [1] 164/4 technical [10] 11/6 11/7 11/8 11/10 40/18 47/24 53/17 97/7 132/18 138/24 teenagers [1] 157/22 teeth [1] 100/14 televised [1] 159/2 television [1] 116/10 tell [2] 30/24 133/9 telling [1] 104/24 tells [2] 16/8 140/11 temperature [1] 55/25 template [1] 149/25 temporal [1] 84/10 temporary [1] 180/7 ten [6] 15/6 32/15 42/13 45/24 132/4 132/5 ten-fold [1] 15/6 tend [1] 22/4 tended [5] 22/11	23/19 23/20 71/7 71/9 tendency [1] 112/10 tenet [1] 145/18 tenor [2] 113/7 114/10 tension [1] 172/4 tenth [1] 46/11 term [5] 9/21 25/1 78/20 78/22 79/8 terms [10] 9/2 9/7 24/10 55/10 67/12 94/25 129/5 138/23 139/5 178/20 terrible [4] 8/14 95/23 132/4 165/21 test [12] 7/7 37/22 42/2 42/4 58/13 81/15 81/17 108/6 124/3 126/19 170/2 179/3 tested [8] 33/4 39/17 46/5 52/21 53/6 55/1 107/23 108/8 testimonies [1] 8/14 testimony [2] 25/6 101/9 testing [21] 37/7 43/5 55/19 58/19 58/21 58/25 59/2 59/12 77/13 93/18 101/7 107/18 108/10 108/23 110/16 110/21 123/11 123/23 125/2 129/24 136/3 tests [3] 15/7 37/23 108/1 text [4] 92/2 92/6 101/12 102/1 than [58] 12/23 13/2 13/21 15/2 15/6 18/10 22/5 22/23 26/3 32/14 32/15 39/3 41/15 42/13 46/18 52/7 55/16 56/4 58/11 59/14 60/9 63/18 67/9 70/10 71/1 75/3 81/14 81/16 85/19 87/18 108/9 108/12 110/22 116/12 118/5 118/14 119/23 128/16 132/1 132/9 133/17 136/3 136/6 139/7 139/10 140/9 143/15 147/25 156/22 168/15 169/25 170/4 183/9 186/1 188/2 189/24 193/13 197/8 thank [27] 1/8 3/8 3/11 31/3 98/21 99/5 115/10 115/11 131/4 131/12 131/20 131/21 144/23 144/24 160/23 163/1 173/11 173/15 185/7 185/9 185/13 197/17 197/18 198/9	

T	124/12 131/9 197/24	147/25 148/1	40/5 48/24 49/2 93/25	149/22
then... [11] 80/17	thereafter [3] 46/25	think [8] 22/3 56/14	94/7 104/8	timeline [1] 195/17
85/24 96/11 104/23	64/7 125/23	78/7 104/25 164/1	threats [1] 4/24	timely [4] 57/21
141/20 148/1 148/3	therefore [9] 16/21	185/10 197/24 198/10	three [21] 2/24 4/12	108/23 148/21 198/11
159/2 172/5 194/17	22/7 46/25 52/5 85/21	thinking [1] 109/2	28/6 38/2 60/2 60/4	timeously [1] 140/18
195/10	142/7 152/7 160/7	third [14] 4/2 15/2	64/7 65/21 66/11	times [15] 8/18 32/15
there [174] 7/15 8/23	174/14	35/17 42/2 58/14	81/21 82/11 84/17	41/15 42/13 52/1 78/8
9/2 9/7 13/23 15/13	these [69] 1/13 2/3	105/23 123/9 123/9	88/24 108/12 118/9	128/17 132/8 132/11
17/12 18/8 20/13 24/2	4/14 4/18 9/9 10/22	134/13 140/23 142/17	118/21 123/15 132/8	142/25 151/21 152/19
24/25 32/5 32/7 32/20	11/25 13/4 13/15	167/8 175/16 190/15	174/25 186/25 197/10	160/2 177/18 178/21
32/22 32/24 33/5	13/17 13/20 15/10	thirdly [5] 118/24	three months [1]	timing [6] 73/20
33/22 33/25 34/3	18/15 27/21 29/7 36/7	123/19 130/16 175/14	118/9	74/11 83/4 135/11
34/14 34/17 35/12	41/21 42/22 49/21	181/5	three weeks [10]	190/24 195/24
35/13 35/14 36/24	59/7 60/12 61/1 62/24	this [322]	2/24 4/12 28/6 60/2	tipping [1] 33/11
37/19 38/3 38/17	65/12 68/2 77/22 78/2	Thomas [3] 21/21	60/4 64/7 81/21 88/24	titled [1] 78/18
39/22 40/8 40/9 41/8	78/12 83/17 88/4	25/8 134/23	186/25 197/10	today [10] 1/20 3/1
41/12 42/24 43/11	88/10 88/14 92/20	Thomas Hale [1]	three-week [1] 66/11	3/16 4/6 137/6 174/25
45/2 45/7 45/20 48/24	94/4 107/22 113/18	25/8	through [25] 55/18	175/6 181/7 197/6
51/15 53/9 53/14	114/22 118/24 120/15	those [103] 1/10 1/14	90/10 95/15 96/19	198/19
53/20 55/6 58/11	125/11 127/11 129/18	2/6 2/8 2/8 2/25 3/3	98/14 98/15 101/2	today's [1] 185/10
58/15 58/16 58/20	131/1 132/12 135/2	3/5 4/5 7/25 8/4 8/22	101/6 106/16 117/8	together [7] 90/22
58/23 59/2 59/3 60/7	135/14 140/25 154/12	10/8 12/12 15/2 21/6	133/1 137/19 146/25	120/22 130/6 141/14
60/16 61/1 61/13	156/5 156/25 158/1	21/9 24/16 27/10	147/2 147/13 148/9	144/9 186/21 189/25
68/12 69/23 70/12	165/12 165/14 172/4	27/22 27/25 28/3 28/9	149/2 152/23 158/1	told [7] 35/11 78/6
71/4 71/12 71/19	172/9 174/19 174/25	30/11 42/10 51/2	161/16 163/3 163/15	112/20 124/17 125/9
71/21 72/13 72/15	175/17 176/8 176/14	51/12 54/14 58/20	179/15 182/25 191/4	125/25 168/4
72/24 73/5 73/25	176/24 177/5 177/14	58/25 67/24 72/16	throughout [13] 40/4	toll [1] 64/3
74/10 74/23 76/13	179/3 181/10 183/7	77/17 79/24 89/12	67/6 69/16 77/20 90/7	Tom [1] 2/21
76/18 77/8 78/8 81/10	184/2 193/25 196/7	93/10 108/8 111/4	101/23 119/25 146/3	tomorrow [7] 3/1
84/10 86/3 86/19	they [96] 4/18 15/19	116/23 117/3 117/7	147/10 155/10 158/16	9/24 27/11 48/15
87/16 89/16 90/4	20/11 20/14 20/16	117/13 117/22 118/7	191/23 193/15	91/12 91/20 198/22
92/12 95/19 96/12	20/17 21/4 23/16	118/11 118/21 118/22	thus [3] 36/16 108/2	tone [1] 132/22
96/14 96/16 97/6	23/19 27/5 32/15	118/24 119/14 119/15	162/13	too [16] 9/2 30/24
97/11 97/11 97/12	33/21 38/17 43/16	119/19 119/21 120/10	thwart [1] 100/17	30/25 39/5 78/25
97/18 97/19 103/20	53/1 59/5 59/13 67/25	121/10 122/2 123/18	ticking [1] 148/20	109/25 136/4 137/7
104/7 107/5 110/5	68/3 68/8 69/6 75/1	125/19 125/23 126/2	Tier [6] 82/2 85/7	137/25 138/22 140/21
110/13 111/3 111/6	75/2 80/20 83/7 93/11	126/7 127/17 128/8	85/13 87/13 87/19	141/3 177/2 179/21
111/21 112/1 112/10	96/10 101/4 102/2	129/17 130/13 130/25	87/20	186/9 192/20
112/12 113/3 113/23	102/3 102/5 102/6	132/1 134/10 134/15	Tier 3 [4] 82/2 85/7	took [18] 5/18 33/7
114/6 115/2 116/4	102/7 102/10 103/18	135/23 139/20 142/4	85/13 87/19	37/14 41/7 43/8 43/14
117/15 117/18 118/13	108/19 109/2 109/3	143/8 144/17 156/15	Tier 4 [2] 87/13 87/20	43/18 52/11 52/14
118/14 118/25 120/1	110/12 111/10 116/6	157/2 157/17 161/21	time [65] 4/6 5/9	56/6 65/12 67/15
121/13 121/18 121/23	117/6 118/21 120/15	162/2 162/16 162/21	12/15 14/11 14/18	74/14 88/5 126/7
122/19 123/6 123/12	120/18 120/21 120/24	162/22 162/25 163/14	14/25 15/19 16/3	128/5 182/5 193/16
123/12 123/17 124/17	126/3 126/3 127/24	164/5 164/20 165/2	16/21 26/12 26/15	tool [3] 149/5 168/19
124/20 125/20 126/6	129/22 129/23 130/4	169/13 169/14 169/18	26/19 30/17 32/1	192/18
126/8 126/9 126/24	130/14 131/11 131/18	174/24 175/21 176/15	35/25 36/22 39/11	top [3] 12/3 73/8
128/6 128/9 129/8	131/20 131/21 134/21	176/15 182/10 184/9	40/25 43/5 47/5 49/11	167/19
129/13 129/15 135/6	135/8 135/20 142/22	184/15 186/5 186/13	49/16 52/24 53/2	topic [2] 103/24
137/21 138/5 140/10	152/1 152/19 153/18	188/4 188/15 189/12	61/21 79/5 80/9 81/13	111/17
141/7 141/15 143/23	154/4 154/5 154/11	191/13 192/1	86/10 88/5 89/9 90/3	Tory [1] 112/11
153/2 153/8 153/9	154/12 160/6 163/23	though [10] 6/13	95/4 99/25 104/9	total [6] 12/14 15/18
158/24 163/2 163/7	163/25 175/15 177/6	129/25 134/18 165/13	105/22 106/1 106/3	46/10 48/18 81/15
164/5 164/19 165/24	178/1 178/9 178/21	174/6 175/9 176/21	111/20 123/18 124/21	89/14
166/7 168/8 170/8	179/22 182/4 183/11	180/4 182/4 183/14	125/21 126/13 126/17	touch [2] 170/23
171/11 172/4 173/4	183/14 184/4 185/2	thought [10] 14/19	126/19 144/9 149/24	171/14
174/4 174/6 174/25	186/11 186/23 187/13	40/7 48/2 62/25 96/8	150/5 152/5 153/20	touched [4] 92/23
176/20 176/22 177/5	187/13 187/14 188/16	96/9 108/15 135/23	154/13 156/4 163/19	130/7 165/22 185/25
178/15 179/1 179/14	188/16 189/10 189/17	153/23 153/25	174/8 175/4 178/17	touching [1] 196/17
179/23 182/20 183/18	191/18 192/19 198/15	thoughtlessness [1]	178/23 180/22 181/14	tour [1] 90/9
188/9 193/12 194/13	198/19	142/11	183/21 183/21 187/3	towards [4] 55/20
194/22 198/2 198/4	things [10] 40/7 44/9	thousands [1] 197/9	191/19 194/13 198/12	72/10 76/11 112/10
there's [4] 22/6	99/17 118/21 132/1	thrash [1] 68/21	timed [1] 78/21	toxicity [1] 99/25
	134/15 138/1 144/17	threat [8] 4/23 34/7	timeframes [1]	trace [4] 7/7 106/7

T	73/2 84/18	two [40] 32/3 39/7 39/15 44/15 50/9 52/20 57/4 59/14 60/2 61/14 62/21 66/13 74/3 74/8 78/20 78/21 79/8 81/21 82/16 86/1 89/13 89/18 91/9 105/20 115/18 116/23 117/3 117/12 121/18 128/25 132/1 143/23 157/21 159/3 165/9 172/4 176/6 176/8 192/13 196/16	unattractive [1] 172/14 unavailable [1] 172/6 unavoidable [1] 150/24 uncertain [1] 45/18 uncertainties [1] 180/19 uncertainty [2] 141/4 183/13 unchecked [1] 84/25 unclear [3] 41/18 76/18 128/23 uncomfortable [2] 185/17 197/13 uncontroversial [1] 124/22 unconvinced [1] 106/18 uncover [1] 98/18 UNCRC [4] 148/7 148/9 150/1 154/24 under [14] 14/6 33/9 40/8 91/8 139/24 141/3 148/6 149/1 149/12 150/8 154/6 154/7 175/4 179/20 under-reporting [1] 14/6 underfunded [1] 169/3 underline [1] 44/13 underlying [2] 17/23 51/13 undermined [1] 172/6 underpaid [1] 163/5 underpinned [1] 162/9 understand [13] 36/21 94/7 102/18 107/1 110/7 110/17 112/14 118/25 122/7 124/22 144/20 152/6 181/9 understandable [1] 129/17 understanding [13] 50/22 93/25 109/15 121/24 129/18 158/11 178/25 179/6 181/4 181/15 181/21 182/22 191/10 understood [6] 40/3 93/13 95/7 97/10 101/2 122/10 undertake [1] 149/9 undertaken [4] 88/2 149/12 157/4 174/17 undervalued [1] 163/5 undiagnosed [1] 9/7 Undoubtedly [2] 196/1 196/20	undue [1] 4/21 unemployed [1] 22/11 unequal [1] 144/14 uneven [1] 95/11 unfolded [2] 109/15 162/19 unfortunate [1] 166/18 unfortunately [1] 196/5 unhelpful [1] 100/1 unilateral [1] 70/15 unintended [1] 95/25 union [10] 56/21 133/9 161/6 161/7 161/9 162/5 167/6 170/15 199/20 199/21 unions [8] 161/13 161/17 166/13 166/19 166/21 169/4 172/23 190/15 unique [2] 149/20 158/14 uniquely [2] 136/21 191/15 unite [1] 134/3 United [6] 133/22 135/18 144/1 144/10 146/23 185/20 United Kingdom [4] 135/18 144/1 144/10 185/20 United Nations [2] 133/22 146/23 units [2] 32/11 117/24 universities [2] 46/14 80/7 university [5] 25/16 46/18 77/12 78/18 80/2 unjustifiably [1] 109/22 unknown [2] 31/13 33/23 unless [5] 66/2 80/3 80/24 81/2 112/23 unlikely [3] 41/21 42/21 54/9 unmistakable [1] 143/18 unnecessarily [1] 96/16 unnecessary [4] 4/21 16/17 113/19 114/23 unobtainable [1] 122/13 unpaid [3] 128/25 129/24 143/5 unprecedented [3] 98/18 134/4 137/1 unresolved [1] 196/7 unresponsiveness [2] 194/25 196/9
trace... [2] 170/2 179/3 tracing [3] 41/19 42/20 55/19 track [1] 106/7 trade [5] 31/22 172/23 178/5 182/22 190/15 Trades [5] 161/6 161/7 161/9 199/20 199/21 Trades Union [1] 161/9 trading [1] 182/25 tragedy [1] 143/18 Tragically [1] 26/5 trained [1] 132/25 trains [1] 35/5 trajectory [2] 55/9 90/5 transfer [1] 124/16 transfers [1] 108/1 translate [2] 102/24 103/19 translated [1] 71/10 translates [1] 106/13 translation [1] 112/23 translators [1] 30/14 transmissibility [2] 33/1 89/25 transmissible [1] 86/21 transmission [49] 32/6 32/8 32/21 32/25 33/22 33/23 34/12 34/15 35/20 35/23 36/16 38/3 38/9 38/18 41/6 42/25 44/1 45/3 45/5 45/8 45/21 46/21 46/23 47/13 47/14 51/16 53/5 53/10 75/11 77/18 85/16 89/22 90/2 105/22 106/20 106/23 107/1 107/7 107/15 108/14 109/5 109/11 109/15 123/20 124/5 124/24 125/3 158/12 181/10 transmitted [1] 45/23 transparency [3] 149/10 160/8 160/9 transparent [2] 113/22 115/1 transport [5] 1/14 35/4 56/12 98/12 164/23 transported [1] 165/6 travel [10] 31/16 31/22 43/24 53/6 61/9 66/16 70/16 70/23	travelled [4] 31/15 39/8 41/25 56/23 travellers [2] 31/21 47/15 traversed [1] 107/10 Treasury [13] 76/5 83/11 84/4 84/5 84/5 139/1 143/14 143/15 194/25 195/5 195/15 195/19 196/11 Treasury's [2] 194/23 196/8 treat [1] 100/16 treated [2] 96/23 140/16 treatment [3] 38/6 120/6 120/7 treatments [1] 98/8 tribute [1] 162/15 trigger [2] 36/6 36/7 trojan [1] 70/1 Tropical [1] 41/4 true [2] 14/23 101/17 truly [3] 74/23 135/10 162/23 trusted [2] 44/17 174/11 truth [3] 98/18 99/13 165/24 try [5] 7/13 30/25 46/17 131/9 197/19 trying [3] 55/16 55/17 163/14 TTP [3] 179/3 179/11 180/11 TUC [24] 161/10 161/10 161/10 161/11 161/13 161/15 161/18 161/18 161/23 161/25 162/5 167/14 167/17 168/16 168/18 169/1 169/2 169/23 170/10 170/16 170/20 189/15 190/1 190/6 Tuesday [2] 1/1 61/6 tuning [1] 16/20 turn [16] 22/13 33/9 106/24 137/11 148/3 151/17 153/1 155/13 156/6 157/8 158/17 159/15 166/12 193/18 193/23 196/14 turning [9] 4/5 19/14 26/11 26/22 36/20 94/18 102/9 111/17 138/19 turnover [1] 137/12 turns [1] 3/16 TV [1] 182/9 tweeted [1] 32/19 Twickenham [1] 52/11 Twickenham Stadium [1] 52/11			
two days [3] 62/21 66/13 89/18 two weeks [4] 59/14 79/8 81/21 82/16 two years [1] 116/23 two-week [1] 50/9 Tydfil [1] 77/23 types [1] 49/21	U			
UK [240] UK CSA [1] 82/1 UK Government [38] 5/25 6/18 6/22 25/24 26/13 26/15 28/21 29/21 31/6 39/11 40/7 48/9 49/6 66/25 67/2 67/17 68/8 68/13 68/25 69/12 70/14 75/20 84/6 87/11 88/7 90/15 105/11 111/24 112/3 139/2 153/11 154/7 154/19 156/13 158/21 171/25 172/8 188/22 UK Government's [5] 5/21 38/8 50/11 50/13 55/11 UK Inquiry [2] 1/24 100/14 UK's [8] 5/8 15/23 17/1 21/24 38/22 132/13 144/11 173/21 UK-only [1] 41/5 UK-wide [7] 17/4 21/14 28/7 69/7 93/3 140/2 195/1 ultimately [4] 71/24 88/17 98/8 169/25 UN [1] 191/17 UN Convention [1] 191/17 unable [5] 35/7 44/18 44/22 53/22 169/10 unacceptable [4] 107/13 109/20 113/9 114/12 unacceptably [1] 171/5 unaccountable [1] 140/1				

U	139/25 140/5 142/17 149/6 150/13 176/19 182/2 184/12 used [18] 53/1 55/21 63/16 69/16 92/7 94/6 102/1 136/12 150/18 163/12 168/20 173/24 178/15 181/18 188/19 191/18 194/6 195/21 useful [3] 78/7 78/24 118/2 usefully [2] 124/8 152/23 using [5] 73/13 99/18 100/15 102/12 188/15 usually [2] 30/12 157/21 utilised [1] 179/13 utmost [3] 1/17 1/25 100/22	72/13 75/3 78/22 88/21 98/21 100/20 104/12 115/11 115/11 115/23 123/17 126/13 129/6 130/4 131/4 131/12 132/22 134/2 144/24 147/10 159/21 160/23 165/17 167/19 173/11 174/20 178/22 179/4 185/9 185/9 198/8 198/14 198/16 198/21 via [9] 29/12 42/1 42/21 88/4 93/3 102/20 112/21 138/7 145/9 victims [1] 24/17 video [3] 3/10 41/21 117/10 view [19] 20/7 20/16 20/23 21/16 23/1 24/9 66/10 69/20 70/7 84/4 105/6 122/1 122/1 123/4 141/17 154/19 172/2 189/17 193/5 viewpoints [1] 157/6 views [5] 45/2 159/1 167/11 172/22 178/17 vigorously [1] 189/15 violence [1] 23/14 viral [5] 21/5 25/1 31/10 47/2 48/11 virtues [1] 165/16 virulent [1] 53/3 virus [63] 4/24 7/13 7/23 9/18 10/24 14/25 17/3 23/18 24/11 24/15 28/23 29/4 29/19 33/15 35/15 36/25 37/25 39/6 39/22 39/25 40/5 40/17 42/7 43/22 47/5 48/25 49/2 49/9 49/20 50/22 53/3 55/16 61/12 61/17 61/25 65/8 67/23 72/4 75/4 87/10 88/10 88/16 93/1 93/19 97/4 97/8 97/25 98/16 104/8 104/21 108/16 109/19 141/4 163/15 164/6 164/17 186/10 186/15 191/20 192/4 192/13 192/20 193/14 visible [1] 86/4 visit [3] 116/4 116/15 126/18 visits [4] 116/5 125/19 127/2 129/5 vital [4] 9/11 139/14 178/20 185/19 vitality [1] 111/20 voice [3] 103/14	158/17 161/18 voices [2] 101/8 160/14 voluntary [2] 90/22 190/2 volunteers [1] 98/9 vulnerabilities [3] 19/11 22/16 157/18 vulnerability [3] 128/11 130/11 165/4 vulnerable [21] 9/12 9/20 10/6 23/5 24/10 27/10 27/25 57/25 60/9 94/14 94/24 98/10 108/17 123/19 146/10 155/9 178/3 182/11 183/25 184/9 192/8	145/10 Waterhouse Inquiry [1] 145/10 Waters [1] 56/11 Watkins [2] 122/4 124/13 Watson [3] 21/22 21/24 22/9 wave [21] 12/4 12/6 12/22 12/25 13/2 13/2 13/7 13/10 14/4 14/7 14/12 14/13 14/16 15/3 15/13 15/15 81/13 88/12 110/2 120/2 139/4 wave 1 [1] 110/2 waves [3] 12/6 13/22 88/15 way [23] 2/10 8/21 16/1 16/2 16/3 67/12 67/22 72/18 72/25 74/1 95/17 111/18 126/20 129/7 148/8 149/1 155/22 159/11 160/12 163/24 173/19 176/1 198/7 ways [5] 96/1 118/18 136/5 144/1 158/24 we [135] 1/6 1/11 1/13 1/15 1/20 2/3 2/6 2/7 2/10 2/14 2/23 3/1 3/2 3/8 3/11 4/17 4/22 5/2 8/15 11/23 12/9 13/3 13/17 14/1 14/20 15/12 16/16 26/16 27/18 27/22 30/9 30/12 30/13 30/14 30/23 30/25 31/4 33/20 36/19 41/10 41/12 42/15 42/16 42/23 44/6 44/7 44/17 44/21 44/22 48/1 48/7 53/19 53/20 54/2 59/21 59/25 60/6 64/19 64/25 65/5 67/14 68/11 69/22 72/21 72/22 73/8 73/12 73/16 73/17 74/21 91/22 92/24 93/1 97/5 98/3 98/15 98/18 101/15 106/12 110/6 111/21 113/1 113/20 114/24 117/3 117/9 118/1 118/3 118/8 119/13 121/18 122/14 123/11 123/15 124/5 124/19 124/22 126/14 126/22 127/9 127/25 128/24 129/18 129/21 130/9 130/19 130/24 131/1 131/8 131/17 138/9 139/21 143/20 143/22 144/25 144/25 158/12 162/13
	V		W	
	vaccinated [1] 98/11 vaccinations [1] 129/1 vaccine [1] 38/6 vaccines [3] 7/7 89/13 98/8 vacillated [1] 129/2 Vale [1] 77/25 valid [1] 143/3 valuable [3] 104/9 162/11 193/10 value [2] 172/21 188/9 valued [1] 130/13 values [1] 142/5 variability [1] 180/20 variant [6] 13/18 14/10 14/14 86/20 86/21 89/4 variation [1] 78/9 varied [2] 27/4 74/3 various [3] 71/8 129/21 167/14 vast [1] 14/12 Vaughan [4] 10/21 36/3 102/9 137/15 Vaughan Gething [4] 10/21 36/3 102/9 137/15 vaunted [1] 133/5 ventilated [1] 13/14 ventilation [3] 13/9 13/13 52/6 ventilator [1] 51/3 verbal [1] 103/11 versus [2] 52/10 105/20 very [48] 1/8 8/24 27/17 30/16 31/5 32/19 34/7 45/18 49/12 51/15 62/19 62/22 63/1 64/22	Wales [342] Wales TUC [14] 161/10 161/10 161/15 161/18 161/25 167/14 167/17 168/16 168/18 169/2 169/23 170/10 170/16 170/20 Wales' [7] 5/5 10/23 10/25 11/1 11/3 104/23 110/9 Wales-specific [1] 28/7 walk [1] 163/25 want [13] 2/15 63/4 68/21 73/10 110/17 110/24 135/13 138/17 181/5 183/6 186/2 186/11 197/16 wanted [1] 147/24 wants [1] 112/21 wards [1] 64/23 warm [1] 30/24 warmer [1] 30/22 warming [1] 30/21 warmly [1] 117/9 warning [2] 80/22 183/20 warnings [1] 109/22 warrant [1] 108/18 Warwick [1] 78/18 wary [1] 36/19 was [566] wasn't [10] 55/13 62/25 78/16 111/22 119/19 122/13 122/25 123/2 130/23 130/24 watch [2] 2/16 139/25 Waterhouse [1]		

W	124/6 124/7 132/20 134/25 134/25 136/5 148/14 153/21 160/20 162/23 165/3 166/17 174/13 175/19 188/1 189/11 191/5 191/18 193/15 197/11 198/4 well known [2] 124/6 124/7 well-being [9] 18/20 18/23 19/1 24/13 98/20 134/25 134/25 191/5 193/15 wellbeing [1] 18/22 Welsh [377] Welsh Government [8] 5/1 5/11 5/18 6/4 7/13 7/22 9/13 11/11 Welsh Government's [7] 3/17 4/16 6/17 7/4 8/5 8/9 10/11 Welsh Governments [2] 6/11 7/3 Welsh LGA [2] 189/20 190/2 Welsh TUC [3] 189/15 190/1 190/6 Welsh-specific [1] 17/7 Wenham [2] 23/8 23/9 went [4] 9/6 31/17 93/22 181/18 were [274] weren't [4] 110/12 118/22 126/3 130/4 Westminster [11] 66/21 67/24 99/25 100/2 100/5 132/24 170/24 171/2 171/9 171/15 172/16 what [54] 9/20 15/12 16/8 27/18 30/16 44/20 49/2 49/7 50/16 50/18 62/10 62/24 65/5 65/8 66/22 66/24 94/15 94/20 94/23 95/9 95/10 100/4 100/6 103/15 104/5 104/25 105/23 109/8 109/20 110/11 112/5 129/5 133/8 133/18 136/5 136/8 136/17 137/3 137/24 138/6 141/5 142/2 143/25 144/4 144/10 147/15 150/16 152/7 153/23 156/8 163/2 177/18 187/7 195/18 whatever [3] 164/2 165/16 175/14 WhatsApp [11] 56/12 91/23 92/2 92/7 101/12 102/1 102/6	102/11 102/12 193/24 194/6 WhatsApps [1] 194/4 when [46] 2/6 2/19 27/17 29/7 34/4 36/6 46/23 47/17 53/3 53/5 69/7 74/10 76/22 83/12 88/5 90/25 94/23 97/24 100/6 105/1 105/2 109/3 110/19 111/25 114/3 115/7 116/2 117/6 132/7 132/12 134/15 135/21 135/25 139/20 139/23 141/5 143/7 148/14 152/4 153/4 157/18 160/17 179/10 181/16 185/5 195/7 where [27] 2/11 3/22 12/1 28/16 38/5 64/11 69/13 79/7 92/12 93/20 99/10 102/2 107/14 112/9 135/20 141/5 147/16 150/14 150/23 151/7 152/7 153/3 159/21 173/6 175/11 177/5 181/18 whereas [4] 54/14 62/1 85/20 180/6 whereby [2] 153/18 156/2 whether [53] 5/13 8/12 29/2 29/4 33/23 33/25 41/18 53/12 56/25 57/2 58/22 59/13 63/4 63/5 71/19 71/21 74/23 74/25 75/1 75/2 75/17 76/16 76/23 82/17 83/2 88/13 88/17 93/15 96/5 96/16 97/19 97/22 104/9 106/14 111/9 111/10 111/12 112/7 112/10 120/17 128/1 128/25 129/2 140/19 143/14 151/21 158/13 158/15 160/17 160/20 175/23 181/18 192/19 which [165] 1/12 4/15 5/14 5/17 5/25 6/4 6/5 6/10 7/12 8/3 8/5 8/6 8/15 8/18 9/13 10/16 11/15 14/1 14/16 16/11 16/15 16/16 16/22 17/5 17/6 18/20 18/24 19/24 20/11 21/16 22/13 23/17 24/3 25/13 26/20 27/13 27/15 27/19 27/25 29/12 32/7 33/7 35/14 35/17 36/12 37/25 43/2 44/2 46/13 47/14 47/21	48/21 50/4 50/21 51/7 52/1 52/8 58/2 58/7 63/22 67/14 67/22 68/2 68/11 68/12 69/12 70/17 70/21 73/12 74/21 74/24 76/19 81/25 83/18 83/19 83/24 85/1 90/15 90/17 90/19 90/21 90/23 91/2 91/14 91/23 92/10 92/20 92/23 92/25 93/2 93/6 93/7 93/11 93/12 93/20 93/23 94/4 95/3 95/17 96/10 103/22 106/13 106/21 107/2 108/21 110/5 111/18 112/15 113/14 114/17 116/6 116/22 117/12 118/8 119/6 120/23 121/16 122/18 123/22 124/3 124/15 124/15 127/14 128/2 128/5 130/9 135/5 136/19 136/23 137/11 137/22 138/2 139/18 139/21 140/3 145/11 146/3 146/11 149/1 149/4 151/5 153/6 158/24 159/21 159/23 160/18 160/19 162/8 162/10 165/22 166/16 167/16 173/8 173/18 176/2 176/14 178/15 186/11 188/5 188/21 188/22 188/23 193/17 194/11 195/3 whichever [1] 187/21 while [6] 20/8 30/23 45/7 108/25 136/1 140/7 whilst [7] 16/17 70/5 79/10 88/1 88/7 160/13 180/1 Whip [1] 136/10 whistle [1] 90/9 whistle-stop [1] 90/9 whistleblowing [1] 168/17 Whitehall [1] 69/24 who [93] 1/10 1/14 2/6 2/8 2/8 2/25 3/3 4/5 8/4 8/22 11/10 14/24 15/1 15/25 21/3 24/16 27/22 27/25 28/3 31/14 32/18 34/24 35/5 36/10 37/4 37/11 39/4 39/8 40/18 42/10 49/12 53/4 58/20 70/4 76/7 84/7 89/12 91/11 98/5 98/7 98/9 98/11 98/13 101/20 107/23 108/8 112/21 117/5 117/25	120/11 123/6 124/3 124/4 124/19 126/18 126/20 129/14 129/17 131/22 132/3 132/25 133/2 134/20 135/20 138/1 140/5 141/5 141/12 143/10 146/2 151/24 152/6 153/17 157/2 162/16 162/25 163/10 164/1 164/5 164/15 165/2 165/5 165/6 165/6 165/7 165/7 169/18 184/9 186/2 186/5 186/13 191/13 192/6 whole [16] 12/3 14/3 17/4 39/13 51/11 64/3 84/3 87/22 87/25 88/23 106/6 119/25 132/6 151/8 179/7 186/16 whom [4] 8/23 11/13 132/14 189/19 whose [1] 192/16 why [38] 2/14 7/16 48/1 48/2 48/3 49/5 59/9 59/10 62/25 65/3 76/25 78/14 78/15 82/25 92/14 94/21 102/18 105/15 105/16 105/18 108/13 109/16 110/7 110/12 110/23 122/15 127/22 133/8 133/20 133/23 137/23 138/17 143/23 144/20 181/9 181/20 185/23 195/12 wide [10] 17/4 21/14 28/7 33/11 66/4 69/7 93/3 140/2 195/1 195/4 widely [3] 124/15 168/20 173/20 wider [8] 16/19 24/12 36/17 76/18 112/7 127/11 144/7 157/5 widespread [1] 191/11 widest [1] 10/15 wildfire [1] 101/6 will [149] 1/17 1/24 2/23 2/25 3/25 4/11 4/14 4/17 4/22 5/2 6/13 6/16 6/23 6/24 7/1 7/13 7/15 9/17 9/24 10/1 10/5 10/18 10/22 10/24 11/5 11/17 15/22 15/25 16/6 16/10 16/16 18/5 19/25 19/25 25/14 25/17 25/19 26/17 27/3 27/5 27/11 28/5 38/16 42/11 42/25 44/17 44/21 45/4 45/6
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W				
<p>will... [100] 48/7 48/12 50/16 51/20 53/21 59/8 62/7 63/3 63/21 64/25 65/5 66/5 68/3 68/11 71/19 73/10 73/12 73/15 73/16 74/21 75/16 76/23 78/14 80/18 80/20 82/17 83/2 83/16 88/13 90/12 91/11 91/19 91/22 92/10 92/14 92/19 92/24 93/2 93/15 93/22 94/3 94/9 95/17 96/3 96/5 96/17 97/5 97/19 97/22 99/15 100/21 100/22 101/8 106/14 110/6 112/19 113/23 114/4 114/4 115/2 115/8 115/8 124/22 135/13 143/16 145/19 146/1 146/7 148/18 151/15 157/10 160/5 160/20 162/1 163/25 164/2 165/12 166/1 166/7 174/19 175/20 176/25 179/18 183/12 186/7 186/7 186/17 186/23 187/10 187/12 187/22 188/24 189/2 189/19 190/25 196/1 196/20 197/10 197/14 197/20</p>	<p>171/13 171/25 172/15 without [22] 4/21 33/19 44/16 57/10 58/13 66/17 106/13 106/14 107/17 113/16 114/19 123/10 123/23 125/2 135/2 137/24 138/22 141/1 152/21 159/8 178/24 179/5 witness [8] 26/11 69/17 107/4 120/14 141/12 174/20 174/22 174/23 witnessed [1] 101/5 witnesses [12] 9/25 19/25 26/18 67/17 110/6 113/4 113/20 114/7 114/24 154/16 172/14 188/20 WLGA [14] 173/22 173/25 173/25 174/3 174/12 174/19 175/2 175/14 175/18 177/13 180/23 181/20 182/7 184/23 WLGA's [2] 175/1 176/17 women [5] 18/18 23/10 23/15 28/10 170/19 wondering [1] 30/9 word [1] 197/21 worded [1] 152/18 words [11] 12/18 35/13 81/2 101/19 110/9 117/1 126/18 143/11 166/18 190/21 192/24 work [28] 18/25 35/13 37/15 37/17 59/3 64/10 79/23 91/17 95/3 100/13 103/9 109/2 141/1 141/18 143/21 157/2 161/21 163/25 164/16 165/6 169/18 171/10 175/9 177/1 180/9 185/22 193/10 196/22 workability [1] 183/17 worked [7] 48/3 94/4 137/15 137/25 141/18 147/5 163/10 worker [4] 116/16 133/1 163/13 163/21 workers [24] 36/15 56/5 57/12 62/23 98/5 98/9 98/12 98/13 98/13 108/23 109/13 129/22 129/23 161/16 164/25 165/6 167/19 168/17 169/7 170/19 170/20 170/21 189/16 192/19</p>	<p>workforce [4] 132/16 163/4 163/5 163/18 working [12] 40/22 49/19 132/23 145/20 159/10 161/14 161/19 164/24 168/16 174/24 184/13 189/22 workplace [10] 46/19 46/19 162/2 162/15 162/21 166/14 168/11 168/13 169/1 169/8 workplaces [1] 169/14 works [1] 188/13 world [4] 26/7 31/19 39/20 97/14 worldwide [2] 32/23 47/6 worrying [1] 86/9 worse [5] 18/9 22/12 22/22 23/15 27/11 worsened [1] 165/23 worst [13] 38/4 38/22 39/1 50/4 51/22 51/24 53/15 53/23 53/25 57/16 61/2 86/7 87/16 worst-case [12] 38/4 38/22 39/1 50/4 51/22 53/15 53/23 53/25 57/16 61/2 86/7 87/16 worth [1] 14/18 worthwhile [1] 185/23 would [111] 6/6 21/19 33/10 33/14 33/16 35/12 36/7 36/25 38/8 39/22 39/25 41/5 41/7 43/25 44/3 44/4 45/17 45/19 46/23 47/17 50/5 50/9 50/23 50/24 50/24 50/25 51/2 51/16 51/25 52/1 52/5 52/6 53/1 53/12 54/13 54/14 55/7 57/10 58/19 59/3 61/1 61/18 61/21 62/17 62/23 63/16 64/6 64/7 66/14 67/10 69/20 69/21 75/16 76/4 78/7 78/11 79/16 80/13 81/5 82/2 82/3 82/15 82/23 84/25 85/1 85/10 85/22 87/3 87/11 87/12 90/19 95/23 96/22 99/23 112/8 116/5 116/11 119/6 119/10 119/11 123/23 125/10 127/1 127/2 135/23 136/1 147/18 149/12 150/2 151/23 151/24 152/1 152/11 154/25 159/8 161/5 163/16 171/4 172/5</p>	<p>172/6 172/7 176/20 177/15 178/10 179/6 181/2 183/22 184/6 184/12 186/12 195/13 wound [1] 100/16 wrando [1] 115/10 Wrexham [2] 54/25 60/19 write [1] 193/3 writing [3] 147/18 164/3 194/10 written [12] 19/22 25/6 71/16 78/1 78/3 84/2 84/7 87/23 118/8 149/16 167/17 198/17 wrong [7] 69/20 95/24 127/15 135/25 148/1 198/1 198/6 wrongs [1] 135/14 wrote [4] 65/25 66/7 89/5 124/14 wrought [1] 5/6 Wuhan [8] 31/13 32/13 33/12 34/14 35/5 35/12 37/10 37/21 Wuhan City [1] 31/13</p>	<p>197/14 197/17 197/18 197/20 197/22 198/9 198/10 198/10 198/14 198/21 you're [2] 2/16 2/17 you've [3] 131/6 181/24 183/11 young [19] 23/4 28/10 117/25 140/5 146/11 147/7 148/4 153/13 153/25 154/10 154/13 155/7 157/23 158/17 158/25 159/4 159/6 159/11 160/1 your [14] 3/25 10/18 11/15 11/17 18/2 31/5 67/16 91/11 116/7 131/6 131/20 188/8 198/14 198/19 your Ladyship [7] 3/25 10/18 11/15 11/17 18/2 31/5 67/16 yourself [1] 64/15 youth [7] 153/6 153/7 153/8 153/17 154/5 154/21 155/3</p>
Y				
			<p>yardstick [1] 100/2 year [6] 12/16 12/23 19/20 33/9 39/7 188/9 years [12] 18/12 18/13 18/14 18/18 18/18 24/2 44/15 48/15 116/23 137/16 179/21 187/8 Yes [1] 197/20 yet [12] 33/3 33/25 120/3 121/10 124/19 128/22 133/4 141/18 163/6 178/21 179/4 183/19 York [1] 39/8 you [72] 1/8 2/15 2/18 3/8 3/11 6/25 9/24 10/1 10/24 15/22 18/5 18/19 22/7 25/14 30/24 31/3 39/18 62/24 68/18 73/16 75/24 98/21 99/5 115/10 115/11 115/13 116/2 116/7 131/4 131/5 131/5 131/10 131/12 140/11 143/21 144/23 144/24 144/25 145/6 160/23 163/2 173/11 173/15 173/19 173/23 174/19 175/14 176/25 179/18 185/7 185/7 185/9 185/10 185/13 185/14 187/20 187/21 188/11 189/19 194/9 197/6 197/10</p>	