

Thursday, 21 November 2024

1  
2 (10.00 am)  
3 **LADY HALLETT:** Ms Carey.  
4 **MS CAREY:** My Lady, may I call, please, Matt Hancock.  
5 **MR MATT HANCOCK (affirmed)**  
6 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3**  
7 **LADY HALLETT:** We meet again, Mr Hancock.  
8 **MS CAREY:** Mr Hancock, your full name, please.  
9 **A.** Matthew John David Hancock.  
10 **Q.** I think you have in front of you a copy of your  
11 statement, ending INQ000421858, and that is the fifth  
12 statement you have made to the Covid Inquiry.  
13 **A.** Yes.  
14 **Q.** And I know you've been here and given evidence before.  
15 You were the Secretary of State between 9 July 2018 and  
16 26 June 2021; is that correct?  
17 **A.** That's right.  
18 **Q.** Can I ask you some background questions before we  
19 descend to the detail.  
20 Do you think now, Mr Hancock, that the Stay at  
21 Home, Protect the NHS, Save Lives messaging struck the  
22 right balance?  
23 **A.** Yes.  
24 **Q.** And why do you say that?  
25 **A.** Because we needed to ensure that the public across the

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1 **MS CAREY:** Thank you, my Lady.  
2 Mr Hancock, we're going to come to the question of  
3 overwhelm a little later, but in terms of protecting the  
4 NHS --  
5 **A.** Yes.  
6 **Q.** -- do you think now healthcare workers were kept as safe  
7 as possible at work?  
8 **A.** Well, it was obviously extremely difficult to keep  
9 healthcare workers as safe as possible, because  
10 effectively the wards of the NHS became the front line  
11 in this deadly battle. When I visited hospitals, GP  
12 surgeries, pharmacies, as I did regularly throughout the  
13 pandemic, I saw for myself. And I did that both  
14 publicly but also quietly, in order to understand what  
15 was happening on the front line.  
16 So part of the point of the Inquiry is to  
17 understand how as a system, as a country, we can do that  
18 as best as we possibly can.  
19 **Q.** I understand that you say it was difficult, but I want  
20 to know do you think they were in fact kept as safe as  
21 possible or not?  
22 **A.** Well, in the circumstances, facing a pandemic of this  
23 scale for the first time in living memory, what I can  
24 say accurately is that I and all those around me in the  
25 team in the health system did everything we possibly

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1 whole of the UK understood the importance of staying at  
2 home whenever possible, in order to stop the spread of  
3 the virus. The Protect the NHS element was important  
4 for two reasons. The first is that it was a motivating  
5 factor to encourage people to follow that advice because  
6 belief in the NHS and support for the NHS is one of the  
7 strongest things that holds this country together.  
8 And the second reason is because it was literally  
9 true that if we didn't stop the spread of the virus then  
10 the NHS would be overwhelmed, by which I mean the system  
11 as a whole would have been unable to cope with the  
12 demand on it, as we'd seen in other countries like  
13 Italy.  
14 **Q.** All right, we're going to come back to --  
15 **LADY HALLETT:** Can you just pause, I'm sorry.  
16 I mean, it's really important that we all are able  
17 to focus on Mr Hancock's answers, and particularly that  
18 Mr Hancock and I can focus on the answers, and,  
19 I'm sorry, I know how important it is to you to have  
20 photographs of your loved ones, but I'm finding it  
21 really distracting because my eye is going over to the  
22 photographs all the time. So please could you just  
23 lower them. I would be really grateful. Thank you very  
24 much.  
25 Sorry, Ms Carey.

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1 could. Does that mean, in a system that employs  
2 1.4 million people in the NHS, with another around  
3 2.5 million in social care, that every decision was  
4 perfect? Of course it wasn't. And part of what we're  
5 here to do is to understand how that could be done  
6 better.  
7 **Q.** Do you think now that the imposition of the visiting  
8 restrictions which meant that some people could not be  
9 at the bedside of a dying relative or could not have  
10 their partner with them in childbirth were too strict?  
11 **A.** I think that we were balancing incredibly difficult  
12 considerations on both sides. I think on balance we got  
13 those broadly right across the pandemic but I entirely  
14 understand and feel very -- the very strong arguments on  
15 both sides. On the one hand, protecting lives and  
16 ensuring people as many as people as possible could  
17 survive the pandemic and, on the other side, taking into  
18 account the deep emotional considerations that were  
19 important. And as you can see in the paperwork,  
20 I engaged with these issues all the way through.  
21 Where I think we got it wrong, for instance, was  
22 the way that the funeral guidance was applied on the  
23 ground. It wasn't as had been intended. But of course  
24 funerals are places where people gather and are deeply  
25 emotional and people come together, and that was also

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1 the thing that was driving the spread of the virus.  
 2 So these were very difficult considerations, and  
 3 broadly, on balance, we -- I think they were about  
 4 right. But we can go through every single decision and  
 5 you could easily make an argument one way or the other.  
 6 **Q.** Do you consider that entering the pandemic with low ICU  
 7 bed numbers and high bed occupancy meant that hospitals  
 8 had to surge all the more and put them all the more  
 9 under strain?  
 10 **A.** Yes, of course.  
 11 **Q.** Do you think now that the decision to suspend all  
 12 non-urgent elective care was the right one?  
 13 **A.** Yes.  
 14 **Q.** I asked those questions at the outset, Mr Hancock,  
 15 because we're going to look at some of them in more  
 16 detail, but I thought it might be helpful just to see  
 17 where you stand now, some years on from the pandemic.  
 18 **A.** Yes.  
 19 **Q.** Can I ask you this though, before we descend into that  
 20 detail --  
 21 **A.** Yes.  
 22 **Q.** -- what did you understand it would look like if the NHS  
 23 were overwhelmed?  
 24 **A.** That people wouldn't be able to get any treatment at all  
 25 in hospitals; that there would be the inability to give

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1 paperwork.  
 2 **Q.** Let me ask you about that. What insight did the efforts  
 3 by you to visit GPs, visits hospitals and the like, what  
 4 insight did that bring to you as the minister that  
 5 actually helped inform your response or inform  
 6 a decision that you made?  
 7 **A.** Well, there were endless -- I'll give you one example  
 8 that is incredibly clear in my mind. In the early stage  
 9 of the second wave, in the peak of it, really,  
 10 in January 2021, I went to Basildon hospital and I did  
 11 a night shift.  
 12 **Q.** Yes.  
 13 **A.** And my -- because I'm not a trained doctor my role was  
 14 to help the nurses to turn patients because patients on  
 15 a ventilator needed to be turned regularly, and some --  
 16 and typically these patients needed two or three people  
 17 to help turn them, so I was one of the team and I spent  
 18 the night doing that.  
 19 But the thing I really took away from this was (a)  
 20 I was in the intensive care unit and there was a patient  
 21 who was lucid and talking and -- but obviously unwell  
 22 and you could see his oxygen levels were low and  
 23 falling, and the doctor took the decision that he needed  
 24 to be intubated and went and asked for the consent of  
 25 that patient to be intubated. And he within -- he gave

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1 the basic level of care that people needed.  
 2 When I said that we needed to stop the NHS being  
 3 overwhelmed and I set that as an objective, what I meant  
 4 was that people in this country have a right to  
 5 healthcare from the -- provided free at the point of  
 6 delivery according to need, not ability to pay. That is  
 7 incredibly important and has been part of the social  
 8 fabric of this country for more than 75 years, and  
 9 I wanted to protect that, not only because it's the best  
 10 way -- one of the ways of saving lives and protecting  
 11 life during a pandemic, but also because of the very  
 12 strong attachment that I, and most people in this  
 13 country, hold to it.  
 14 Of course, of course, every part of the NHS was  
 15 under pressure, and some individual parts were -- found  
 16 that pressure overwhelming but the system as a whole  
 17 withstood the pressures, thanks to enormous efforts from  
 18 literally millions of people. And, as I say, I spent as  
 19 much time as I could on the front line doing night  
 20 shifts when I could, actually participating myself  
 21 because I found as the leader of the health system  
 22 I needed to be on the ground listening to people and  
 23 finding out what was actually happening, as well as,  
 24 of course, what was being provided to me officially in  
 25 my role as Secretary of State which you can see in the

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1 his consent and within about a minute he was  
 2 anaesthetised and intubated and the doctor came over to  
 3 me and said, "I think he's got a less -- he's got less  
 4 than a 50/50 chance of waking up", and seeing this man  
 5 going from lucid and talking to effectively, you know,  
 6 likely never to open his eyes again was deeply moving,  
 7 and, of course, people working in the ICU saw this day  
 8 in, day out, many times a day, and the doctor then had  
 9 to go and call the patient's wife and I remember  
 10 thinking, the patient didn't even say, "Can I speak to  
 11 my wife first?" He knew what the chances were if you  
 12 are intubated.  
 13 And then afterwards I was visiting the wellness  
 14 centre that was put -- that the hospital had put  
 15 together to look after staff and the doctor came down to  
 16 see me there and burst into tears and said, "We're in  
 17 a second wave, Secretary of State, you cannot allow  
 18 a third."  
 19 And I'd spent the whole autumn before that  
 20 fighting to get the lockdown -- to stop the second wave  
 21 that was obviously coming and it just -- that was --  
 22 you know, the impact of that I was -- I mean, I'd been  
 23 determined to everything I could but that made it even  
 24 stronger.  
 25 **Q.** Now, Mr Hancock, I think you have given that example

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1 before, and it's not to diminish the impact that it had  
 2 on you, but having seen that, what did you do when you  
 3 went back to work the next day to think: I am going to  
 4 try and do something to help those staff members or to  
 5 help the patient?

6 **A.** Well, you have to remember that at that time I was in  
 7 a battle with other parts of government to ensure that  
 8 the measures that we were taking were enough to stop the  
 9 spread of the virus. And there were pressures from  
 10 others to try to release the measures what -- in my  
 11 view, too soon and it stiffened my resolve to resist  
 12 those measures to relax too soon, and we were also in  
 13 the middle of the vaccine rollout, which was the  
 14 ultimate way out of it, and it was critical that we  
 15 didn't release too soon before the vaccine had the  
 16 chance to work, and so that was a direct consequence of  
 17 that particular example.

18 But I've got -- there's other examples we can talk  
 19 about if you like.

20 **Q.** All right. May I just ask this. It's not always easy  
 21 to focus on the scope of Module 3, and her Ladyship,  
 22 though, has heard about lockdown decisions and the  
 23 rightness or wrongness and the timing of them.  
 24 I'd like, if you can, during the course of your evidence  
 25 to really focus on things that practically help the NHS.

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1 said, is to set the strategic direction, secure the  
 2 budget --

3 **A.** Yes.

4 **Q.** -- and support the delivery of health and social care.

5 **A.** Yes.

6 **Q.** Mr Hancock, your statement sets out how decisions were  
 7 made, the make-up of your red box, your early starts and  
 8 your late nights and so I'm not going to ask you about  
 9 that.

10 Can I ask you, though, about your relationship  
 11 with your devolved counterparts?

12 **A.** Yeah.

13 **Q.** We know that there are four nations calls, we know that  
 14 you met them on a number of occasions, certainly at the  
 15 beginning, but can you just help, not about lockdown  
 16 decisions, but how was your relationship with them in  
 17 relation to decisions that affected healthcare in each  
 18 of the four countries?

19 **A.** Well, the running of the NHS in each of the four nations  
 20 of the UK is, of course, devolved so, as you know, at  
 21 the start of the pandemic I thought that it was  
 22 important to bring the four health ministers together  
 23 and I went and visited the other three and then from  
 24 then on, we had a weekly Zoom call.

25 Those meetings were -- I say Zoom. It was --

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1 I appreciate that if we all go into lockdown and we all  
 2 don't get infected it's inevitably going to help the  
 3 NHS, but for actual practical things that we might want  
 4 to adopt in the future, or things we might not want to  
 5 do. So can I just ask you keep that in mind throughout  
 6 your evidence?

7 **A.** Of course, although you'll also understand that the  
 8 operation of the NHS is independent so you need to speak  
 9 to the chief executive of the NHS in order to answer --  
 10 ask some of those questions.

11 **Q.** Well, we --

12 **A.** My role was overarching, protecting the system as  
 13 a whole.

14 **Q.** I follow that. That brings me on to your role. You've  
 15 told us, I think, you don't have a medical background.  
 16 I think you actually have a background as an economist;  
 17 is that right?

18 **A.** Yeah.

19 **Q.** And you then became MP for West Suffolk in May of this  
 20 year.

21 **A.** Until July of this year.

22 **Q.** July of this year. It says May in your statement, but  
 23 not to worry.

24 **A.** Oh, no, May, when the election was called, yes.

25 **Q.** And the role of Secretary of State, as you have just

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1 I can't remember what platform it was on.

2 Those meetings were incredibly helpful for  
 3 understanding and actually -- and discussing the  
 4 decisions that we were making, as well as the sort of  
 5 practical interaction of the systems. But the NHS  
 6 itself is devolved, so really they were mostly concerned  
 7 with things that you just said are outside the remit of  
 8 this module because they were mostly concerned with  
 9 things like PPE availability, testing, lockdown  
 10 decisions, vaccines.

11 The operation of the NHS was essentially for each  
 12 of the four of us on those calls, although in England  
 13 independent and delegated to the chief executive of  
 14 NHS England.

15 **Q.** All right. May I ask you, please, about a read-out of  
 16 one of the weekly calls.

17 Can we have on screen INQ000279766\_1.

18 This is a read-out of a meeting between you and  
 19 the ministers in the other nations. It's 18 May 2020.  
 20 And if we just scan down the page, we can see there  
 21 a number of topics, not all of which are within  
 22 Module 3's scope. But at the bottom bullet point:

23 "[Jeane Freeman] made a request to reset the  
 24 relationship between the English and Scottish  
 25 administrations regarding Covid-19 handling. All on the

12

1 call agreed they are keen to ensure they can have  
2 conversations and share information and confidence ..."

3 Can I ask you, was that resetting of the  
4 relationship anything to do with the matters that are  
5 within Module 3 scope or is that matters that are  
6 unrelated?

7 **A.** No, this was all about now Nicola Sturgeon was causing  
8 all sorts of difficulties.

9 **Q.** Right, I'm not going to ask you about that, then,  
10 Mr Hancock.

11 Generally speaking, though, was there good  
12 collaboration between you and your counterparts --

13 **A.** Yes, at a health level there was excellent  
14 collaboration.

15 **Q.** Right.

16 **A.** Between the CMOs, who themselves had their own call and  
17 then between the four health ministers, and you can see  
18 from the minutes and the WhatsApp group that we had  
19 a really genuinely collaborative approach.

20 **Q.** One of the matters you did say, not in relation to the  
21 devolves, was in, I think, your witness statement to  
22 an earlier module, you spoke occasionally of  
23 "inappropriate political interference from No. 10" and  
24 I'd like to ask you, please, whether that interference  
25 related to any of the matters within the Module 3 scope

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1 problem, it was resource constraints more broadly.

2 **Q.** All right. Can I ask you, please, about asymptomatic  
3 transmission. And I know that you have answered some  
4 questions on this topic before, but it's really about  
5 the effect it had on hospitals and the staff working in  
6 them and the patients going --

7 **A.** Absolutely, yes.

8 **Q.** Now, I know that you have said previously that this is  
9 an area where you considered you failed, and you said  
10 that you failed to drive home the importance of  
11 asymptomatic transmission and you said that you consider  
12 this had very significant consequences.

13 From your perspective, what were those  
14 consequences for the healthcare system?

15 **A.** Well, the challenge with asymptomatic transmission was  
16 that the system as a whole and the advice to the system,  
17 the clinical advice, was that asymptomatic transmission  
18 could not be considered a material factor until -- and  
19 that only changed in April 2020.

20 **Q.** Yeah.

21 **A.** And my failure was to -- my inability to override that  
22 consensus. But I've described how, you know, that was  
23 a global clinical consensus. But the consequence of  
24 that was that there was a -- the formal advice going  
25 into the system was that asymptomatic transmission

15

1 as well?

2 **A.** Well, of course, some of it did, for instance -- the  
3 biggest interference that caused difficulties was within  
4 testing where some of the political appointees in No. 10  
5 caused incredible difficulties but that's not to do with  
6 this module.

7 The -- within the running of the NHS we were  
8 protected in a way because of the independence of the  
9 NHS and therefore many of the operational decisions were  
10 taken by the chief executive of NHS England formally and  
11 therefore the -- you know, if there were people being  
12 difficult from No. 10, part of my job was to provide  
13 a shield from that and I know that I ruffled some  
14 feathers in doing so, but my job was to -- my job,  
15 ironically, was also to Protect the NHS from some of  
16 that.

17 **Q.** All right, so we shouldn't -- it's not the case that  
18 you wanted to bring in testing on X date and someone  
19 said, "No, you can't", or you wanted however many  
20 millions or billions and someone from No. 10 said, "No,  
21 you can't", we shouldn't read that into that?

22 **A.** Well, obviously I had to go and get the budget. But one  
23 of the things the Treasury was very good at in the  
24 pandemic was ensuring that the NHS had the budget  
25 available. Budget constraints were rarely the immediate

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1 should not be considered as the most likely cause of  
2 transmission.

3 Now, in terms of the impact on the NHS though, in  
4 early March we took the decisions to increase PPE  
5 requirements within the NHS presuming that anybody could  
6 have Covid. And one of the reasons that there was such  
7 a sharp increase in demand, and all the logistical and  
8 practical consequences that I'm sure we'll come on to,  
9 was that -- was that we increased the -- we increased  
10 the demand for PPE by increasing the recommended use of  
11 PPE within hospitals.

12 So, in a way, whilst the formal advice was that  
13 asymptomatic transmission wasn't the most likely, and  
14 therefore shouldn't be considered as the basis for  
15 policy decisions, within the NHS we -- working alongside  
16 Ruth May, who had the formal responsibility for this  
17 within NHS England, we actually effectively overrode  
18 that and put in place PPE requirements that took into  
19 account the possibility of asymptomatic transmission.  
20 So I wouldn't regard that as an area where this had as  
21 big an impact as in other areas.

22 **Q.** We're going to look at PPE obviously.

23 **A.** Sure.

24 **Q.** But can I just track through for those who aren't  
25 familiar with the chronology of asymptomatic

16

1 transmission. You say in your statement that from about  
2 26 January of 2020 you were concerned about reports from  
3 China of asymptomatic transmission?

4 **A.** Yeah.

5 **Q.** And you say this, that you asked officials for advice on  
6 that?

7 **A.** Yeah.

8 **Q.** And you say this:

9 "At this stage PHE [Public Health England] was  
10 adamant that a coronavirus could not be passed on  
11 asymptotically and that tests did not work on people  
12 without symptoms."

13 **A.** Correct.

14 **Q.** Who at PHE was that adamant?

15 **A.** The then clinical leadership.

16 **Q.** Right. And how was that communicated to you,  
17 Mr Hancock?

18 **A.** In every -- every time I asked.

19 So from 27 January I had daily meetings on Covid  
20 and, for instance, Sharon Peacock would come to those  
21 meetings and she was one of the people who made this  
22 argument very firmly to me: tests don't work if people  
23 don't have symptoms and there are six known  
24 coronaviruses that affect humans and none of them have  
25 asymptomatic transmission. So that was the strongly

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1 transmission?

2 **A.** Yes, I was close to the German health minister,  
3 Jens Spahn, and he was worried about this too, and  
4 I remember speaking to him on the phone about that.

5 **Q.** Right. So there's varying views: there's some evidence  
6 of asymptomatic transmission from China and Germany, PHE  
7 are telling you, on the other hand --

8 **A.** "No".

9 **Q.** -- "No". On what basis was it that you trusted the  
10 advice of Public Health England despite reports to the  
11 contrary?

12 **A.** I challenged the advice from Public Health England  
13 repeatedly, from then over the next three months and  
14 eventually the formal advice was changed. I mean, for  
15 instance, I went to the lengths of setting up a phone  
16 call with the Director-General of the World Health  
17 Organisation about this evidence from China and he said  
18 that he thought -- he said that it was a mistranslation.  
19 So the whole global clinical system was trying to say  
20 there's no asymptomatic transmission, and I kept seeing  
21 straws in the wind, if you like, anecdotal evidence that  
22 there was and continued to challenge on this point.

23 **Q.** Mr Hancock, are you aware that the WHO guidance, not to  
24 say it's not important, but it's not binding --

25 **A.** Correct.

19

1 held view at that stage.

2 **Q.** Can I pause you there so we can just look at 27 January.  
3 It's set out in your statement meeting record.

4 Could we have on screen INQ000421858\_13.

5 And one can see there -- you say you raised  
6 concerns with officials.

7 **A.** Yes.

8 **Q.** The Private Secretary's note of the meeting said it  
9 opened by outlining your concern upon hearing the virus  
10 is transmissible when patients are asymptomatic, and  
11 need to plan -- and set out the need for a plan.

12 **A.** Yes.

13 **Q.** The CMO said:

14 "There is still a lack of clarity over what the  
15 Chinese official position is."

16 But he said it:

17 "... was unlikely to transmit whilst patients were  
18 asymptomatic (but this was/is unable to be definitive)."

19 And at the end of that meeting the record note  
20 says you asked the department to gain clarification from  
21 China on whether asymptomatic transmission is occurring  
22 and to scenario plan accordingly?

23 **A.** Absolutely.

24 **Q.** And I think you also had some evidence from Germany as  
25 well that was pointing towards asymptomatic

18

1 **Q.** -- on England?

2 **A.** So the WHO guidance of course influences public health  
3 views, and the views of Public Health England, which is  
4 an agency of the department, were -- clearly agreed  
5 on -- with it. I could not, at the stroke of a pen,  
6 overrule that advice. That is not within the power of  
7 the Secretary of State.

8 **Q.** So just pausing here now at the end of January 2020,  
9 given that there is some evidence of asymptomatic  
10 transmission, did you at that point consider there  
11 needed to be any specific measures put in place to  
12 protect healthcare workers?

13 **A.** Yes.

14 **Q.** What did you do at the end of January as far as the  
15 healthcare workers were concerned?

16 **A.** Two things. The first is we brought in -- we'd already  
17 brought in a set of PPE guidelines for what became -- it  
18 wasn't even called Covid-19 at that point, what became  
19 Covid-19 -- called the -- the guidelines around high  
20 consequence infectious diseases. Which is essentially,  
21 in lay terms, hazmat suit style PPE. And you can see in  
22 the minutes I was at that time asking to ensure that we  
23 had that PPE available, because this was before any --  
24 there were any known cases in the UK I think. They came  
25 around this time.

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1 The second thing that I did was, anticipating that  
2 there would be a huge rise in the amount of PPE,  
3 I instructed the opening of the PPE stockpile, which had  
4 been -- yeah, I knew was constructed for these purposes,  
5 and also, in January 2020, I ordered the mass purchase  
6 of PPE from around the world, knowing that there was  
7 going to be huge global demand. So that started -- that  
8 work started in January -- January -- 2020, buying the  
9 PPE.

10 **Q.** All right, we're going to come on to the stockpile as  
11 well, Mr Hancock --

12 **A.** Yes, but it's not just about the stockpile, it's also  
13 about getting going buying from around the world.

14 **Q.** I follow that.

15 Jump forward to April, please, and even on 2 April  
16 the WHO were saying there'd been no documented  
17 asymptomatic transmission?

18 **A.** Yeah, but by its nature it's very hard to document,  
19 because it's asymptomatic. So that wasn't evidence that  
20 there wasn't asymptomatic transmission. It was deeply,  
21 deeply frustrating.

22 **Q.** It wasn't a criticism of you, it was just to set out --

23 **A.** No, I don't feel the criticism, I'm -- what I'm  
24 expressing is how I felt at the time, which was like --  
25 don't -- you're trying -- they were trying to prove

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1 responsibility of NHS England to ensure that it's  
2 minimised. But I was deeply concerned to stop this, the  
3 problem of people catching Covid in hospitals. And this  
4 was a repeated problem. I mean, we can -- the use of  
5 testing within hospitals is another issue where I was  
6 trying to drive the use of testing --

7 **Q.** Pause, pause, I'm going to come on to it --

8 **A.** Okay.

9 **Q.** -- all right? I can sense your frustration. Let me  
10 just ask you this. Clearly, the advice to you was:  
11 don't assume asymptomatic transmission until we know  
12 it's happening?

13 **A.** Correct.

14 **Q.** Some may argue that you should assume it is happening  
15 until you know that it's not happening?

16 **A.** Absolutely.

17 **Q.** You're the minister in the middle.

18 **A.** Yes.

19 **Q.** Given the uncertainty about whether or not a new virus  
20 is or isn't transmitting asymptotically, what approach  
21 do you think should be adopted in the event of a future  
22 pandemic?

23 **A.** The precautionary principle, absolutely. Which we did  
24 on things like the guidelines around use of PPE within  
25 hospitals.

23

1 a negative, if you like. They were saying: because  
2 there's no documented evidence, therefore we can't say  
3 that it's happening. It's like -- well, you know, you  
4 can't see asymptomatic transmission, you can't see it.  
5 That was the problem.

6 **Q.** Yes, that's the danger. I follow that. But this is  
7 where I want to get to on this point.

8 On 3 April the CDC in America publish a study,  
9 don't they --

10 **A.** Yeah.

11 **Q.** -- saying that there is?

12 **A.** Yeah.

13 **Q.** Right. And you say in your statement you instructed the  
14 department to review its guidance. Which guidance were  
15 you talking about there, Mr Hancock?

16 **A.** All of the guidance that had been based on the  
17 presumption of no asymptomatic transmission.

18 **Q.** And did that include, from your perspective, a review of  
19 infection prevention and control?

20 **A.** Absolutely, yes.

21 **Q.** All right.

22 **A.** You've got to remember, you know, as the evidence shows,  
23 there was high transmission in hospitals. And  
24 nosocomial infection in hospitals is always a problem  
25 even when there isn't a pandemic. It is the

22

1 **Q.** So one should assume that it is happening until you can  
2 prove that it's not?

3 **A.** That would be a very -- that would be the safer  
4 assumption in future, yes.

5 **Q.** And you would say, therefore, that your IPC guidance for  
6 example, should be predicated upon that assumption that  
7 asymptomatic is happening?

8 **A.** That asymptomatic transmission is happening.

9 And there's another thing that I would recommend,  
10 which is challenge studies, which is where you  
11 intentionally infect consented adults, obviously, in  
12 order to find out. So by using challenge studies you  
13 can find -- you can investigate this question better  
14 than if you refuse to use challenge studies. And  
15 I think the barriers to using challenge studies was one  
16 of the problems -- not on this -- and in particular  
17 on -- you can accelerate vaccine testing using challenge  
18 studies.

19 **Q.** I stopped you as you were going on to talk about  
20 testing, but clearly an ability to test for asymptomatic  
21 transmission depends on you having the capacity of  
22 testing available.

23 **A.** Yeah, but it also depends on your presumption of whether  
24 a test works on somebody who is asymptomatic, and we  
25 were told that they didn't, and that wasn't true.

24

1 Q. No, all right. A number of the witnesses have impressed  
2 upon her Ladyship the need for testing to be up and  
3 running ASAP.

4 A. Absolutely.

5 Q. I take from that answer you wouldn't disagree with that?

6 A. I spent -- you just -- in one of the earlier questions  
7 you said "jump forward" from January to April, and  
8 I thought, well, that's quite a big jump, a lot happened  
9 in February and March in the health department, and one  
10 of those was driving up testing capacity, as the records  
11 show.

12 Q. All right. Can we turn to NHS overwhelm. And in your  
13 statement you say in terms:

14 "One of the most considerable achievements of the  
15 UK during the pandemic was ensuring that the NHS was  
16 never overwhelmed, or in other terms, the NHS was always  
17 available to all according to need, not ability to pay,  
18 and we did not have to ration care."

19 A. Yes.

20 Q. All right. There was, do I take it, no agreed  
21 definition of what it meant within government as to what  
22 "overwhelmed" meant or "overwhelmed" looked like?

23 A. There was a -- that's not quite right. There's a sense  
24 of what "overwhelmed" looks like. It's not a -- it's  
25 accurate to say there's no formal definition, but the

25

1 I saw some of that.

2 The system as a whole, though, withstood the  
3 challenges. And if I might just add one other thing at  
4 this point. It was not only -- what I was saying was  
5 not only accurate in the big-picture sense, it was also  
6 important to say. Because at the same time as having to  
7 tackle Covid, we wanted to ensure that people who  
8 desperately needed NHS treatment for other reasons,  
9 where it was safe to do so, would come forward and get  
10 it and, you know, that balance between "Protect the  
11 NHS", ie, don't use it unless you have to, and "Please  
12 do come forward if you really need it" was something  
13 that was in my mind throughout this in terms of how we  
14 communicated.

15 LADY HALLETT: Can I interrupt, I'm sorry, Ms Carey.

16 You said that the NHS was always available to all  
17 according to need. Well, it was always available to  
18 those with Covid who needed ICU treatment, but it wasn't  
19 always available to those who needed cancer screening or  
20 who needed a major elective surgery like a hip  
21 operation. So I just -- I can understand why you say we  
22 had to do that, but I don't understand how you can  
23 maintain that it was right to stop non-urgent elective  
24 care, and then say but it was always available to all  
25 according to need. Because it wasn't, was it?

27

1 best approximation you could have and what I held in my  
2 mind at the time, for it to mean, was what happened in  
3 Lombardy in February 2020.

4 Q. So do I take it from that it was a desire to ensure that  
5 if people needed a ventilator, they got it; if they  
6 needed to get into ICU, they were able to get  
7 an intensive care bed?

8 A. Yes.

9 Q. Right.

10 A. What it does not mean is that these -- the availability  
11 of these things were not stretched and in some cases  
12 deeply stretched. For example -- I'll give you  
13 an example of what I mean by that.

14 In normal times one nurse cares for one patient in  
15 ICU.

16 Q. Correct.

17 A. In order to ensure that there was enough ICU capacity  
18 one of the things we did was stretch that so that one  
19 nurse cared for six people. Now, imagine the impact of  
20 that on that nurse, on all ICU nurses during the  
21 pandemic. It's a deeply challenging situation. It's  
22 very hard. And there will always, always be boundary  
23 cases where people feel that they or their loved one  
24 should have had that level of care and feel that it  
25 wasn't available, and I absolutely understand that and

26

1 A. Well, I don't think that -- I don't want to get into the  
2 linguistic analysis of it, what I care about is the  
3 substance, and the substance is that it was not safe  
4 clinically to go for some cancer treatment during the  
5 pandemic because cancer treatment sometimes involves  
6 reducing the immune system. It was better to delay some  
7 non-urgent operations, in order to protect both the  
8 space in the NHS and the patients themselves because, as  
9 we know, hospitals are -- you're more likely to catch  
10 Covid in a hospital than in almost any other setting.

11 So that -- of course those decisions were taken  
12 but according to -- it depends how you define "need".  
13 And "need" -- at the same time needing to protect people  
14 from the pandemic.

15 So I think that -- I think the broad thrust of the  
16 NHS being available is true and being -- and whilst  
17 individual parts were under enormous pressure, like  
18 there was a time when 111 was under massive pressure,  
19 there were many hospitals individually under pressure  
20 and we triaged patients to other places. But the  
21 overall point is that we did not have a collapse in the  
22 system.

23 MS CAREY: I'm going to come back to that, I suspect.

24 You mentioned ratios. So let me deal with that at  
25 this stage. You set out in your statement that it was

28

1 you that suggested to Sir Simon Stevens, the then  
 2 chief executive of NHS England, that ratios be  
 3 stretched. When was it that you suggested that to  
 4 Sir Simon?  
 5 **A.** I don't recall.  
 6 **Q.** Are we January, February, March? Can you help at all in  
 7 the timeline?  
 8 **A.** It will have been during the period when we were  
 9 building the Nightingales, as well. So it was  
 10 probably February 2020, but we'll be able to -- it'll be  
 11 there in the paperwork.  
 12 **Q.** It's not meant to be precise. It was 10 February.  
 13 That's not what I'm asking you, it's generally to try  
 14 and get an overview at what point it was you decided to  
 15 ask Sir Simon to stretch the ratios in the way that  
 16 you did?  
 17 **A.** Yes, so one of the things that we were doing -- yes,  
 18 February -- the answer to the question is February.  
 19 **Q.** All right, and on what basis did you make that decision?  
 20 **A.** Oh, so, it was clear that there was likely to be very  
 21 significant pressure on the NHS, and I wanted to ensure  
 22 that there was as much capacity as possible in the NHS,  
 23 and I was pushing for the building of extra hospitals --  
 24 we'd seen the Chinese had built a hospital in two weeks.  
 25 And one of the responses that came back was, "There's no  
 29

1 And so that led to acute pressure on particular aspects  
 2 that were necessary for dealing with Covid-19, like  
 3 ventilators, oxygen supply, et cetera, that may not have  
 4 been necessary for other purposes.  
 5 So, it was not just the pressure of numbers, and  
 6 at this point, remember, anticipated numbers, because  
 7 there were very few in hospital in February, it was the  
 8 pressure of -- it was the pressure of very large number  
 9 of people presenting with the same condition.  
 10 **Q.** Okay. On what basis did you or were you advised to go  
 11 to 1:6, as opposed to 1:3, 1:4? Who was telling you  
 12 that's an acceptable stretching?  
 13 **A.** That was a -- I think that was an NHS decision.  
 14 **Q.** All right. Did you appreciate in the context of  
 15 intensive care, stretching to ratios of 1:6 would mean  
 16 providing a very different level of care --  
 17 **A.** Yes, of course.  
 18 **Q.** -- to patients?  
 19 **A.** Yes, of course. And not only did I appreciate it, I saw  
 20 it for myself. I mean -- and I talked to the ICU  
 21 nurses. You know, I took the advice, I think it  
 22 probably came from -- through Simon Stevens, probably  
 23 from Ruth May as the Chief Nursing Officer, but -- and  
 24 it would have been Simon Stevens' decision, actually,  
 25 the actual 1:6.

31

1 point in building extra hospitals because we don't have  
 2 enough staff", to which my response was, "Well, what  
 3 we're going to have to do is stretch ratios of -- the  
 4 staff/patient ratios as much as is clinically possible,  
 5 even though that's difficult, and at the same time build  
 6 more hospitals", which is what became the Nightingale  
 7 project.  
 8 So it was essentially -- the reason I pushed that  
 9 was because I was rejecting advice that we couldn't  
 10 increase NHS capacity in short order.  
 11 **Q.** Now, the stretching of the ratios into Nightingales is  
 12 a slightly different matters because we have heard  
 13 evidence they were being stretched within an ICU unit  
 14 within a hospital itself because the ICU unit had to  
 15 expand by --  
 16 **A.** Yeah, absolutely.  
 17 **Q.** -- double or triple its capacity?  
 18 **A.** Yes, so it's not just the Nightingales, that was another  
 19 part of the overall stretching of the NHS's capacity to  
 20 deal with this. And there's one other factor which made  
 21 this -- which is important here. Which is that -- which  
 22 is that in normal times the NHS is dealing with many,  
 23 many diseases, obviously. The pressure wasn't just the  
 24 pressure of numbers, it was the pressure of very large  
 25 numbers, all suffering from exactly the same disease.  
 30

1 The -- but did I appreciate it? Absolutely.  
 2 **Q.** Did you -- let me ask you this. How did you assure  
 3 yourself that stretching to those ratios wasn't putting  
 4 the nurses under absolutely intolerable pressure?  
 5 **A.** Well, the actual decision will have been a decision, as  
 6 I say, for Sir Simon Stevens, so you'd have to ask him  
 7 that. My role was to say we have to expand NHS capacity  
 8 and to push against the initial feedback which is that  
 9 the limitation on this will be the number of people that  
 10 we have.  
 11 **Q.** All right, but the question I wanted to know, was how  
 12 you assured yourself, not the actual ratio, it doesn't  
 13 matter for these purpose if it's 1:4, 1:6, but how did  
 14 he ensure the stretch, per se, didn't put those nurses  
 15 under intolerable pressure?  
 16 **A.** I had to rely on my clinical advisers and the  
 17 NHS England advice and I'm sure the CMO will have had  
 18 a view on this as well, that that was an appropriate  
 19 level to go to. You have to remember that the formal  
 20 running of the NHS was independent and so this really is  
 21 a question for Sir Simon Stevens.  
 22 **Q.** Well, given that you were suggesting to him that the  
 23 ratios be stretched, people might forgive me for asking  
 24 you what --

(Unclear: Multiple speakers)

32



1 **A.** -- to ask me --  
 2 **Q.** -- you did to assure yourself that they weren't put  
 3 under just the most immense strain?  
 4 **A.** Yes, but that's, if I may say so, a slight  
 5 misunderstanding how the system operated. My job was  
 6 strategic. It was to drive the system, but also to  
 7 accept advice from the system. So the conversation  
 8 would have gone, over a period of days or  
 9 probably weeks: we need to ensure we expand NHS  
 10 capacity; can we build more capacity?  
 11 And the first response was: there's no point in  
 12 doing that because we won't have enough staff. Can we  
 13 stretch the staff numbers? They would have come back  
 14 and said, yes, we can, we think that it's okay to  
 15 stretch them to 1 in 6, and I would have said, as you  
 16 said, the degree of stretch, whether it's 1 in 4, 1 in  
 17 6, was not a decision for me. And that's how the system  
 18 operated. I was strategic.  
 19 But, really, for all of these questions you are  
 20 going to have to ask Sir Simon Stevens because he was  
 21 running the NHS, remember; I was the Secretary of State.  
 22 And we worked very closely and very well together but  
 23 there was a clear distinction and this section is about  
 24 the NHS so, you know, it's perfectly reasonable to ask  
 25 him.

33

1 **A.** Yes.  
 2 **Q.** -- both for those with Covid --  
 3 **A.** Yes.  
 4 **Q.** -- and those in ICU that were not Covid?  
 5 **A.** Yes.  
 6 **Q.** Higher strain, higher mortality.  
 7 **A.** Absolutely. So --  
 8 **Q.** You don't sound surprised by this finding.  
 9 **A.** I'm not surprised at all and we said it at the time --  
 10 and you have to remember that I was trying to drive up  
 11 NHS capacity because -- I know it's technically outside  
 12 the remit of this particular element of the Inquiry, but  
 13 really my role was overarching rather than specific to  
 14 the NHS because you have to remember at the same time  
 15 I had the Cabinet Office and others trying to tell me  
 16 that we shouldn't be taking the actions that I thought  
 17 were going to be necessary in order to stop the spread  
 18 of the virus. And so I knew that we were going to have  
 19 a problem. And therefore I had to increase hospital  
 20 capacity as well as try to reduce the spread of the  
 21 virus.  
 22 So, not only do I know this, and I saw it, but we  
 23 articulated it. And the Chief Medical Officer in one of  
 24 the early press conferences set out that there are four  
 25 reasons that you get more people dying in a pandemic.

35

1 **Q.** All right. Let me ask you not about the impact on the  
 2 staff that were stretched in that way but on the impact,  
 3 actually, on those in ICU.  
 4 Could I have on screen, please, INQ000480139\_7.  
 5 I think, Mr Hancock, you've been sent an extract  
 6 from an ICNARC report who look at intensive care data  
 7 and we have heard from Kathy Rowan who heads up ICNARC.  
 8 She told us, if one looks at paragraph 6.1, that:  
 9 "Prior to the pandemic, ICNARC reported that how  
 10 busy an intensive care unit is on any given day  
 11 impacts on patient outcomes ..."  
 12 **A.** Of course.  
 13 **Q.** "... with higher strain associated with higher acute  
 14 hospital mortality."  
 15 **A.** Absolutely.  
 16 **Q.** And the strain is the mismatch there between supply and  
 17 demand, availability of beds and staff or other  
 18 resources, and the ability to admit those that were  
 19 needing critical care.  
 20 And their ultimate conclusion, if one goes over  
 21 the page, please, to paragraph 6.4, that when they  
 22 adjusted for potential differences in important patient  
 23 factors, compared to typical ICU strain, they found  
 24 significant association between exposure to higher ICU  
 25 strain and higher acute hospital mortality --

34

1 One is the direct impact of Covid. The second is the  
 2 impact of unavailability of health services that would  
 3 be available at other times as per our exchanges  
 4 earlier, for instance cancer care. And then, of course,  
 5 the impact on the measures taken, for instance,  
 6 lockdown, and the fact that if you have higher hospital  
 7 admittance then the treatment of those with Covid  
 8 becomes more difficult, and we saw this in the first  
 9 phase and we saw it in the second phase as well, and  
 10 it's one of the reasons that I feel so strongly about  
 11 the need to ensure that we're ready to bring in measures  
 12 to stop the spread of the virus next time round.  
 13 **Q.** Do you think, though, Mr Hancock, if you just stand back  
 14 for a moment that the fact that the nurses are being  
 15 stretched to the ratios that we've looked at and the  
 16 potential adverse consequences for those who were in  
 17 ICU, doesn't that not in fact demonstrate that the NHS  
 18 was in fact overwhelmed?  
 19 **A.** No, because people could get treatment. The treatment  
 20 was not as good as normal, in the same way that the  
 21 waiting times for a knee operation was not as good as  
 22 pre-pandemic. But that is not the measure -- I'm not  
 23 saying that the NHS was perfect in the pandemic, and I'm  
 24 not saying that it wasn't severely pressured in many  
 25 areas and that that pressure had consequences.

36

1 The point of saying that it wasn't overwhelmed is  
2 that the system as a whole withstood the pressure, and  
3 as I say, that is not only accurate but it was also  
4 important to say during the pandemic because we had to  
5 reassure people that the NHS remained there for them.  
6 Remember, there were people who didn't turn up -- they  
7 might have found a lump and didn't go to their GP  
8 because they thought, "I don't want to put pressure on  
9 the NHS." And we have seen that in the excess mortality  
10 figures of people who didn't have Covid, as well as  
11 people who died with Covid.

12 So I was acutely aware of this and it weighed  
13 heavily on our decision-making at the time.

14 **Q.** Let me come to intensive care capacity, then, please,  
15 because you say in your statement that at no stage were  
16 you advised that intensive care capacity was exceeded:

17 "I understand that there may have been some  
18 individual hospitals where intensive care capacity was  
19 exceeded, and patients needed to be transported  
20 elsewhere, but there was capacity in the system as  
21 a whole."

22 And are you referring there to not just the  
23 baseline capacity but the capacity the hospitals had  
24 once they had surged up?

25 **A.** I am but, again, the detail of that and the triage of

37

1 **Q.** What I wanted to ask you was, do you think in reporting  
2 that way that gave perhaps a more positive picture of:  
3 we've got a lot of beds available, it's okay, rather  
4 than demonstrating that some of these hospitals were  
5 running --

6 **A.** Incredibly hot.

7 **Q.** -- 20, 30 more beds?

8 **A.** Absolutely, but -- sorry, the point I was going to make  
9 was precisely to your question, which is that you also  
10 have to remember that at the start of the pandemic we  
11 didn't have -- I couldn't get an answer out of the NHS  
12 about how many beds they had. And by the end of the  
13 pandemic that data was much better but -- and in  
14 the second phase it was much better, but that sort of  
15 definitional issue, of course we should consider now as  
16 part of the Inquiry, but at the same time it was a moot  
17 point because if you say to the NHS, "How many beds have  
18 you got?" and they say, "Well, it all depends how you  
19 define it", then the extent to which that includes surge  
20 or not is second order.

21 And just in their defence, the reason that they  
22 couldn't define -- they couldn't say exactly and  
23 definitively how many beds, is because it depended on  
24 how many people were available, because the NHS counts  
25 beds according -- not just the physical bed but the bed

39

1 people to a different hospital if a hospital became full  
2 was -- that was core business of NHS England and  
3 I didn't get involved at a day-to-day level.

4 **Q.** I wasn't asking you about the transfers, it was just  
5 simply when you're talking about ICU capacity, in your  
6 mind, that's baseline plus whatever surge capacity there  
7 was?

8 **A.** Yeah, of course. At only baseline capacity there was no  
9 way we could have treated as many people as we did.

10 **Q.** Were you made aware of how far over baseline hospitals  
11 were operating?

12 **A.** Yes, and remember I was visiting hospitals whenever  
13 possible and I saw it. I remember going into Bart's and  
14 seeing the ICU beds which in normal times have a stack  
15 of equipment behind them on the wall and they were --  
16 there were just far more beds than there was space for.  
17 Of course I saw it for myself, yeah.

18 **Q.** In England we've heard that NHS England reported  
19 occupancy based on the surge capacity which sometimes  
20 suggested there was a lot of beds available but didn't  
21 really alight upon the fact that these hospitals were  
22 operating at double their intensive care --

23 **A.** Yeah, exactly, and you've got to remember also --

24 **Q.** No, no -- can I finish? Thank you.

25 **A.** Of course.

38

1 with the ability, then, to support a patient which  
2 includes people and equipment and what have you. If you  
3 have a bed -- if you have an intubation bed with no  
4 oxygen flowing to it then it's no use for these  
5 purposes.

6 So that's why it was difficult, so I'm not  
7 saying -- I'm not blaming the NHS for inability to  
8 measure that at the start. What I'm saying is these  
9 things were difficult to measure and so picking precise  
10 points in the methodology just was not our lived  
11 experience.

12 But this was another reason that I went to see --  
13 went to hospitals and went and talked to people.

14 **Q.** It's not so much about whether it's difficult to  
15 measure, but from the public's perspective if you're  
16 saying there's still 10% of beds available across the  
17 country, it might be thought by someone that's  
18 presenting a rather rosy picture when in fact those  
19 hospitals were operating double, triple their usual  
20 baseline capacity?

21 **A.** And in some cases --

22 **Q.** But you agree it presented a rosy picture, or not?

23 **A.** I think that we got -- I think that by the end of the  
24 pandemic and in the second phase we were able to present  
25 this much more accurately. Whether it was rosy or not

40

1 in the first instance, as I say, I don't think you can  
 2 define that because we just didn't have the data  
 3 available at all.

4 **Q.** Can I give you an example, please, of some evidence  
 5 we've heard from Queen Elizabeth Hospital, Birmingham,  
 6 and I want to know if this kind of information filtered  
 7 up to.

8 **A.** Yeah.

9 **Q.** They had, in March 2020, 67 ICU beds and they went  
 10 to April, the following month, to 126, so it nearly  
 11 doubled?

12 **A.** Yeah.

13 **Q.** That meant, for them, finding 205 additional doctors.

14 **A.** Yeah.

15 **Q.** 429 nurses.

16 **A.** Yeah.

17 **Q.** And an extra 59 actual physical beds.

18 **A.** Yeah.

19 **Q.** At a time when they had 25% absence of the workforce due  
 20 to ill health.

21 **A.** Yeah.

22 **Q.** Now, were you being told that's actually -- let me  
 23 finish, please.

24 Were you being told that's actually what it means  
 25 if a hospital has to double up its surge capacity? We

41

1 **Q.** Now, were you made aware that not everyone who needed  
 2 an ICU bed got an ICU bed?

3 **A.** Yes. Yes. In individual cases that happened, yes.

4 **Q.** We've heard a number of examples, some of which we've  
 5 provided to you, and I'd just like to take you through  
 6 some of them for your comments on them, if I may.

7 **A.** Right.

8 **Q.** You are aware, I think, that on the first day of  
 9 evidence we heard from Mr Sullivan, who told us about  
 10 his daughter Susie, who had Down's syndrome, and was  
 11 taken to hospital, and she was refused admission to ICU  
 12 because what was recorded on the notes was she had  
 13 cardiac comorbidities, she had a pacemaker, and had  
 14 Down's syndrome. Did you get reports like that, that  
 15 people were being denied ICU care?

16 **A.** I did get reports like that and I also got reports about  
 17 the misuse of DNR notices as well.

18 **Q.** We'll come on to that.

19 **A.** Well, they're all part and parcel of the same thing,  
 20 because it's about availability of care.

21 **Q.** Yeah.

22 **A.** And if you recall, I was also getting advice from the  
 23 BMA and others that we should have a code of who you  
 24 should give care to and not --

25 **Q.** I'm going to come on to that as well.

43

1 have to find vast numbers of staff?

2 **A.** Yeah, not only was I being told but I was seeing it.  
 3 I went to the Queen Elizabeth Hospital in Birmingham.  
 4 I saw it for myself. So yes, of course, and I was  
 5 deeply involved, for instance, in trying to hire more  
 6 doctors and get doctors who had retired back into the  
 7 workforce in order to try to solve these problems.

8 So, you know, the reason I interrupted is the  
 9 question gives the impression that I was somehow sat in  
 10 an office this whole time. I was out on the ground as  
 11 much as I could be and talking to people about what the  
 12 real-world problems were as well as getting the official  
 13 advice through paperwork. That's how you lead in  
 14 a crisis as big as this.

15 **Q.** Can I ask you to just pause for a second.

16 Some of these questions are not designed to trip  
 17 you up, Mr Hancock --

18 **A.** No, no.

19 **Q.** -- but I want to understand whether some of the detail  
 20 that we've now heard did in fact make its way to you.  
 21 That's all I was asking.

22 **A.** Okay, and I'm being emphatic in my response that it's  
 23 not -- not only did I get it in reports as much as the  
 24 data was available, but I chose to go out there and see  
 25 it for myself.

42

1 **A.** Yes, but what I'm saying is I was deeply involved --  
 2 of course. Not only did I know these things were  
 3 happening, I was fighting on behalf of those to whom it  
 4 was happening.

5 **Q.** Can I just stick with what happened to Susie.

6 And can I have up on screen, please,  
 7 INQ000483295\_8.

8 This, Mr Hancock, is a serious incident  
 9 investigation report that was carried out into the care  
 10 that she received, and one can see that she was admitted  
 11 to intensive care. The essential advice was if she  
 12 worsens she should be considered for escalation up to  
 13 ICU.

14 **A.** Yeah.

15 **Q.** And then in due course, about three hours later, was  
 16 deemed not suitable because of her cardiac comorbidities  
 17 and Down's syndrome.

18 Can we look, please, at what was going on in the  
 19 hospital at the time. And if we highlight, please, the  
 20 paragraph beginning "It is recognised":

21 "It is recognised that intensive care units were  
 22 having to clinically prioritise patients ..."

23 **A.** Yes.

24 **Q.** Occupancy on this particular hospital on 27 March, the  
 25 day Susie was taken in, was 27.

44

1 **A.** Why is the hospital redacted?  
 2 **Q.** Because it's not necessary to name the hospital. This  
 3 is just an example of issues that the Inquiry has been  
 4 made aware of.  
 5 But put that to one side for a moment, Mr Hancock.  
 6 Just concentrate on what was going on in the hospital.  
 7 There was 27 level 3 patients, which was already  
 8 an increase from the 21, and the baseline there was  
 9 23 beds, normally staff for 9 level 3, which is the  
 10 highest level of care, ICU beds, and 14 level 2. So  
 11 they were already running at over capacity.  
 12 Did you ever get examples of particular problems  
 13 like this brought to you? I know you're looking at it  
 14 from a national picture, but did you ever get --  
 15 **A.** Yes, of course.  
 16 **Q.** All right. It might suggest that, in her case, the  
 17 decision was wrongly taken to deny her ICU or it might  
 18 be that the notes are very badly and incorrectly drawn,  
 19 but either way do you not think this is an example of  
 20 tragic overwhelm in the NHS?  
 21 **A.** This is an example of a tragic case and serious case  
 22 reviews happen -- are intended to get -- to find out  
 23 what happened. And individual clinicians make judgments  
 24 like this in normal times but made judgments like this  
 25 because of the pandemic more so, and of course there was

45

1 **Q.** You don't sound surprised by the findings of this  
 2 research either, and, in fairness, neither was  
 3 Professor Whitty when we asked him --  
 4 **A.** I'm not surprised in the least. And of course we knew  
 5 that these pressures were intense. You know,  
 6 Professor Whitty himself worked on the wards.  
 7 **Q.** Yeah.  
 8 **A.** I visited them and I worked, in an appropriate capacity,  
 9 as a non-clinician. Of course we knew. Absolutely.  
 10 And this is what we were trying to prevent. This is  
 11 what we were trying to prevent by fighting for  
 12 lockdowns, by buying as much PPE as we could get our  
 13 hands on, by developing the testing.  
 14 I know that -- you say these things are outside  
 15 the remit -- you can't present this as if it's a -- sort  
 16 of dessicated statistics. These were -- this is what  
 17 was going on in the ICUs of the nation. This is why  
 18 it's so important that we're prepared to stop pandemics  
 19 before they start. And so absolutely, yeah.  
 20 **LADY HALLETT:** Did you tell your cabinet colleagues and the  
 21 Prime Minister, then Mr Johnson, of all of this material  
 22 that you were well aware of?  
 23 **A.** Yes, as much as was -- of course we talked about it,  
 24 yeah. Yeah.  
 25 **LADY HALLETT:** So you --

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1 enormous pressure and of course it had consequences,  
 2 absolutely.  
 3 **Q.** The Inquiry has sent you its research conducted by IFF,  
 4 and can we just have a look at that because it's not  
 5 an isolated experience.  
 6 Can I have up on screen INQ000499523\_3.  
 7 And we have there a summary of the research. I'm  
 8 not going to suggest to you, Mr Hancock, this is  
 9 representative of entire healthcare professionals but  
 10 clearly a large number were surveyed, over half of whom,  
 11 58% of healthcare professionals, reported that some  
 12 patient could not be escalated to the next level of care  
 13 due to lack of resources --  
 14 **A.** Yes.  
 15 **Q.** -- during either wave of the pandemic, so wave 1 and 2.  
 16 "A&E doctors ... and paramedics ... were more  
 17 likely to have ever been unable to escalate care ..."  
 18 If we just go on to page 17.  
 19 And if one looks at the bottom two responses, from  
 20 critical care nurses and critical care doctors, during  
 21 the first wave those doctors were significantly more  
 22 likely to have ever been unable to escalate care. 20%,  
 23 and 19% of nurses and doctors, respectfully, said that  
 24 that happened to them on a daily basis?  
 25 **A.** Daily basis, yeah.

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1 **A.** I don't know the detail of how much -- you know, whether  
 2 I presented a particular slide or what have you, but,  
 3 yeah, absolutely. Stopping the NHS from being  
 4 overwhelmed was something I talked about frequently.  
 5 And I can see that you have picked up on that  
 6 language as if I was trying to say everything was  
 7 perfect, and that is emphatically not what I meant and  
 8 it is not how I mean that. And I understand if that is  
 9 how it could be interpreted that that was not the  
 10 reason. It was used as a term of reassurance. And that  
 11 is true. But it was absolutely part of our discussions  
 12 to say -- in fact, the then Prime Minister would say,  
 13 "It mustn't be topped out", I remember because I thought  
 14 that was an unusual phraseology. But, yes, this was  
 15 part of our discussion, the enormous pressure on  
 16 the NHS, yes.  
 17 **LADY HALLETT:** So you made it plain to your cabinet  
 18 colleagues and the Prime Minister at the time that  
 19 numbers of doctors and nurses were unable to provide the  
 20 level of care that their patients needed? You made that  
 21 plain to all your colleagues? You didn't present a rosy  
 22 picture that some have suggested?  
 23 **A.** I have in previous modules been accused of painting  
 24 a rosy picture. There are -- for each of those -- as  
 25 I said in those modules, for each of those specific

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1 accusations there are -- there are inaccuracies in the  
 2 other accounts that we didn't go through in detail. But  
 3 all you need to know, Chair, is I was not one for buck  
 4 passing. And maybe we've seen a little bit of that in  
 5 previous modules.

6 **MS CAREY:** I ask you this because, in your Module 2  
 7 statement, you said had the NHS been overwhelmed  
 8 treatment would have had to be rationed. And it was  
 9 being rationed, wasn't it, Mr Hancock?

10 **A.** What I was trying to avoid and what we successfully  
 11 avoided was an overall rations to say people, according  
 12 to these characteristics, aren't going to be cared for.  
 13 That's what would have happened if we had let the virus  
 14 get more out of control. And we managed to avoid that  
 15 both in the first and the second phase.

16 Did people get as good care as they would have  
 17 done in normal times? Of course not. There was  
 18 a pandemic.

19 **Q.** No --

20 **A.** So I totally -- I mean, I think we're agreeing with each  
 21 other --

22 **Q.** I think we are. It's just this. If people can't get  
 23 into ICU, for example, because the doctors don't  
 24 consider that they can be escalated, we've sent you  
 25 an ICNARC report which suggests that older people --

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1 **A.** The system as a whole had to cope with more than it has  
 2 had to cope with at any other time in modern history.  
 3 And, thanks to the work of those in ITU, did so.

4 Now of course -- of course -- there were deeply  
 5 challenging problems, as we've just seen, and that's --  
 6 there were countless examples of that.

7 At the same time, we had people who were at risk  
 8 of dying from not coming forward, and it was therefore  
 9 important and my responsibility and my duty to ensure  
 10 that the public felt that, should they really need it,  
 11 the NHS was there for them. And balancing these  
 12 considerations was difficult and hard, but they did need  
 13 to be balanced. And so that's why I use, and used, and  
 14 I was right -- I still believe I was right to use, that  
 15 language, because of course there are individual -- it's  
 16 similar to PPE provision, right?

17 I have said that there was no national shortage of  
 18 PPE. That is true. It is verified by all of the  
 19 paperwork. But that doesn't mean that there weren't  
 20 shortages in individual places where the logistics  
 21 couldn't get it to. And this is a similar concept. My  
 22 responsibility was for the system as a whole and then to  
 23 try to relieve the individual pressures as much as  
 24 possible.

25 But it comes back to the point that this modular

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1 **A.** You sent me endless evidence showing that the NHS was  
 2 under incredible pressure as if I didn't -- as if  
 3 I wasn't there.

4 **Q.** No, I know --

5 **A.** But I was on -- I visited as often as I could. I talked  
 6 to the doctors. Of course I relied on the official  
 7 advice that I was getting, but the -- but I went to see  
 8 it. And I spoke to people regularly, as did my senior  
 9 advisers. We were emotionally engaged in trying to stop  
 10 this from being -- from getting worse, frankly.

11 **Q.** I want to deal with one final aspect on this, please.  
 12 Can I ask, please, that we look at a clip of footage  
 13 from a witness that gave evidence by the name of  
 14 Kevin Fong. I think you've seen his transcript but  
 15 I'd just like to watch a short clip of what he told us.

16 **(Video clip played of a portion of witness**  
 17 **Professor Kevin Fong)**

18 **Q.** Watching that now, and looking at the number of  
 19 different examples, statistic, real life stories, do you  
 20 think perhaps the use of the phrase "overwhelm" is not  
 21 the right word to use when we're talking about how the  
 22 NHS coped or otherwise in the event of a pandemic?

23 **A.** I agree with everything that that was said in that clip  
 24 and I saw it for myself.

25 **Q.** Yeah.

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1 approach is -- sort of narrows the point. The best way  
 2 to solve that problem was to have measures in place at  
 3 a national level to stop the spread of the disease, and  
 4 that is -- that was core to my responsibility as well.

5 So that's my explanation, and I think you can have  
 6 an endless debate about the linguistics; what matters is  
 7 the substance.

8 **Q.** Well, yes and no, Mr Hancock, because actually if you  
 9 make a statement like "the NHS was not overwhelmed" and  
 10 you can't get an ICU bed because you're old or you have  
 11 Down's syndrome or because there aren't enough nurses,  
 12 plenty of people would say that is "overwhelm", wouldn't  
 13 they? And that's why it's not just semantics.

14 **A.** I'm saying that the substance is what matters here and,  
 15 for instance, when an ICU didn't have any more capacity,  
 16 the NHS's response was to then ensure that there were  
 17 transfers available to other places, because the picture  
 18 was never even across the country. That is the  
 19 system-wide response but it doesn't take away from the  
 20 individual pressures. And as I say, there were other  
 21 reasons to explain why -- and to use the word, the  
 22 language that I did, and you have to take them into  
 23 account as well. You just can't take one element of  
 24 this response into account on its own, you can't do it,  
 25 because then you miss some other consideration that had

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1 to be balanced.

2 **Q.** Let me ask you this, finally, on this topic perhaps  
3 before we break. In your final paragraph of your  
4 statement to Module 3, you say this:

5 "Finally, I would strongly recommend that  
6 an early objective of any future pandemic is to make  
7 sure the NHS is never overwhelmed."

8 **A.** Yes.

9 **Q.** How, practically, do you suggest that that can be  
10 achieved in the event of a future pandemic?

11 **A.** As soon as you see that a pandemic is -- it comes back  
12 to the pandemic doctrine that we've discussed in the  
13 previous two modules. As soon as you see that  
14 a pandemic is going to require action that -- what are  
15 called non-pharmaceutical interventions, you get on with  
16 it straight away, you don't wait in the hope that it'll  
17 disappear or stick your head in the sand.

18 **Q.** Right, so you buy more PPE, you start your surge  
19 capacity plans; is that what you're talking about?

20 **A.** No, what I was talking about very specifically was  
21 bringing in lockdown measures as soon as they might be  
22 needed, because you're going to have to bring them in  
23 anyway.

24 **Q.** Right. Outside of lockdown measures, thinking about it  
25 from the NHS perspective --

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1 are suffering some distress at this evidence. Please  
2 can I encourage them to seek any support if they need  
3 it, but also if people are at home feeling distressed,  
4 could they check out where they could get support.

5 **MS CAREY:** Yes, thank you very much, my Lady.

6 **LADY HALLETT:** Thank you. 11.30.

7 (11.15 am)

8 (A short break)

9 (11.31 am)

10 **LADY HALLETT:** Ms Carey.

11 **MS CAREY:** Thank you.

12 Mr Hancock, can I pick up on one of the things you  
13 referred to before the morning break. Which was  
14 potentially some of the difficult decisions that may  
15 have to be made in the event that effectively there was  
16 no extra bed or there was two people vying for one ICU  
17 bed.

18 **A.** Yeah.

19 **Q.** We've called it an escalation tool or "in the event of  
20 saturation" has been another way it's been described.

21 **A.** Yeah.

22 **Q.** Generally speaking, do you think that ministers should  
23 be involved in such guidance, by which I mean not the  
24 actual detail of who might get the bed, but the need for  
25 an escalation tool per se?

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1 **A.** Well, you can't think about the NHS response out of  
2 lockdown measures. The system as a whole -- this is  
3 an overall policy response. You know, there were seven  
4 elements of the battle plan and you can't just say,  
5 well, how did that one work? You have to ask how the  
6 system worked. Because it's impossible to answer the  
7 question without talking about overall measures because  
8 we were in a pandemic.

9 Obviously -- but what I can say is, as well as  
10 lockdown measures, you, of course, also need to have  
11 an adequate and accessible PPE supply. You need to have  
12 a testing system that's ready to grow and ready to  
13 expand rapidly. You need to make sure you can get  
14 a vaccine as soon as you possibly can. You need to  
15 undertake the challenge trials to understand spread not  
16 just by observing evidence in the wild, so to speak, but  
17 by having a scientific approach to doing that and  
18 getting over the improper ethical caution around using  
19 challenge studies.

20 You have to have an overall system response and  
21 that is why -- I'm getting to the point of repeating  
22 myself so I'll stop.

23 **MS CAREY:** Would that be a convenient moment?

24 **LADY HALLETT:** Certainly.

25 I think some members of the public gallery here

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1 **A.** Of course ministers should be involved in the principled  
2 decision about whether such a tool is necessary, and  
3 also the level at which such decisions should be made.

4 **Q.** What do you mean by the level at which a decision --

5 **A.** I was very strongly of the view that these decisions are  
6 best made locally, according to the local judgment of  
7 the clinicians with the most information, rather than  
8 through a national tool.

9 **Q.** Ah, well, that's what I wanted to ask you about.  
10 Because I think you are aware that on 21 March 2020 the  
11 four CMOs commissioned guidance in the event that  
12 critical care was saturated and I'd like, please, just  
13 to look on screen -- this was intended to be a UK-wide  
14 tool.

15 **A.** Yes.

16 **Q.** Can we have a look at -- thank you -- please -- I'll  
17 just read it out for the record, INQ000478863.

18 This is an email to you on 27 March and, just to  
19 help you, it was commissioned on the 21st and then not  
20 in fact published around 27 March. It happens in a very  
21 short space of time.

22 **A.** Yeah.

23 **Q.** All right? And we've heard, just so that you know, from  
24 one of the doctors involved in drafting the guidance.

25 **A.** Yeah.

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1 **Q.** All right. Let me just turn up my document.  
 2 Were you made aware, as this email sets out, that  
 3 some local regions were requesting guidance, and in fact  
 4 there was a desire by a number of different  
 5 people working within the ICU sector that they wanted  
 6 a tool in the event they had to start making those  
 7 decisions?  
 8 **A.** I was aware there were some voices calling for that,  
 9 including within the BMA as well.  
 10 **Q.** Because we've heard from, for example, the Royal College  
 11 of Anaesthetists and the Faculty of Intensive Care  
 12 Medicine, saying that they felt extremely exposed  
 13 without such guidance, and indeed some of our spotlights  
 14 started developing their own tool in the absence of  
 15 guidance. All right? So there was clearly a degree of  
 16 a desire for the tool.  
 17 **A.** But it would be inaccurate to say that that was  
 18 a consensus or indeed, in my view, a majority view, but  
 19 there were some people calling for it.  
 20 **Q.** All right. I think you said you didn't see it in your  
 21 statement but you were aware that it was going to be  
 22 published?  
 23 **A.** That's not quite right.  
 24 **Q.** Help us with that then, please.  
 25 **A.** If I can give a slightly longer answer.

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1 **Q.** Yes.  
 2 **A.** Right. Then we go forward six weeks or so and there  
 3 were calls, public calls -- you know, the BMA were in  
 4 the press, there were private calls for it from, as you  
 5 say, some of the local areas, and this is an example of  
 6 the sort of thing I would then talk to people on the  
 7 ground about and -- so I took a wide array of views.  
 8 **Q.** Who did you speak to? Give us some examples.  
 9 **A.** Well, I remember talking to Chris Whitty about it, but  
 10 I can't recall exactly who those conversations would  
 11 have been with.  
 12 **Q.** Can I ask you though, Mr Whitty is not working in an  
 13 ICU ...  
 14 **A.** No, but he's very -- he has a lot of experience of  
 15 working in ICUs and we all knew the pressure that ICUs  
 16 were under.  
 17 **Q.** All right.  
 18 **A.** I may have spoken to some people at the royal colleges  
 19 who I spoke to regularly throughout the pandemic.  
 20 My view was that these decisions must not be taken  
 21 by ministers. They are best taken as close to the  
 22 patient as possible, with as much information about that  
 23 individual patient, and that doctors make these sorts of  
 24 decisions all the time. Of course they were having to  
 25 make far more of these decisions in the pandemic because

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1 **Q.** Of course.  
 2 **A.** It comes back to the exercise that we did in the middle  
 3 of February. When we did that exercise, it was proposed  
 4 in the meeting that such a piece of guidance should be  
 5 put together, and I objected, and in the Inquiry  
 6 Simon Stevens said that I'd called for it and wanted to  
 7 make the decision myself, and that was inaccurate and  
 8 not --  
 9 **Q.** Pause, I want to take it slowly to help you.  
 10 **A.** Okay.  
 11 **Q.** Just pause, Mr Hancock.  
 12 **A.** So the first time I came across this concept was in that  
 13 exercise.  
 14 **Q.** Which is Nimbus?  
 15 **A.** Nimbus, yes.  
 16 **Q.** All right.  
 17 **A.** And in the Nimbus exercise it was put forward as  
 18 a proposed solution to there being -- you called it  
 19 saturation, I call it if ICUs were overwhelmed, right?  
 20 **Q.** Yes.  
 21 **A.** That is -- it comes back to our previous discussion.  
 22 And I -- we had a discussion about it and I concluded  
 23 then that we shouldn't have such a tool and that my main  
 24 conclusion from Nimbus was we must ensure this never  
 25 happens.

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1 of the enormous pressures. And I then -- so I knew that  
 2 there were these public calls. I then received this  
 3 note that's in front of us, and my recollection is that  
 4 this was the first time such a tool was brought to my  
 5 attention.  
 6 **Q.** Okay.  
 7 **A.** And I immediately went to see Chris Whitty, who I knew  
 8 was sceptical of such a tool, and even though -- so  
 9 I was surprised to see that it had been commissioned by  
 10 the CMOs.  
 11 **Q.** Yes.  
 12 **A.** And he agreed that he -- he agreed with me that it  
 13 wasn't necessary. And then I phoned up Simon Stevens  
 14 and I said I'm really uneasy about this sort of tool,  
 15 and he said he thought that it was not a good idea  
 16 either.  
 17 **Q.** Right.  
 18 **A.** And having spoken to those two people, that's all  
 19 I needed.  
 20 **Q.** Right.  
 21 **A.** To make -- having followed the debate for the previous  
 22 six weeks, and it been in my mind throughout that time,  
 23 I therefore -- you know, the system -- you can see what  
 24 happens in government, right? The system effectively  
 25 got ahead of itself without -- before asking whether

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1 this was something that we should consider. And started  
 2 putting in place -- you know, arrange a meeting -- that  
 3 "HMIG" is a meeting of the healthcare ministerial group  
 4 on Sunday so --  
 5 **Q.** We're going to come on to that.  
 6 **A.** -- they got going.  
 7 **Q.** We're going to come on to that.  
 8 **A.** So I just said -- I got this, I took advice from those  
 9 two people and made the decision that it shouldn't  
 10 happen.  
 11 **Q.** Right.  
 12 **A.** The other thing that is happening at this point is -- of  
 13 course, this is the worse point in the first phase of  
 14 the pandemic because this is when case numbers were  
 15 really shooting up and we didn't know if the system, as  
 16 a whole as opposed to individual incidents, was going to  
 17 cope and, frankly, I was petrified that the actions that  
 18 we were taking in terms of lockdown might not be strong  
 19 enough to stop the NHS being completely overwhelmed and  
 20 us getting to the situation as we had seen in Lombardy  
 21 of a generalised across-the-board inability to access  
 22 care, and all the consequences of that.  
 23 **Q.** Right, so just pausing there, just to try and get  
 24 a sense of why it was you were opposed to it. Is it  
 25 your evidence that you were opposed to it because you

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1 then there's supposed to be a meeting between ministers  
 2 to discuss the tool which didn't happen?  
 3 **A.** You say "supposed to be".  
 4 **Q.** Yes.  
 5 **A.** A meeting had been organised. That doesn't mean --  
 6 there's no value judgment on whether there was  
 7 a meeting, because if you say "supposed to be" and then  
 8 I cancel that it implies it was a mistake. It wasn't  
 9 a mistake.  
 10 **Q.** Let me rephrase it for you then.  
 11 **A.** Thank you.  
 12 **Q.** There was a plan for a meeting --  
 13 **A.** Yes.  
 14 **Q.** -- which then was cancelled?  
 15 **A.** I cancelled.  
 16 **Q.** All right. I'm just trying to give you a bit of context  
 17 for where we are to help you when you answer the  
 18 questions.  
 19 **A.** Sure, yeah.  
 20 **Q.** All right. So there is the plan for a meeting to  
 21 discuss with the ministers this tool and these are some  
 22 of the discussions about what led to the background,  
 23 what the strategy is, and what the risks and mitigations  
 24 are, and it said that "Lead authors have advised" -- if  
 25 we look at the bottom of the page -- that:

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1 felt there wasn't a need for a national tool, and that  
 2 actually there should be individual tools taken within  
 3 trusts or regions?  
 4 **A.** I felt strongly that if we tried to write a national  
 5 tool, its local interpretation might end up being too  
 6 legalistic or box ticking. What I wanted is the doctors  
 7 to have the discretion to make the decisions as they see  
 8 fit, with the best way to save lives in the  
 9 circumstances.  
 10 **Q.** Can I ask you, please, then about that weekend that  
 11 you've just alluded to.  
 12 **A.** Yes.  
 13 **Q.** And can we have a look on screen, please, at  
 14 INQ000048276-3.  
 15 And as is the way, Mr Hancock, with emails, we  
 16 have to start towards the back and work our way  
 17 forwards.  
 18 **A.** Yeah.  
 19 **Q.** But essentially what is going on here, so that you know,  
 20 is the tool has been drafted and, incidentally, in your  
 21 statement you said, "I didn't see any of the proposed  
 22 guidance." Is that right or wrong? Did you actually  
 23 see the guidance that was being proposed?  
 24 **A.** I don't recall.  
 25 **Q.** All right, okay. It's getting ready for publication and

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1 "... most clinicians in acute settings will be  
 2 receptive to this guidance as it provides a standardised  
 3 approach on which to base difficult decisions in  
 4 unprecedented times. However, it is likely it could be  
 5 sensationalised by media and cause unnecessary panic and  
 6 concern among the ... public."  
 7 So there's competing arguments there about how  
 8 this may in fact be viewed once it's published?  
 9 **A.** Yeah.  
 10 **Q.** And then if we go, please, to page 2 of the document,  
 11 30 March, which I think was a Monday -- sorry 28 March,  
 12 my fault, second email down:  
 13 "I've just heard from the CMO's office this isn't  
 14 going to ministers tomorrow and has been paused for now.  
 15 I'll make sure duty team have the current version ..."  
 16 And it was because:  
 17 "[Secretary of State] and Simon Stevens have  
 18 spoken and have a cancelled the Ministers implementation  
 19 group", that was there to discuss the tool.  
 20 "This is because both are unhappy issuing the tool  
 21 as it stands (noting how potentially controversial it  
 22 is/difficult landing)."  
 23 It does not say there they're unhappy about it  
 24 because they think there should be localised decisions,  
 25 not a national tool. Is it the case that you were more

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1 worried about how this might look and whether the  
 2 professions themselves wanted the tool to provide them  
 3 with the guidance for the difficult decisions they may  
 4 have to make?

5 **A.** Oh, I see. No, that wasn't my consideration at all.  
 6 Obviously I had to take into account the impact of such  
 7 a tool on people's confidence in the NHS. My assessment  
 8 in reading this, and the previous page, is that it says  
 9 most people -- most clinicians will be comfortable with  
 10 it, or something like that. I thought that I'm not sure  
 11 that's right. There were, as I say, some voices calling  
 12 for one of these but that was not a generalised  
 13 approach, and my assessment is that it is very hard to  
 14 write something that would improve on an individual  
 15 clinician making a decision according to the Hippocratic  
 16 oath and their best medical assessment of how to save  
 17 lives.

18 That is -- and so I don't -- I, actually, until  
 19 I've re-read this now, I hadn't really considered the  
 20 wider controversy that might happen as critical. The  
 21 question is, what's the best way to save lives? That  
 22 was the question I was asking throughout this entire  
 23 period on every single subject, including this one.

24 **Q.** If you didn't read the guidance itself, how do you know  
 25 whether it's going to improve or not on the --

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1 system. That's why, from his perspective, it didn't  
 2 come in.

3 **A.** Right.

4 **Q.** Given there wasn't an urgent need for it right now, did  
 5 you consider revisiting the need for this guidance at  
 6 any stage during your tenure?

7 **A.** No, I think it would have been a mistake to bring this  
 8 in and I think in a future pandemic it would be  
 9 important not to constrain decision-makers in this way.  
 10 We train doctors to an incredibly high standard,  
 11 including to be able to make decisions like this, and  
 12 substituting an, effectively, ministerial decision for  
 13 a decision of the doctor who is looking after that  
 14 patient would be, in my view, a mistake.

15 **Q.** At any stage did you say to NHS England for example,  
 16 "I'm not bringing in a national tool but I would  
 17 encourage local regions or particular trusts to adopt  
 18 their own"?

19 **A.** No, I think decisions like this need to be made  
 20 according to the professional judgment of the clinicians  
 21 closest to the patient.

22 **Q.** Yeah, I understand that. What I'm saying is if your  
 23 opposition to it was in part that there needs to be  
 24 local decision-making, did you do anything to encourage  
 25 or support those that wanted a local decision-making

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1 **A.** Because I had deep experience in government and the  
 2 consequences of writing guidance which is to reduce the  
 3 discretion of those on the front line and to increase  
 4 a rules-based approach and I couldn't think -- and so  
 5 I thought that the idea of taking these decisions  
 6 nationally through guidance was wrong. I believe in the  
 7 principle of subsidiarity for improving the quality of  
 8 decision-making. The closer a decision can be made to  
 9 those who are affected, generally the better that  
 10 decision is.

11 **Q.** There's nothing in this email that mentions "We need to  
 12 be actually doing this at a local level", is there? If  
 13 one follows to the bottom --

14 **A.** There isn't, but I didn't write this email, so -- this  
 15 is an email from Max Blain at No. 10 -- he was head of  
 16 comms. So, of course, the comms people would consider  
 17 the controversy element of it, this is a communications  
 18 email, this isn't about the substance of the decision.

19 **Q.** The final bullet on that email says, "Everyone is clear  
 20 that this needs to be right and not rushed out."

21 **A.** Right.

22 **Q.** The CMO's view is that it's not urgent -- there's not  
 23 an urgent need for it right now.

24 And he's told us it didn't come in because as at  
 25 27 March or 28 March there was still capacity in the

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1 tool?

2 **A.** No, I didn't want a local decision-making tool as in  
 3 mid-level, as in at a hospital level, I wanted doctors  
 4 making these decisions, not administrators, not  
 5 ministers.

6 Now, the -- as I've said many times, the  
 7 operational running of the NHS is for NHS England and  
 8 the individual hospital trusts, but -- and so I am aware  
 9 now that some trusts brought in some guidance. I don't  
 10 think it would be -- I don't think it's right to  
 11 constrain doctors' ability to act in the best interests  
 12 of their patients in this way.

13 **Q.** All right. Can we look at some of the decisions that  
 14 were taken to increase capacity within the system?

15 **A.** Yeah.

16 **Q.** Obviously, firstly, there was the discharge decision.  
 17 And I'm not asking you about the impact it had on the  
 18 care sector itself, but did you agree with expedited  
 19 discharges as a way of increasing hospital bed capacity?

20 **A.** Where that was clinically appropriate, yes. But on  
 21 that, as with other areas, that really is a question for  
 22 NHS England.

23 **Q.** I was just asking you for a broad overview of whether  
 24 you were in agreement with the principled decision, not  
 25 the detail, all right?

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1 **A.** Yeah, remember hospitals are dangerous places in  
 2 pandemics. You know, there were more people -- the  
 3 estimate is that more people caught Covid in hospitals  
 4 than in almost any other setting, and that's often  
 5 forgotten in the debate around this.

6 **Q.** We're going to look at nosocomial infection rates  
 7 a little later, all right.

8 **A.** Yeah.

9 **Q.** Okay. There was clearly the decision to suspend  
 10 non-urgent elective care, and you said, I think at the  
 11 outset, that that was a decision that you agreed with  
 12 and you thought it was a right decision?

13 **A.** Well, obviously reluctantly, but, faced with a series of  
 14 awful options, that was the least bad. I mean -- but  
 15 that -- that applies to almost every decision that we  
 16 took in the pandemic.

17 **Q.** When that decision to -- was taken, I think you were  
 18 urged to explore with NHS England whether there was any  
 19 elective work that would be protected at the height of  
 20 the pandemic.

21 **A.** Yeah.

22 **Q.** And what was the answer and why was it you wanted to  
 23 just explore that with them at all?

24 **A.** Because I recognised the impact, the negative impact of  
 25 taking that decision and I wanted to make sure that it

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1 **A.** As soon as we safely can. But that's the sort of  
 2 decision he'd go and take anyway. He was, after all,  
 3 the independent head of NHS England.

4 **Q.** Clearly you accept, don't you, that the decision to  
 5 pause elective care had a significant impact on the  
 6 waiting times for either diagnosis or for treatment?

7 **A.** Yeah, of course, yeah.

8 **Q.** All right. I'd like to ask you about an email that you,  
 9 I think, were sent.

10 Can we have up on screen INQ000421416\_3.

11 We are in March 2020, Mr Hancock, I think around  
 12 the 28th or thereabouts, and this is an email that was  
 13 forwarded on to you, all right?

14 **A.** Right.

15 **Q.** It says it's a sad case -- this is:

16 "... one of my constituents was due to have  
 17 a cancer operation at [a] hospital this week but it has  
 18 been cancelled due to the issues with Coronavirus ...  
 19 "He completely understand the pressures on the  
 20 Health Service but he understands if he does not have  
 21 this operation he will lose his battle with cancer in  
 22 the next 12 months."  
 23 It makes the point that he's 68, he obviously  
 24 wants to be around for his children, his grandchildren.

25 **A.** Yes.

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1 was mitigated as much as possible. But on that I would  
 2 very much -- it's a classic case where the minister  
 3 asked questions to ensure that people have considered  
 4 these things properly, but the operational decisions are  
 5 for NHS England and the clinical decisions are obviously  
 6 for the clinical staff.

7 **Q.** All right. So, as a strategy, you approved of it?

8 **A.** I broadly approved of it, reluctantly, yeah.

9 **Q.** All right. For what it's worth, Mr Hancock, the experts  
 10 that we've heard about not non-Covid care have agreed  
 11 with the decision in principle, they think it was the  
 12 right one, but what they're concerned about is the  
 13 resumption of non-urgent elective care and how quickly  
 14 or otherwise that was rolled out, particularly after the  
 15 first wave.

16 **A.** Oh, yeah, absolutely.

17 **Q.** All right. Well, you say "Oh, yeah, absolutely", help  
 18 us then, please, what was your position on how quickly  
 19 or otherwise non-urgent elective care was resumed?

20 **A.** It was a difficult balancing act, and I relied on the  
 21 judgment of the chief executive of NHS England.

22 **Q.** You didn't say -- did you say to him, "You need to bring  
 23 in targets", to Simon, did you say anything like that to  
 24 him? Or just "I want you to restart it as soon as you  
 25 can"?

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1 **Q.** He's going backwards and forwards to prepare for the  
 2 operation.

3 "The family are saying online 'Boris Johnson said  
 4 that no emergency operations will be cancelled due to  
 5 Coronavirus but that is not true'.  
 6 He says:  
 7 "I am ... conscious that you are up to your eyes  
 8 [in it] but is there anything you, the [Secretary of  
 9 State] or one of the Ministers can do? I very much want  
 10 to help this family."  
 11 They were writing to the chief executives too.  
 12 And if we go, please, then to page 2 of this  
 13 document.  
 14 In the middle of the page sets out that they were  
 15 clear -- I think "Simon" is probably a reference to  
 16 Sir Simon Stevens:  
 17 "We are clear that no urgent cancer operations  
 18 should be cancelled. Individual clinicians and patients  
 19 will discuss what's most appropriate given the risk of  
 20 increased infection."  
 21 Forward on another page where there's reference to  
 22 you at the bottom of the page. You had three concerns:  
 23 "Do we need to clarify the position on urgent  
 24 cancer treatment and other ... therapies. There have  
 25 been a further two cases people having cancer surgery

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1 stopped -- while they're not urgent in the sense  
2 of a matter of days, it probably could not be deferred  
3 several weeks. Do we need to issue any further guidance  
4 on this?"

5 **A.** Yeah.

6 **Q.** And then here you are as at 30 March saying:

7 "['I'd] like to begin thinking about the plan for  
8 restarting non-Covid care ..."

9 **A.** Yeah.

10 **Q.** "... perhaps Simon ..."

11 Stevens, is that?"

12 **A.** Yeah.

13 **Q.** "... and [you] could have an initial discussion at [the]  
14 Quad [meeting] next week?"

15 And then there's risks of people coming into A&E  
16 and what that might entail.

17 So this shows that you were clearly concerned from  
18 early on in the pandemic, Mr Hancock, about how best to  
19 restart.

20 **A.** Yeah, but also what it shows is I'm asking -- I'm asking  
21 questions of Simon Stevens and respecting his  
22 independence running the NHS.

23 **Q.** Yes. Now, no one is going to criticise you for asking  
24 the questions but it really brings us on to what did you  
25 do to make sure that those questions were being answered

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1 **Q.** All right. I'm not asking about the individual  
2 decisions, it's just a global question. There is no  
3 doubt though, if one looks at some of the data, in fact  
4 the UK was very slow to restart its elective care, in  
5 a way that affected the figures that we've seen.

6 I want to just ask you about hips in particular.

7 Can we have on screen INQ000474262.

8 Because this is an excerpt from the --  
9 INQ000474262\_61, please.

10 This is an extract from the hip experts that  
11 the Inquiry has heard from.

12 **A.** Yeah.

13 **Q.** And essentially what I'm going to show you is a graph  
14 that shows that UK fared much worse than Europe when  
15 there was a drop in hip replacements, understandably  
16 everywhere but 14% in Europe and yet 46% in the UK.

17 And can we have a look at the graph, please, on  
18 page 62, and can we highlight the top graph if you're  
19 able.

20 Again, we see there -- so there's obviously  
21 a pausing of elective care across Europe but a wide  
22 variation in how the UK has performed, and essentially  
23 we've done badly because there's a 46% drop in the  
24 number of cases of people having a hip replacement  
25 whereas the average across the EU was 14%.

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1 and that elective care was being resumed.

2 **A.** Yeah.

3 **Q.** What did you actually do? What did you actually say to  
4 him?"

5 **A.** Well, we had -- so the "Quad", as it's put in here, was  
6 the weekly meeting that we had to discuss all NHS  
7 matters. I mean, we'd speak on the phone much more  
8 regularly than that but we'd have an overall meeting  
9 once a week with Chris Wormald and myself, Simon and  
10 Amanda Pritchard. And that was the core decision-making  
11 meeting, if you like, when issues were on the boundary  
12 between whether they were my responsibility or  
13 Simon Stevens' responsibility. And we would have had  
14 a series of discussions about the appropriate speed for  
15 restarting, given the wider pandemic.

16 And my concern throughout this was that the NHS  
17 needed to ensure it took full accountability for  
18 nosocomial infection, and as you'll know I had a series  
19 of meetings about nosocomial infection specifically as  
20 well, and also that there was the danger to people of  
21 catching Covid whilst in hospital for non-elective care.  
22 But at the same time obviously we did need to restart as  
23 soon as that was safe to do so.

24 But for the individual decisions, they're a matter  
25 for Simon Stevens so you'll have to ask him about them.

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1 Now, were you sort of ever made aware of perhaps  
2 not hips in particular but the kind of delays and, on  
3 the face of it, slowness at the resumption of non-urgent  
4 elective care?"

5 **A.** I was.

6 **Q.** And what did you do about it?

7 **A.** Well, I spoke to Simon Stevens about it, and you'll have  
8 to ask him about the individual decision -- I don't mean  
9 the individual decisions as in each hip at a time, about  
10 the policy towards restarting, because that was very  
11 clearly in his bailiwick.

12 **Q.** I understand that, but, Mr Hancock, you're the one early  
13 on in the pandemic saying: we've got to have a plan for  
14 resuming elective care --

15 **A.** Yeah.

16 **Q.** -- you're on to this early, if I remember --

17 **A.** Yes.

18 **Q.** Let me finish. You're on to this early, but if we look  
19 at the data, perhaps your desire to resume it did not,  
20 in fact, pan out with what happened on the ground. And  
21 why is there -- if the minister is saying, "Get started,  
22 get restarted", why are we seeing such poor figures like  
23 the one I've just shown you?

24 **A.** I'm afraid all I can answer is that these decisions on  
25 the restart were decisions for NHS England, and this is

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1 a module about the performance of the NHS. So you have  
2 to ask the person who was in charge of the NHS at the  
3 time.

4 **Q.** All right, but you're not powerless. If you say to him,  
5 "Do something", he doesn't ignore you?

6 **A.** Exactly, you can see in the paperwork that I am pushing  
7 on this subject, but, I mean, the NHS was legally  
8 independent. I in fact ended that legal independence.  
9 You know, Simon and I worked very closely together but  
10 some decisions were his and others were mine. So this  
11 isn't something that I've seen before and it isn't  
12 a decision that I would have myself taken.

13 **Q.** All right. Do you think -- let me broaden the question  
14 then.

15 Do you think in the event of a future pandemic  
16 there need to be contingency plans at either ministerial  
17 or certainly department level --

18 **A.** Yeah.

19 **Q.** -- for a strategy for how to, if not continue it, at  
20 least resume quickly?

21 **A.** Well, I think -- yes, and actually that needs to be part  
22 of a broader change in the NHS, to try as much as  
23 possible to separate out urgent care and elective care  
24 into different settings. And I know that's something  
25 that Simon Stevens believes very strongly and was

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1 that you are supportive of them. You thought it was  
2 important to have them if we needed them?

3 **A.** Yes.

4 **Q.** All right. Given that we -- as looked at this morning,  
5 there are already stretched ratios within ICUs in  
6 hospitals, what was the plan for further stretching the  
7 staffing in the event that we had I think seven  
8 Nightingales in England?

9 **A.** The plan was to build the Nightingales within the  
10 umbrella of an existing trust, so that the Nightingale  
11 hospitals did not have to set up HR and recruitment  
12 systems from scratch but rather could be supported by  
13 an existing trust. For instance, the Nightingale  
14 hospital in the ExCeL centre in London was effectively  
15 run by Bart's Hospital.

16 **Q.** Yeah, so was it your understanding that there would be  
17 additional staff or that -- the 1:6 ratio would include  
18 staff that you'd lost from the hospital, who'd gone to  
19 staff the Nightingale?

20 **A.** Well, the answer is -- isn't binary. We were at the  
21 same time trying to recruit staff, more staff, back into  
22 the NHS, but the starting point was that that hospital  
23 trust was responsible for the staffing of the  
24 Nightingale, and we were doing everything we could to  
25 ensure that that and all hospital trusts could get more

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1 working on even before we went into the pandemic.

2 But that so-called split between hot and cold  
3 sites is very effective and a much more normal  
4 arrangement in other European countries. So that may be  
5 part of the explanation here, but I can't really give  
6 you any more than that because this wasn't my area of  
7 responsibility.

8 **Q.** All right, fine. Were you aware, as minister, of the  
9 use of elective hubs to ensure that there was some  
10 diagnosis or treatment for non-pandemic conditions?

11 **A.** Yes, of course.

12 **Q.** Do you think there was sufficient use made of them --

13 **A.** Definitely not.

14 **Q.** And how do you think we could improve use of elective  
15 hubs?

16 **A.** Have more of them.

17 **Q.** Have more of them?

18 **A.** Definitely. It should be happening now, yeah.

19 **Q.** And is that a decision for the NHS, for NHS England or  
20 is that something ministers can assist with?

21 **A.** Well, now, because we changed the law so that the NHS is  
22 not statutorily independent, it is something that  
23 ministers can do. But it wasn't at the time, directly.

24 **Q.** And different measure of increasing capacity is  
25 Nightingales. And I think you say in your statement

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1 staff as well as stretch the ratios.

2 **Q.** Do I take it that you consider, Mr Hancock, that there  
3 was a need to have the Nightingales just in case we  
4 needed them?

5 **A.** No. We needed the Nightingales in order to provide the  
6 care for those who went into them. Hundreds of people  
7 received care in Nightingales hospital and survived  
8 because of it. Of course the Nightingales were also  
9 entirely justified on an insurance policy --

10 **Q.** Yes.

11 **A.** -- because we didn't know when the pressures were going  
12 to stop accelerating. And in the event several of the  
13 Nightingales weren't used, but even those I think we can  
14 justify with what we knew at the time.

15 **Q.** Pause there, because I had like to just look, please, at  
16 INQ000474444.

17 Which might help you, Mr Hancock, because it's  
18 a quick and easy guide to when the Nightingales were set  
19 up, what activity they saw in each wave --

20 **A.** Yeah.

21 **Q.** -- and the costs of them, for what it is worth.

22 **A.** Yeah.

23 **Q.** And we can see there, yes, there were hundreds but it's  
24 not thousands of people that was going into the  
25 hospitals to being treated for Covid?

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1 A. Yeah.

2 Q. Obviously some of them were repurposed, but if you look  
3 at Birmingham, for example, it had no patients admitted  
4 in wave 1 or wave 2 and wasn't used as a vaccination  
5 centre or to resume elective care.

6 A. Yeah.

7 Q. The question really is, once we thankfully didn't need  
8 them in wave 1, what, if any, involvement did you have  
9 in how they were being repurposed for wave 2?

10 A. Well, I was -- I have two feelings in response to this.  
11 The one is that I have absolutely no doubt that they  
12 were justified even as an insurance policy. And even if  
13 no lives had been saved by them, we didn't know, when  
14 I commissioned them -- well, I commissioned the  
15 expansion, it was actually Amanda Pritchard who came up  
16 with the idea of using existing buildings to put  
17 hospitals in and led the project and did a brilliant job  
18 at it.

19 So I think they are entirely justifiable because  
20 they were an insurance policy in case we hadn't managed  
21 to turn the curve of the growth of the virus when we  
22 had.

23 At the other end I also felt frustration at the  
24 time that they weren't being used for other purposes,  
25 but that happens all the time when you're health

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1 A. You're asking me for recollection of something  
2 four years ago. I'm pretty sure that I said it. The  
3 place to look would be the minutes of the quad meetings.

4 Q. Do you think, and I'm asked to ask you this, given the  
5 expenditure which in England alone was 358-plus million,  
6 that this was a good use of resources diverting money  
7 that could have been used to improve the NHS estate, for  
8 example more portable ventilation, and the like?

9 A. That is not an accurate description of the tradeoff.  
10 The tradeoff was: should we spend taxpayers' money that  
11 was effectively borrowed from future generations for  
12 this insurance policy? At this point the constraint on  
13 the NHS was not cash resources, it was real-world  
14 resources. And so yes, I thought it was a good use of  
15 money to have this insurance policy.

16 Q. I think you are aware that between wave 1 and wave 2,  
17 NHS England, supported by the Department of Health,  
18 asked for funding for a further 10,000 beds.

19 A. Yes, I'm not only aware. I was deeply involved in this  
20 bit, yes.

21 Q. Hold your horses, all right? Let me just ask the  
22 question and then you can answer. All right?

23 A. Yeah.

24 Q. You were aware that there was the request by NHS England  
25 and the department. You've just told us you were deeply

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1 secretary because you're responsible for a large body  
2 which is statutorily independent from you and is huge  
3 and so all sorts of stuff goes on in the health service  
4 that you would rather were done better, and your job is  
5 to try to make that happen either through specific  
6 intervention, persuasion, or through changing policy at  
7 a national level. But I didn't want to change policy  
8 because I wanted the Nightingales to be there if they  
9 were --

10 Q. Yeah, if they were needed.

11 A. Yeah.

12 Q. I understand that, but actually what I wanted to know  
13 is, what did you do to ensure that in wave 2 they were  
14 utilised to their best effect, particularly when we've  
15 got, for example, Birmingham admitting no one and  
16 seemingly doing nothing?

17 A. Yeah, well I will have raised this -- it's probably in  
18 quad minutes I will have raised this with the NHS, but  
19 obviously operational matters are for them.

20 Q. I follow that, but didn't you say to them, "Well, hold  
21 on, you've got a big facility there in Birmingham that's  
22 not doing anything, can we repurpose it, can we use it?"

23 A. Yes, that's exactly the sort of thing I would have said,  
24 yes.

25 Q. You would have said or did say?

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1 involved in it, all right? Unfortunately, though, that  
2 request was refused by the Treasury and there was  
3 a direction or a steer coming from the Prime Minister  
4 that you should focus on using the Nightingales, using  
5 the private sector, hopefully discharging more people,  
6 maybe there not being as -- sorry, using the flu  
7 vaccination to prevent flu patients going into the  
8 hospital.

9 Help us with the deep involvement that you say you  
10 had in this, and what did you try and do to either get  
11 the beds or get the funding?

12 A. Well, there were a significant number of meetings in  
13 No. 10 over that summer to work out how we were going to  
14 handle the winter of 2020 to 2021.

15 Q. Yes.

16 A. One of the things that I did get over the line, get the  
17 funding for, was an expansion of all of the A&Es in the  
18 country, in England. And -- because I was only  
19 responsible for the NHS in England.

20 And in addition to that expansion of A&Es,  
21 I wanted an expansion of bed capacity.

22 Q. Yeah.

23 A. For two reasons. The first is in case there was  
24 a second wave in the winter, which started to become  
25 evident from late July onwards. And the second is

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1 because I think that the resilience of the NHS to future  
2 pandemics requires more beds. And that, you know, you  
3 never put the entire army in the field in one go. You  
4 have resilience. And in the same way, having resilience  
5 rather than running at 100% all the time in our health  
6 system is an appropriate use of national resources.  
7 It's what we ought to do.

8 So I raised it with the Prime Minister, I raised  
9 it with the Treasury, I will have done that in formal  
10 and informal settings. I raised it with the Cabinet  
11 Secretary, and you can see that I did that verbally and  
12 in messages. I internally campaigned for this extra  
13 funding and, as I say, I won on some counts and I didn't  
14 win on this one.

15 **Q.** Right. What do you think were the consequences of the  
16 refusal for the 10,000 beds, from your perspective?

17 **A.** The pressures on the NHS were greater in the second wave  
18 than they would have been otherwise.

19 **Q.** By the time you left office had you taken any steps or  
20 made any request to ask HMT for the funding for the  
21 10,000 beds?

22 **A.** It had been a very -- I lost that battle, it was a clear  
23 "no", in the summer of 2020. The -- when I left office  
24 we were starting to gear up for a spending review but  
25 I wasn't engaged in -- we were starting to think about

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1 NHS.

2 **LADY HALLETT:** This was 10,000 beds generally?

3 **A.** Permanently.

4 **LADY HALLETT:** Oh, I see, I'm sorry --

5 **A.** To get them in place for that winter and keep them there  
6 in case there --

7 **LADY HALLETT:** I understand, thank you.

8 **MS CAREY:** Can I move on to a different way of increasing  
9 capacity which was use of the private sector.

10 **A.** Yeah.

11 **Q.** And in your statement -- perhaps if we could have up on  
12 screen INQ000421858\_20, which sets out the use that was  
13 made of the private sector, or independent sector, as  
14 you call it in your statement, between March and  
15 May 2020.

16 **A.** Yeah.

17 **Q.** And we can see there at paragraph 78, over 7,000 --  
18 approximately, I should say, 7,300 non-elective  
19 admissions; over 111,000 outpatient attendances; over  
20 4,300 ordinary elective admissions; 12,900 day cases;  
21 and over 19,000 diagnostic imaging tests and  
22 chemotherapy treatments.

23 The money spent on the private sector, you say you  
24 considered to be value for money.

25 **A.** Yeah.

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1 it but it was not in advance stage of discussion.

2 **Q.** Okay.

3 **A.** You start basically -- the NHS and at a policy level we  
4 start preparing for winter in July.

5 **LADY HALLETT:** On the basis that you had the Nightingale  
6 hospitals and some like Birmingham weren't used at all,  
7 how did you justify the application for 10,000 more beds  
8 from the Treasury?

9 **A.** Because I was very worried about a second wave and I was  
10 worried about political opposition to a second wave  
11 being harder than first time round, and the history of  
12 pandemics is that the second wave tends to be bigger  
13 than the first. That is not just an -- that is not just  
14 what happened in the UK in the Covid pandemic, and  
15 that's because of a -- it being -- essentially  
16 sociologically -- across society harder to win the  
17 argument for the action that's needed second time  
18 around, and that's exactly what happened.

19 **LADY HALLETT:** As a minister you're used to dealing with the  
20 Treasury and you have to justify your case for increased  
21 funding with good arguments. How were you going to meet  
22 the argument, "but we've already funded Nightingale  
23 hospitals and they're not being used", how did you plan  
24 to meet that argument?

25 **A.** Because we needed overall long-term resilience in the

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1 **Q.** Just help us understand your role in either approving  
2 the funding or monitoring what funds the -- what use was  
3 made of the funds?

4 **A.** So I didn't have a very significant direct role in this  
5 at all. I supported the use and the commissioning of  
6 the private hospitals. I asked the department for  
7 an assessment that we were getting decent value for  
8 money and I got that assurance, I think from David  
9 Williams, and my junior minister Ed Argar signed off  
10 ministerially on these but they were negotiated by  
11 Simon Stevens.

12 **Q.** All right, okay. And one other measure to try and help  
13 the predicted influx of patients into hospitals was use  
14 of NHS 111, wasn't it?

15 **A.** Mm-hmm.

16 **Q.** Is it correct that by January 2020, you wanted NHS 111  
17 to be the single point of contact?

18 **A.** I wanted it to be available as a first point of contact.

19 **Q.** Yeah. Well, in fact, we know that from, I think,  
20 mid-March the public were urged to use 111 as the first  
21 port of call, if I can put it like that?

22 **A.** Yeah.

23 **Q.** Given that that was a clear way of helping to triage  
24 patients and not sending patients to hospital that  
25 didn't need to be there, what steps did you take to

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1 monitor the efficacy of NHS 111?

2 **A.** So I had regular briefings on 111. There was a stage  
3 when it was under deep pressure and the reason for that  
4 pressure is that at the meeting to decide on bringing in  
5 lockdown, the -- Simon Stevens pointed out that if we  
6 bring in a lockdown measure and say, "If in doubt called  
7 111" that would lead to enormous pressures on 111, and  
8 asked in the meeting for a short delay in the bringing  
9 in of the lockdown measures by, I can't remember, 24 or  
10 48 hours, in order to spend that time urgently expanding  
11 the capacity of 111 and getting them prepared with  
12 scripts and what have you, essentially operational  
13 requirements.

14 The Prime Minister, based on the urging of the  
15 Mayor of London who was -- and most of the cases -- the  
16 biggest intensity of the virus was in London at that  
17 point, decided to bring in the measures immediately as  
18 in as of midnight that night.

19 **Q.** Right.

20 **A.** That was a -- I think that was an entirely -- either  
21 decision would have been entirely reasonable. It was,  
22 with hindsight, probably better to take the decision  
23 that the Prime Minister did take because we needed to  
24 stop the spread of the virus and -- but it had this  
25 operational consequence that 111 was under deep pressure

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1 than was predicted and was not matched by the capacity  
2 of the 111 system.

3 Now, were you aware of the significant number of  
4 abandoned calls in March 2020?

5 **A.** I was aware that 111 was under pressure. If I may say,  
6 if I'd received this at the time, I would have said that  
7 I don't think calls abandoned after 30 seconds is a good  
8 metric.

9 **Q.** No.

10 **A.** Because if people call 111 to find out something that is  
11 not clinically urgent, if you like, and abandon their  
12 call after 31 seconds, then they either might have found  
13 that information on the website or found it somewhere  
14 else or didn't really care deeply about that call.  
15 Calls abandoned after a longer period would be a more  
16 appropriate metric.

17 So, yes, there's pressures, but I'm not sure this  
18 is the best way of describing them.

19 **Q.** All right. Put aside -- on any view, there are a large  
20 number of calls that are abandoned --

21 **A.** Yes.

22 **Q.** -- within that month and a large number of calls --

23 **A.** (unclear) delay in how long people took to get that  
24 response, yeah.

25 **Q.** But take it at a wider perspective --

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1 for several weeks, a few days of exceptional pressure,  
2 and then -- and whilst they got more people in and the  
3 demand sub...(unclear words: multiple speakers).

4 **Q.** All right, well, let's look at that exceptional  
5 pressure.

6 Can I have up on screen, please, INQ000474285\_17.

7 This is an extract from the expert report of  
8 Professor Snooks who looked at the pressures on 999, 111  
9 services, and a number of pre-hospital --

10 **A.** Yes.

11 **Q.** But in short, once it comes up on screen --  
12 INQ000474285\_17, and if it doesn't work I'll do it  
13 another way, Mr Hancock, all right?

14 This shows us sort of a broader view of number of  
15 calls to NHS 111, either answered within 60 seconds,  
16 abandoned after at least 30 seconds, and the calls  
17 answered over 60 seconds.

18 But can I just help you to this extent.

19 In January 2020, 111 calls were at 1.5 million.  
20 In March that rose to just over 2.5 million, all right?  
21 But in March 2020, 1.1 million of those calls were  
22 abandoned and went unanswered. Now, it may well be that  
23 some of those people rang back, but there was  
24 a significant number of people abandoning calls to 111  
25 and clearly the level of demand was substantially higher

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1 **A.** Yeah.

2 **Q.** -- the point I was asking you was, if you ask the public  
3 to ring 111 as their first port of call, isn't it  
4 incumbent that you can staff and properly resource that  
5 call centre?

6 **A.** In a pandemic sometimes you have to make difficult  
7 decisions between unpalatable options and the  
8 Prime Minister made the decision to bring in the  
9 lockdown immediately which led to these pressures being  
10 as urgent -- as acute as they were, rather than leaving  
11 24, 48 hours to get 111 up and running. In a perfect  
12 world you wouldn't have pandemics and we were in  
13 a pandemic, so that was another example of two  
14 unpalatable choices and, I think, with hindsight, having  
15 reflected on this question, I think the Prime Minister  
16 made the least bad choice.

17 **Q.** There were clearly, though, concerns in your mind about  
18 strengthening 111 because in May of 2020 you ask that  
19 question at a quad meeting: what can we do to really  
20 strengthen 111 so it becomes the first port of call  
21 instead of A&E?

22 **A.** Yeah.

23 **Q.** What were you being told in May that provoked you asking  
24 such a question?

25 **A.** Well, this was -- by May the acute problems in 111 had

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1 been mitigated, and the NHS had expanded capacity and  
 2 the system was running well. This isn't about what  
 3 I was being told. This is about the action I was trying  
 4 to take. At my instigation I wanted us to bring in  
 5 a system of 111 First, and the idea there is that before  
 6 going to A&E you call 111 and if you can be dealt with  
 7 on the phone, you are. And personally, I think it  
 8 should be our national system and normal, if you like,  
 9 and every citizen know that if you're going to go to  
 10 A&E, before going to A&E you call 111, and that be a  
 11 sort of process both so that A&E knows better what's  
 12 about to come through its doors, so for operational  
 13 reasons within A&E, and also because a whole lot of  
 14 cases might be able to be solved on the phone or triaged  
 15 to a non-acute setting.

16 **Q.** Yes.

17 **A.** So I think we should bring that in anyway. I tried to  
 18 bring it in over that summer. It was a major  
 19 operational change --

20 **Q.** Pause there. I'm going to ask you about it, all right?

21 **A.** Okay. But that's what that was all about.

22 **Q.** Right, okay, so let's go to May 2020.

23 To help you, Mr Hancock, can I have on screen  
 24 INQ000409864 because there was a meeting about non-Covid  
 25 A&E and NHS 111 on 22 May, all right?

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1 aren't going to A&E and they're not ringing 111, but  
 2 they're still getting injured or still needing  
 3 treatment, where are they going? Is that the missing  
 4 demand you were worried about?

5 **A.** Yes.

6 **Q.** And what did you do about the missing demand?

7 **A.** Well, the note itself explained -- gives some  
 8 explanations for why there might be less demand. There  
 9 are less sports matches in a pandemic. And therefore  
 10 there would be fewer injuries. And there's -- the  
 11 number of non-Covid infectious diseases, actually, we  
 12 didn't know this at the time but fell very, very sharply  
 13 during the pandemic because of social distancing, and so  
 14 that is a reasonable answer, and I had a meeting on  
 15 non-Covid A&E regularly. So I would have -- if you say  
 16 what did I do in the future? I've asked about it here  
 17 and I would imagine I would have followed up in future  
 18 meetings but I can't remember exactly.

19 **Q.** The Healthcare Safety Investigation Branch prepared  
 20 a report in relation to 111, and they concluded this.  
 21 There was strong messaging around patients staying at  
 22 home if they reached a self-care at home disposition.  
 23 For some callers, though, this was discouraged -- this  
 24 had discouraged them, that messaging, from recontacting  
 25 NHS 111 or seeking medical advice from elsewhere even if

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1 And you were updated on the figures for A&E,  
 2 attendance had dropped by more than 30% but had begun to  
 3 rise, right, and then NHS 111 during the crisis:

4 "This shows calls through to 111 service rose  
 5 steeply in early March."

6 As we just looked at:

7 "Capacity couldn't increase at the same rate so at  
 8 peak 40% of calls were not answered. Later in March  
 9 there was reduction in capacity ... while the increased  
 10 activity was maintained."

11 There was a particular spike when you offered  
 12 testing to symptomatic people through 111. By May  
 13 activity levels are now much more in line with historic  
 14 levels and we're now answering the vast majority of  
 15 calls.

16 Bottom bullet point, please.

17 "[Secretary of State] noted he was surprised that  
 18 with the sharp fall-off in A&E, NHS 111 is not picking  
 19 up more of the burden (at least via the telephone  
 20 service). He asked where that demand has gone. It was  
 21 noted that lockdown means fewer patients of other types  
 22 coming in [people with injuries and the like]. This  
 23 means there's missing demand somewhere in the  
 24 system ..."

25 And -- obviously you were concerned that if people

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1 their condition deteriorated.

2 Were you aware that there was some people that  
 3 were actively not contacting NHS 111 and/or not going on  
 4 to seek medical advice from elsewhere?

5 **A.** Yes, and I was talking about this publicly at the time.

6 It comes back to the point I was making in the first  
 7 session on reassuring people that the NHS was available  
 8 and open and not overwhelmed. It's all part of the  
 9 same -- it's all part of the same piece.

10 **Q.** Let me ask you about that now then. In hindsight, do  
 11 you think the government and/or your department took  
 12 sufficient action to encourage those who needed  
 13 healthcare to come forward?

14 **A.** We encouraged people from pretty early on to make clear  
 15 that the NHS was still available if it was needed. It  
 16 was a very difficult balancing act, those  
 17 communications.

18 **Q.** I follow that and you're not the only witness to have  
 19 given that answer, Mr Hancock, but --

20 **A.** It's my experience of it.

21 **Q.** I know, but where I want to go is, what do we do  
 22 differently next time to help encourage people to come  
 23 forward where they may have to stay home because there  
 24 has to be a lockdown?

25 **A.** We need to make sure that that is a clear part of

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1 communications throughout, I think, and that's what we  
2 did. The challenge is in communications. Communicating  
3 more than one message at once is always very difficult  
4 and this was a two-part message, which is Stay at Home,  
5 (unless you really need the NHS in which case please do  
6 go).

7 **Q.** You mentioned NHS 111 First and could we just have back  
8 up on screen, please, INQ000409864\_2.

9 There's a bullet point missing at the top which  
10 says 111 First, don't worry about that, but you mention  
11 there:

12 "There is a real risk that the level of demand  
13 on A&E from self-presenting, causing crowding ..."

14 And you need to prevent -- there is a need to  
15 prevent social distancing in a core health setting:

16 "[We] need to triage through 111 before  
17 self-presenting."

18 So you don't want A&E bursting at the seams,  
19 effectively; is that what you're saying?

20 **A.** Correct.

21 **Q.** And your overriding steer, a number of bullet points  
22 down, is to bring in NHS 111 First, which was  
23 essentially -- it's a booking system as I understand it?

24 **A.** Well, to the extent that you could use it as a booking  
25 system, I think that that's what we should have. But

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1 recollection is it is essentially about upgrading the  
2 NHS computer systems to allow this to happen. And  
3 anybody who knows anything about NHS computer systems  
4 knows that they are in dire need of improvement and  
5 things like this take time.

6 **Q.** All right.

7 Ambulances, please. We have heard, inevitably,  
8 about increases in both the number of calls and the  
9 waits people had to endure before an ambulance was  
10 available to get them. Can I ask you, please, about  
11 some of the things that people told the Inquiry's Every  
12 Story Matters record.

13 Could we have on screen, please, INQ000474233\_110.

14 Thank you very much.

15 And can you see in the middle of the page,  
16 Mr Hancock:

17 "Patients shared many experiences of them or  
18 a loved one being very unwell and calling their GP,  
19 NHS 111 or 999 ... but facing delays or not receiving  
20 care. Some contributors either gave up or had to wait  
21 until their symptoms became very severe before trying  
22 again. There were similar experiences among those who  
23 had suspected or confirmed Covid-19 and those who had  
24 other urgent medical problems."

25 And we can see a quote there from one of the

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1 of course sometimes you've still got to turn up at A&E.

2 **Q.** Yes, no, sure, but wasn't the plan for there to be  
3 a booking system so that not everyone turned up at 9 am  
4 but you separate them out through the day to help the  
5 hospital, help maintain social distancing, help prevent  
6 the spread of infection?

7 **A.** So you wouldn't want a booking system to be universal,  
8 you'd want it to be a contributor. If somebody has  
9 a problem that requires treatment but the assessment  
10 by 111 is "This could wait an hour and A&E is very, very  
11 busy", you might say, "Please come in an hour's time and  
12 book in a slot", but you'd also obviously want the  
13 ability for 111 to say "This sounds urgent, get yourself  
14 to the nearest A&E without having to go through the  
15 rigmarole of a booking procedure". So, so long as it  
16 isn't required to book but is an available facility to  
17 book, I think 111 First should be, both in a pandemic  
18 and in normal times, the way that we access the NHS.

19 **Q.** So here is you talking about the rollout of NHS 111  
20 in May. In fact you announced it in September and the  
21 plan was to roll it out from December?

22 **A.** Yeah.

23 **Q.** Can you help us with why it took from a sensible plan  
24 in May to not being rolled out for many, many months?

25 **A.** The operational reasons you'll have to ask the NHS. My

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1 contributors:

2 "One night I was sick over and over again. At 1am  
3 I called 999 and they said they would send an ambulance.  
4 By 6am it still had not arrived and I got back into bed,  
5 pregnant and exhausted. At 11am someone phoned to ask  
6 if I still needed the ambulance and that other cases  
7 were more 'urgent'. They advised me to contact my GP.  
8 I did and the GP refused to see me saying I should  
9 contact 999 again. At this point I gave up. There was  
10 no help."

11 That's just one quote of a number of people --  
12 about 30,000 people contributed to the Every Story  
13 Matters record. I'm not saying they all made reference  
14 to ambulance problems, but were you made aware of the  
15 intense pressures there were on the 999 system and the  
16 length of delays that some people were experiencing?

17 **A.** Yes. And again, I visited ambulance stations throughout  
18 the pandemic. In fact, one of my very first visits was  
19 to an ambulance station and I remember meeting the man  
20 who was responsible for co-ordinating sending out of  
21 ambulances and he burst into tears on me. It was  
22 incredibly difficult for him because the pressures and  
23 the number of calls and they hadn't seen anything like  
24 it before.

25 **Q.** I think you were aware there was a shortage of drivers

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1 amongst -- in the ambulance --

2 **A.** Yes, there were.

3 **Q.** -- sector. Can you think of any practical way of

4 resolving a shortage in a short term, in the event that

5 we need to up-scale the sheer number of people who can

6 drive an ambulance?

7 **A.** Well, one example may be that we should have people who

8 are trained as ambulance drivers on a standby, a bit

9 like we have the Territorial Army.

10 **Q.** Yes. Was there any plans in place by the time you left

11 office to have such a reserve?

12 **A.** Well, we -- knowing the pressures first time round,

13 I think my recollection is that in the second peak,

14 whilst there were still enormous pressures on

15 ambulances, they were not as acute. And again,

16 I visited ambulance stations and talked to the ambulance

17 service about this and I talked to individual ambulance

18 drivers and paramedics in order to get a sense of it

19 from the ground up, as well. So my recollection is that

20 second time round we -- the ambulance service was able

21 to withstand those pressures better. And I'm sure that

22 the -- I'm sure there's lessons that can and should be

23 learned, and the two waves compared and contrasted

24 against each other, but obviously the running of the

25 ambulance service itself is -- was for the NHS at

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1 that, what do you actually do to say, "Well, come on,

2 guys, how come one part of the country is doing well and

3 another part is not?"

4 **A.** Well, this is a perennial problem across different parts

5 of the operation of the NHS. This is primarily a matter

6 for the NHS themselves. In this instance I had a series

7 of meetings with Pauline Philip, a very impressive NHS

8 senior manager who had run hospitals incredibly

9 effectively, was then brought to the national level to

10 try to tackle these inequalities of service.

11 I mean, this is a problem in normal times, then

12 exacerbated in the pandemic both by a combination of the

13 pressures but also the fact that the pressures

14 themselves were differentiated across the country.

15 **Q.** Were you made aware of concerns amongst ambulance staff

16 about the fact that they were in the back of

17 an ambulance cab, often in very close proximity to

18 a potentially Covid positive patient, with inappropriate

19 PPE?

20 **A.** I was absolutely aware of the problems of getting PPE to

21 ambulance staff, and I remember one person, who was

22 responsible for getting PPE to a particular ambulance

23 hub, talking to him on one of my visits and him saying,

24 "I've got to protect my team". And so getting the PPE

25 out to all the individual locations was a massive

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1 an operational level.

2 **Q.** Finally on ambulances, please. Delays are, sadly,

3 nothing new in handover times from -- we're all familiar

4 with ambulances being stacked up outside A&E departments

5 and the like.

6 **A.** Yes.

7 **Q.** Do I take it you would agree that the pandemic made

8 an existing problem worse?

9 **A.** Yes, absolutely, yeah.

10 **Q.** We have heard evidence that it was not uncommon for

11 patients to be held in an ambulance for six to

12 twelve hours. Were you getting reports of that kind of

13 length of delay before the patient could actually be

14 taken into the emergency department?

15 **A.** Not only did I get those reports but also I knew of

16 hospitals where the delays were much, much shorter, and

17 it was deeply frustrating that, at some settings, they'd

18 organisationally managed to get this sorted and at

19 others the ambulances were unavailable because they were

20 parked on the ramp for six hours or twelve hours, as you

21 say. And that was obviously deeply frustrating.

22 **Q.** All right. Can I ask you about that frustration,

23 because then you've got an inconsistent picture: some

24 places not doing so badly, some places doing really

25 badly. When you, as minister, hear of reports like

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1 logistical problem.

2 **Q.** Yes, all right, we're going to come on to the PPE.

3 Just finally, please, before we finish this topic.

4 Clearly, delays waiting to get into emergency

5 departments, and then were you aware of the delays once

6 in the emergency department, with patients waiting up to

7 12 hours or more before a decision to admit them was

8 taken?

9 **A.** Yes, I mean, that was a problem before the pandemic, let

10 alone during it.

11 **Q.** The Royal College of Emergency Medicine have carried out

12 a report into the impact much delays in emergency

13 departments. It did some modelling and it showed that,

14 in 2021, of those who waited eight to twelve hours in

15 an emergency department, there were 4,519 excess deaths

16 in England associated with long waiting times in

17 emergency departments.

18 What, if any, steps did you take to try to resolve

19 the logjam of people coming off the ambulance into

20 emergency departments and then into hospital if they

21 needed that care?

22 **A.** Well, again, this was a frequent subject discussed

23 between me and Simon Stevens, who was responsible for

24 this. The challenge -- responsible as in it was his --

25 he was responsible for this policy area, it wasn't his

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1 fault.

2 You know, the challenge of how to unblock  
3 emergency departments is a significant one. Many  
4 improvements have been made. One of the examples of  
5 things I did was got the money from the Treasury to  
6 expand all of the emergency departments during this  
7 period to make sure there was physical space. But  
8 actually one of the biggest barriers to flow in to  
9 emergency departments is flow out of emergency  
10 departments into the hospital proper. And that,  
11 of course, was also -- that in turn was -- is a question  
12 of getting the appropriate discharge at the other end.

13 So you can't see the hospital in isolation from  
14 the call handling system, whether it's 999, 111, through  
15 to A&E, through to the admitted element part of the  
16 hospital, through to discharge and social care, it's one  
17 system. And if you've got a blockage in one part of the  
18 system it bungs up every other part of the system.

19 So you can't look at this in isolation from the  
20 challenges of discharge into social care, which is why  
21 Simon was so keen to ensure that we had discharge from  
22 hospital into social care and pushed so hard for that  
23 policy, because he was responsible for ensuring that  
24 when the ambulances turned up at A&E people could get  
25 off the ambulance into A&E, and the only way to make

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1 that person or the family being asked. It's appalling  
2 and totally unacceptable. So the steps I took was to  
3 make clear publicly as soon as I heard about it that  
4 this was completely unacceptable. And we reiterated and  
5 made clearer, as far as I can remember, the guidance  
6 around it. But it was something that I had to get  
7 involved in, even though it's technically a matter for  
8 the NHS. Because one of the tools I had during the  
9 pandemic was to communicate directly to NHS teams on the  
10 ground through the press conferences, and this is one  
11 example where I used the press conferences not so much  
12 to communicate to the public, important as that was, but  
13 to communicate to NHS staff that this mustn't happen.

14 **Q.** All right. You said "do not recover"; did you mean "do  
15 not resuscitate"?

16 **A.** I do.

17 **Q.** All right. It's fine, I just want to be clear about the  
18 language in this area.

19 You said there that you heard directly from some  
20 of the families involved. In what fora did you hear  
21 them?

22 **A.** My recollection is hearing through an MP, and of this  
23 happening in the Brighton area. So that's my -- that's  
24 my recollection, but we'd have to look at the paperwork.

25 **Q.** You say in your statement at paragraph 107 that on

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1 enough space there was to make sure people could get  
2 from the A&E department into the hospital proper.

3 **Q.** Mr Hancock, I want to change topic completely and just  
4 deal with a couple of discrete topics before we take our  
5 lunch break, and then we're going come to some bigger  
6 topics.

7 **A.** Okay.

8 **Q.** Can I ask you about DNACPRs, and you did in fact refer  
9 to DNR orders earlier this morning.

10 **A.** Yeah.

11 **Q.** I think -- were you made aware of concerns blanket or  
12 inappropriate DNACPRs were being imposed. And if so,  
13 what did you do about those concerns?

14 **A.** Yes, I was made aware of concerns about inappropriate  
15 use of do not recover notices. There were reports in  
16 the press as well, and I thought that this was  
17 appalling. The principle of healthcare has to be based  
18 on consent, and any DNR notice without appropriate  
19 consent is wrong and potentially illegal.

20 So, yes, I heard these concerns directly from  
21 families, and I heard them through a number of different  
22 routes.

23 I mean, put yourself in the shoes of the family  
24 whose loved one has not been resuscitated because  
25 somebody has said that they shouldn't be without either

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1 10 April 2020 you attended a meeting in fact with  
2 officials discuss the adult social care plan but DNACPRs  
3 came up in the course of that meeting. And your private  
4 secretary has noted the meeting, says that you commented  
5 that the DNR discussion needs to note that for many  
6 people not going to hospital is the best decision but  
7 this must be a sensitive clinical decision based on  
8 individual needs and circumstances.

9 Not going to hospital is not the same thing as not  
10 being resuscitated. Were you clear in your mind that  
11 a DNACPR was only there to prevent cardiopulmonary  
12 resuscitation and was not to be treated as a do not  
13 treat order?

14 **A.** Absolutely.

15 **MS CAREY:** All right.

16 My Lady, it's a little early but would that be  
17 a convenient moment?

18 **LADY HALLETT:** Certainly. I shall return, provided it's  
19 slightly warmer where I am sitting, at 1.40.

20 **MS CAREY:** Thank you very much.

21 (12.41 pm)

(The short adjournment)

22 (1.40 pm)

23 **LADY HALLETT:** Ms Carey.

24 **MS CAREY:** Thank you, my Lady.

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1 Mr Hancock, can we turn to PPE, please. Do you  
 2 accept that at times healthcare workers treated Covid-19  
 3 patients with inadequate PPE, thereby putting themselves  
 4 at potential risk?

5 **A.** Yes.

6 **Q.** Did you understand that FFP3 masks were more protective  
 7 than FRSM blue masks?

8 **A.** Yes.

9 **Q.** Can you help, please, with who led you to that  
 10 understanding that the FFP3 was more protective?

11 **A.** Well, it's obvious. So I don't -- I'm not sure I was  
 12 ever told it technically but if I were taken through the  
 13 performance of different parts -- elements of PPE, it  
 14 would have been via Ruth May.

15 **Q.** Did Public Health England ever say to you: in fact  
 16 there's no clinical evidence on the ground that FFP3 are  
 17 more protective than the blue masks?

18 **A.** Not that I can recall, no.

19 **Q.** All right. Would it surprise you to learn we've heard  
 20 evidence to that effect?

21 **A.** I saw that and in these things I take the evidence as  
 22 given by the experts.

23 **Q.** You are aware presumably, though, that there were lots  
 24 of bodies acting on behalf of healthcare workers arguing  
 25 for increased usage of FFP3 throughout the pandemic?

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1 **Q.** Can I just ask you, please, what do you understand the  
 2 precautionary principle to mean?

3 **A.** Well, you have to take into account the reasonable  
 4 worst-case scenario and act on that basis where you can.  
 5 So the central balancing that had to be done with  
 6 respect to PPE was supply, set against precautionary  
 7 healthcare considerations. So -- and that's what the --  
 8 those drawing up the IPC recommendations did: they had  
 9 to balance what was available, and realistically  
 10 available, to buy, with what was needed to -- all with  
 11 the goal of saving the most lives. I left that balance  
 12 to them to make and I didn't -- I regarded it as  
 13 an essentially clinical decision, taking into account  
 14 available stock, the IPC decision. That isn't something  
 15 that I would have interfered with or indeed did  
 16 interfere with.

17 **Q.** Pausing there. You were not responsible, as we know,  
 18 for drafting the IPC guidance or indeed approving it, as  
 19 I understand it; is that correct?

20 **A.** That's correct, yeah.

21 **Q.** But are you saying to us you were of the view that IPC  
 22 guidance was drawn up on the basis of what was available  
 23 not what was actually necessary to be recommended to  
 24 healthcare workers?

25 **A.** In a pandemic, availability of stock has to be taken

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1 **A.** Yes.

2 **Q.** And I think in fact you received a number of letters  
 3 from BMA, RCN, TUC, CATA, as it's now called, or CAPA as  
 4 it then was, urging you to allow FFP3 usage more widely  
 5 than the IPC guidance enabled?

6 **A.** Yes, and not only receive letters. That, again, gives  
 7 the impression that this was somehow a dry exercise,  
 8 which obviously you get from the paperwork, by its  
 9 nature, but I spoke to all these people as well, and the  
 10 royal colleges and -- and more than anybody,  
 11 Donna Kinnair, who was the head of the RCN at the time.

12 **Q.** Did you understand that that desire for increased usage  
 13 of FFP3 was linked to an argument that Covid  
 14 transmitted via aerosol transmission?

15 **A.** Yes.

16 **Q.** Can I ask you about that, please. To what extent, if  
 17 any, were you involved in arguments or aware of  
 18 arguments about the extent to which Covid transmitted  
 19 via aerosols?

20 **A.** Of course, I -- I was -- again, it was -- I was acutely  
 21 aware of these things, this -- and that debate.

22 **Q.** You said this morning that you would advocate for  
 23 a precautionary principle being adopted in relation to  
 24 asymptomatic transmission?

25 **A.** Yeah.

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1 into account, because if you promise -- imagine if the  
 2 IPC guidance had retained the initial hazmat style --

3 **Q.** The HCID --

4 **A.** HCID, the definition -- that would not have been  
 5 possible. And so there is an element of the art of what  
 6 is possible. In the same way that whilst I wasn't  
 7 individually involved in signing contracts for PPE,  
 8 I was deeply involved in trying to push the system to  
 9 buy more. But on the IPC guidance itself, of course you  
 10 have to consider what is feasible, because this isn't  
 11 some academic exercise it's about saving lives. But in  
 12 terms of when that IPC guidance was then drawn up,  
 13 I didn't sign off on it and I accepted the guidance as  
 14 essentially a piece of clinical guidance with which  
 15 I wouldn't quibble. It was a -- if I had a question  
 16 around it I'd go to Ruth May and I'd talk to Donna about  
 17 these things all the way through.

18 **Q.** Are you aware of the basis upon which Covid was  
 19 downgraded or declassified as an HCID and why that  
 20 decision was taken?

21 **A.** Yes, it's -- I think the decision was obvious in  
 22 a sense, because spread had got wider than this being  
 23 a very rare and single occurrence. But again  
 24 I wasn't -- that wasn't my decision, it was a clinical  
 25 decision. I think, in that case, by the CMO.

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1 Q. And may be ACDP or NERVTAG -- put aside who it was that  
2 made that decision, it was in fact declassified because  
3 it was less fatal than other coronaviruses that we've  
4 heard of.

5 You're not suggesting, are you, that it was  
6 downgraded because we wouldn't have had enough PPE to  
7 maintain the HCID classification, are you?

8 A. No, my example was that if you tried to maintain it, it  
9 would not have been feasible.

10 Q. All right. We have heard evidence from IPC guidance --  
11 those drafting the IPC guidance, that issues of supply  
12 did not in fact affect the guidance that they issued.

13 Are you suggesting to the contrary, Mr Hancock?

14 A. No, I'm suggesting that I wasn't involved in the  
15 drafting of it. But my point about supply is you do  
16 have to live in the real world once you're fighting  
17 a pandemic. Of course people who were drafting the  
18 guidance would also have been aware of it. The  
19 balancing point here is that you -- the practical  
20 reality is that there is a certain amount of PPE and you  
21 have to use it as effectively as you can whilst buying  
22 as much of it as possible. That is the real world  
23 reality here.

24 Q. You said this morning, in relation to the precautionary  
25 principle, you adopted it absolutely, "Which we did on

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1 30 January 2020 you received Public Health England's  
2 audit of the PPE stockpile and there was no clear record  
3 of what was in the stockpile and some kit was passed its  
4 sell-by date?

5 A. Yes.

6 Q. The Inquiry has also heard that as at 18 February the  
7 stockpile did not contain a single gown. Were you aware  
8 that there were no gowns in the PPE stockpile?

9 A. Well, I was once I found that out but I wasn't in  
10 advance, no.

11 Q. Did you find out about it around the end of January  
12 beginning of February, something like that?

13 A. Yes, I asked for that audit at around that time.

14 Q. Were you made aware that NERVTAG in June 2019  
15 recommended getting surgical gowns in for the event of  
16 even a flu outbreak?

17 A. I don't recall being aware of it but obviously I've seen  
18 it in the evidence to the Inquiry.

19 Q. Had you been made aware that there was a need for gowns,  
20 would you have been able to apply any pressure to speed  
21 up the procurement process?

22 A. Rather like our discussions about the lines of  
23 accountability with NHS England, similarly with PHE,  
24 I certainly could have raised that with the PHE  
25 leadership but it would have been their responsibility

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1 things like guidelines around the use of PPE within  
2 hospitals".

3 A. Yes.

4 Q. In what way do you say the guidelines around PPE in  
5 hospitals adopted that precautionary principle?

6 A. Well, for instance, the use of masks, which was required  
7 as part of the IPC, which was not recommended to the  
8 general public. The failure to recommend it to the  
9 general public until later was directly a consequence of  
10 asymptomatic transmission being ruled out in the  
11 official advice, yet it was adopted within our hospitals  
12 demonstrating that there was an element of the  
13 precautionary principle there.

14 Q. There will be those, many in this room, no doubt, that  
15 say if you were truly adopting the precautionary  
16 principle, FFP3 would have been used not the blue masks.  
17 Do you have any views or comments to make on that  
18 suggestion?

19 A. I can absolutely see that argument, and had FFP3 masks  
20 been recommended I would have accepted that. That was  
21 a -- but as I say, that was a clinical decision for the  
22 team who put together the IPC recommendation not for me.

23 Q. Can we take a stage back to the stockpile, please.

24 A. Yeah.

25 Q. And you say in your witness statement that as at

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1 to do it. I say this because the clarity around the  
2 roles within the health system was really clear. The  
3 fact that that would have been effectively  
4 an independent decision by them doesn't mean that we had  
5 any lack of clarity over whose decision it was, in the  
6 same way I know what was Simon Stevens' decisions on the  
7 NHSE side, what was my decisions, and if there was an  
8 ambiguity, we would put it on the quad agenda and  
9 discuss it.

10 LADY HALLETT: But who would provide the funding for getting  
11 more PPE?

12 A. That would come from PHE's budgets but obviously one of  
13 my roles with respect to PHE was to fight for their  
14 budget.

15 MS CAREY: Sir Christopher Wormald told us it was entirely  
16 normal government procurement that meant that even  
17 thought it was recommended to buy gowns in June,  
18 by February 2020, 8 months on, we still hadn't got  
19 a single gown in the stockpile.

20 A. Yes.

21 Q. Do you accept, though, that entering the Coronavirus  
22 pandemic, as we did without a single gown, severely  
23 hampered the ability to provide safe and appropriate PPE  
24 for healthcare workers?

25 A. The stockpile that we had was not as goods as it needs

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1 to be in the future, absolutely. But I saw Sir Chris's  
2 evidence and he was absolutely right, if I may say so.  
3 There have been some criticisms of the department,  
4 indeed me personally, because of the accelerated  
5 procurement that we put in place. This is an example of  
6 normal procurement processes. So you can see why we  
7 needed to accelerate them. This is how slowly  
8 government buys stuff, it's just really, really slow,  
9 and it's gone back to being incredibly slow since the  
10 pandemic. That's just life in government.

11 I don't like it, by the way, I think we should buy  
12 stuff quicker but that's --

13 **Q.** No, it sounds rather fatalistic, doesn't it?

14 **A.** Yes, but he was completely accurate in describing it as  
15 normal government procurement. I mean, sometimes this  
16 stuff takes even longer.

17 **Q.** You say in your statement that one of the other problems  
18 with stockpile is it was not spread across the  
19 country --

20 **A.** Yes.

21 **Q.** -- and that the warehouse that held the stockpile had  
22 only one main door which slowed the distribution of PPE.

23 **A.** Yeah.

24 **Q.** So, is this a fair summary, there was no clear record of  
25 what was in it?

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1 the future.

2 **A.** Yeah.

3 **Q.** Would you agree or disagree with that?

4 **A.** I think that's a typically astute observation from  
5 Jeane Freeman.

6 **Q.** Can you help, or do you know why we didn't have that  
7 since it seems to be a relatively simple solution to  
8 a problem that we encountered?

9 **A.** I have absolutely no idea.

10 **Q.** All right. Mr Hancock, from your perspective did  
11 England ever run out of PPE for the NHS?

12 **A.** As a whole, no, but individual locations did.

13 **Q.** So you accept that we came close?

14 **A.** We came extremely close. We came within, you know, a  
15 small numbers of items on a regular basis during April  
16 and May 2020.

17 **Q.** All right.

18 **A.** By the second wave we were in better shape.

19 **Q.** I'd like to just look at perhaps some of those examples.  
20 I think you are aware in April 2020 that there were  
21 reports that a hospital in North London, Northwick Park  
22 had no critical care beds left and in fact there were  
23 exhausted nurses wearing bin bags to protect themselves.

24 I'd just like to call up that article, please.

25 INQ000474608.

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1 **A.** Yeah.

2 **Q.** There was a total absence of some PPE, namely gowns, and  
3 to boot, there are clear problems getting your hands on  
4 it because the warehouse has only got one door?

5 **A.** And some of it was out of date once we got our hands on  
6 it, yes. Why there wasn't a precise list of what it was  
7 in an easily pickable way with a computer system that  
8 tell you where different bits of kit were, preferably  
9 with photographs attached of an example of it, for  
10 instance, as you would have in a modern, efficient  
11 storage system, I do not know.

12 **Q.** By the time you left office, was there such a list that  
13 you were aware of?

14 **A.** Yes.

15 **Q.** All right.

16 **A.** But I still wouldn't say that by the time I left office  
17 it was comprehensive, but we were much further along the  
18 route and we had pickable PPE stockpiles in lots of  
19 locations, and indeed, there was a problem that we ended  
20 up overbuying PPE because the PPE demand fell again and  
21 we -- and the department, after my time, ended up with  
22 too much PPE.

23 **Q.** Jeane Freeman told us that she thought that having  
24 a rolling stockpile which would entail distributing PPE  
25 on a rolling basis to prevent it expiring would help in

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1 It's Thursday 9 April, so an article in

2 The Independent and there are three nurses there wearing  
3 their bin bags. Perhaps if we could just scroll through  
4 the article, they say they've now been diagnosed with  
5 Covid after they were forced to wear bin bags. They  
6 were pictured last month amid a shortage of masks, gowns  
7 and gloves. And if we scroll down again, I think there  
8 may be another photo. Or it may not come up on our  
9 screen. There we are it does.

10 Nurses added:

11 "There are too many Covid patients coming in to  
12 cope with. We've put on our brave smiles but inside  
13 we're terrified."

14 I'm asked to ask you, as the person with ultimate  
15 responsibility for health and social care, how did the  
16 UK reach the point that healthcare workers are having to  
17 wear bin bags?

18 **A.** Well, the -- in this instance, I saw these reports and  
19 asked whether that hospital had enough PPE and I was  
20 told that it had had regular PPE deliveries in the  
21 preceding days and that the hospital itself reported  
22 back that it had adequate PPE supplies. So all I can do  
23 is tell you what I was told at the time and I was  
24 immediately on it to try to solve these sorts of  
25 problems. But, of course, there were individual

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1 shortages because this was a massive logistical  
2 operation under extreme pressure.  
3 **Q.** Can I ask you when you say, "I was immediately on it to  
4 try and solve these problems", what did you actually do?  
5 Help us with what you did.  
6 **A.** So there were some exhibits that explain what happened.  
7 The -- I saw these reports. I also heard other reports.  
8 I asked the department to get in contact directly with  
9 the hospital, and the hospital reported that it had  
10 adequate PPE supplies. And this is an example of the  
11 fact that within the NHS, within a logistical operation  
12 of suddenly having to get PPE out to, effectively,  
13 1.4 million people and social care, there are inevitably  
14 problems and challenges.

15 Obviously the logistical operation is a matter for  
16 the NHS. What I was trying to do, and what we  
17 effectively did do, was ensure that there was always  
18 overall PPE supply. But it got extremely close.  
19 Sometimes within hours. And for the people operating  
20 that PPE supply chain on the ground, it was incredibly  
21 difficult because they'd go from, in normal times,  
22 having PPE supplies, you know, coming in at a scheduled  
23 rate in an organised way, to suddenly being waiting for  
24 the next batch of PPE to arrive before they could  
25 distribute it around the hospital. So I'm not

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1 **LADY HALLETT:** Here there seems to be a problem with getting  
2 the supplies distributed around the hospital.

3 **A.** Around the hospital, absolutely.

4 **LADY HALLETT:** Did you do anything about that?

5 **A.** The answer is that I spoke to the NHS about that because  
6 it was not -- it's not something that I, as  
7 Secretary of State, personally, could have done in every  
8 hospital. You have to run the system. You have to  
9 run -- I run the department and then spoke to the NHS.  
10 So effectively it's the management of that hospital who  
11 is responsible for getting the PPE supplies out of  
12 the -- from where it's received in the hospital out to  
13 the parts of the hospital.

14 **MS CAREY:** In your statement you say that data about PPE was  
15 first incorporated into the Covid dashboard on  
16 21 March 2020, and you were aware certainly by mid-April  
17 there was a potential for a "stock out"; does that mean  
18 no more stock?

19 **A.** Yes.

20 **Q.** In relation to gowns.

21 **A.** Yeah.

22 **Q.** And I'd like to ask you, please, about an email chain  
23 just showing how close we came to that.

24 Can we have on screen INQ000478872. And I don't  
25 know if it's possible to expand the table at the bottom.

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1 criticising them --

2 **LADY HALLETT:** If you could focus on Ms Carey's questions.  
3 Essentially, you discover through your officials making  
4 enquiries that the hospitals say they have supplies, the  
5 nurses say they haven't. Did you just accept that  
6 conflict or did you say, "What's going on? Why aren't  
7 these supplies --

8 **A.** Yes.

9 **LADY HALLETT:** -- if they're there, being distributed around  
10 the hospital?"

11 **A.** Well --

12 **LADY HALLETT:** Miss Carey's question was, what did you do?

13 **A.** So, I -- the answer to the precise question what I did  
14 was, I found out whether that hospital had supplies.

15 **LADY HALLETT:** Yes. Then what?

16 **A.** My responsibility was not to distribute it within the  
17 hospital. I raised and discussed PPE distribution  
18 repeatedly with NHS England management and they, too,  
19 were extremely keen to ensure that the PPE we had got  
20 distributed properly within the NHS system. At the same  
21 time we tried to improve the delivery systems, to  
22 different hospitals.

23 **LADY HALLETT:** But that's a different problem. That is  
24 getting the supplies to the hospital.

25 **A.** Yes.

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1 Let's just see if we can -- thank you very much.

2 "[Number] of weeks after 10 [April] until stock  
3 out."

4 And if we can look at gowns, no -- no more weeks?

5 **A.** Yeah, tell me about it.

6 **Q.** 1.9 weeks of aprons, 2 weeks of cleaning equipment,  
7 nearly 3 weeks -- and so on, 3 weeks of gloves.

8 **A.** Gowns I think at one point we got to within 6 or 7 hours  
9 of running out.

10 **Q.** Yes. Go back, please, to page 1. There's certainly  
11 reference to days, I'm going to ask you about hours in  
12 a minute, but:

13 "... thanks to Emily for the update.

14 "We have enough gowns to get through tomorrow and  
15 enough coming in tomorrow for the next day ...

16 "No trust has run out and there's been lots of  
17 mutual aid (especially in London)."

18 le trusts or hospitals --

19 **A.** Helping each other.

20 **Q.** -- helping each other out.

21 Is that the Foreign and Commonwealth Office --

22 **A.** Yes.

23 **Q.** -- are looking into mutual aid? And:

24 "... they have cleared a deal with Egypt ...

25 "The dashboard will show that ... we are out of

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1 stock (we ... have c60k and need to send out c6k)."  
 2 And you're relying on a delivery from Amazon, no  
 3 less, for another 60,000.  
 4 Were we running out of gowns to the hour?  
 5 **A.** Yes. We were -- I mean, we were working incredibly hard  
 6 to make sure that we didn't have a stock out, and we  
 7 nearly -- we nearly did.  
 8 **Q.** And one of the responses to that was, I think you,  
 9 effectively, were aware that PHE produced acute  
 10 shortages guidance on 17 April which allowed for  
 11 sessional use or reuse of some PPE, including gowns and  
 12 masks in specified circumstances. Do you remember being  
 13 asked to approve that guidance?  
 14 **A.** I'm not sure whether I approved it or whether it went  
 15 through the IPC approvals process.  
 16 **Q.** I can tell you we've seen an email chain, it goes  
 17 through you and you approved the guidance.  
 18 **A.** Okay.  
 19 **Q.** Do you accept that the failure to have gowns in the PPE  
 20 stockpile resulted in part for the need for -- that  
 21 acute shortage of gowns --  
 22 **A.** Yes, of course, if we'd had more gowns at the start --  
 23 so that is literally true in the way you ask it.  
 24 There's also a broader point, because we have to --  
 25 I come back to this point that what matters is -- what  
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1 **A.** Obviously I was -- I spoke to Donna Kinnair at this  
 2 point and it was understandable that some people would  
 3 feel uncomfortable with this guidance, because I didn't  
 4 want to put -- see that guidance in place either. But  
 5 the challenge was how do you save as many lives as  
 6 possible. Right? That was the objective here.  
 7 And the advice I got, which I signed off, was  
 8 that, in certain circumstances, reuse of PPE is better  
 9 than no PPE, and I accepted that point.  
 10 **Q.** I follow the reuse or sessional use of PPE being better  
 11 than none, but what did it strike you as saying about  
 12 the way the system had prepared itself and was coping if  
 13 the Royal College of Nursing have to produce guidance  
 14 which says to the nurses "At some point, in certain  
 15 circumstances, you can actually refuse to treat  
 16 a patient"?  
 17 **A.** Well, the Royal College of Nursing represented one view  
 18 and my clinical advisers on this, represented by and led  
 19 by the Chief Nursing Officer, Ruth May, took into  
 20 account all these considerations and made the best  
 21 decision that they could based on the -- on saving as  
 22 many lives as possible.  
 23 It's perfectly reasonable for a trade union to  
 24 take a different view, but that doesn't necessarily mean  
 25 that they're right. But we talked -- we had a high  
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1 I was responsible for was making sure the system as  
 2 a whole operated as well as it possibly could to save as  
 3 many lives as possible. And that was my job. The --  
 4 Chris Wormald makes the point that we had about half  
 5 a billion items in the initial stockpile. We used  
 6 15 billion during the pandemic as a whole. It is not  
 7 feasible to have 15 billion in a stockpile. But it is  
 8 of course literally true, in the way that you asked the  
 9 question, that if we'd had 1 million gowns at the start  
 10 we would have been 1 million further away from running  
 11 out, which would have been several days, and therefore  
 12 avoided being this close. But we were this close. And  
 13 we worked incredibly hard to ensure that there was as  
 14 much as there was.  
 15 **Q.** Were you aware that that acute shortages guidance caused  
 16 real upset in particular to the Royal College of Nursing  
 17 who didn't support the guidance?  
 18 **A.** Yes.  
 19 **Q.** And in relation to the Royal College of Nursing, they  
 20 were so concerned by April 2020, were you aware that  
 21 they introduced a -- some guidance to the nurses on the  
 22 circumstances in which nurses could refuse to treat?  
 23 **A.** Yes.  
 24 **Q.** What did you do when you learnt that the RCN had to go  
 25 so far as to bring in a refusal to treat guidance?  
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1 quality dialogue throughout this. In fact,  
 2 Donna Kinnair, as head of the RCN, and I were involved  
 3 in working together to try to buy more PPE as well. So  
 4 they were absolutely leaning into trying to solve the  
 5 problem, and it's totally reasonable for a trade union  
 6 and the chief nurse responsible for the system as  
 7 a whole to have different views on how to respond to  
 8 a very difficult situation.  
 9 **Q.** Did you or anyone else in the department ever discuss  
 10 the possibility of a widespread refusal to treat by  
 11 UK healthcare workers?  
 12 **A.** No, I didn't think we -- we didn't expect a refusal to  
 13 treat to become widespread. And also I was making --  
 14 I was in conversation with people on the front line as  
 15 well, and my sense was that everybody really was trying  
 16 their very best in very difficult circumstances, and  
 17 that was the attitude of the whole system.  
 18 So whilst there may have been some who took the  
 19 view of the RCN, actually the vast majority of people  
 20 were just doing their best in awful circumstances. And  
 21 frankly that was the attitude of -- within the health  
 22 system, setting aside the problems that we had in  
 23 central government, within the health system that was  
 24 basically the attitude that everybody took all the way  
 25 through. And I think that's reflected in all of the  
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1 paperwork that you've seen.

2 **Q.** You make the point a number of times in your statement  
3 that whilst you acknowledge there were individual  
4 shortages, at no stage there was a national shortage.

5 **A.** Yeah.

6 **Q.** And can I ask you, Mr Hancock, bluntly, is that really  
7 the point? Is it not cold comfort for those that were  
8 down to the last hours' worth of masks or gowns or  
9 gloves?

10 **A.** Well, it is better to be down to the last hour's worth  
11 than to run out, and in some places they did run out and  
12 that was awful. And my job was to ensure that that  
13 happened as little as possible, and nationally we never  
14 ran out of it.

15 In a way, it comes back to this -- the difference  
16 between semantics and substance, right? The reason in  
17 Inquiry is so valuable to the nation, so important, is  
18 to get to the substance of it. So, you know, I don't  
19 really get hung up on the semantics of it, what I care  
20 about is that in future we need to have better PPE  
21 stockpiles, we need to learn the lessons of what went  
22 wrong, and this Inquiry, frankly, is at its best when  
23 it's focusing on that, and that's what really matters.

24 **Q.** I didn't ask you about semantics, Mr Hancock. I was  
25 asking you or making the point that although nationally

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1 the role I could play, and the responsibility we had as  
2 a department, as opposed to the responsibility of  
3 an individual hospital chief executive to do the  
4 distribution within a hospital, our responsibility was  
5 to make sure that there was as much PPE available as  
6 possible in the almost impossible global circumstances  
7 of the sharp rise in demand.

8 **Q.** From your perspective, was there any link in your mind  
9 between shortages of PPE and the rising rates of people  
10 who were acquiring Covid in hospitals?

11 **A.** That is a very important question. I don't know the  
12 answer to that. I have seen evidence that there were no  
13 recorded deaths as a consequence but I've also seen  
14 evidence to the contrary. And that is a -- that's  
15 a research question.

16 **Q.** No, and I follow that, I take the point that statistics  
17 may or may not ever be able to determine --

18 **A.** Yes, it's a bit like asymptomatic transmission.

19 **Q.** I know, but that's why I wanted to know from your  
20 perspective whether you were worried that there was in  
21 fact that link?

22 **A.** Oh, I worried about -- I worried about it. Whether it  
23 actually happened or not, I don't know. But  
24 I worried -- of course I worried about it.

25 **Q.** Can we have a look, please, at the rates of nosocomial

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1 there was available PPE, that's not particularly  
2 helpful, is it, to the healthcare workers that had to  
3 struggle on and reuse PPE. It's not semantics, is it?  
4 Are you trying to present a rosier picture of the PPE  
5 position than was in fact the case given the evidence  
6 that we've shown you?

7 **A.** No, I'm not, I'm being absolutely clear about what  
8 happened and what lessons we need to draw for the  
9 future. What happened was there were individual  
10 stock outs in individual places, there was not  
11 a national stock out. In a way, one of the lessons we  
12 can draw is even if there isn't a national stock out,  
13 there still are problems in local areas and, therefore,  
14 not running out isn't good enough, we need to make sure  
15 PPE is widely available, easy to get hold of.

16 So the point I'm making, and the reason I'm making  
17 it emphatically, is that what matters is the substance  
18 of being able to protect lives, and that's what we cared  
19 about in the health department and spent, you know,  
20 every hour that we possibly could solving that problem.  
21 Now, how does that feel to the nurse on the ground?  
22 Well, what they care about is: is there PPE for me  
23 today?

24 **Q.** Yeah.

25 **A.** Yeah. And that's what I cared about. And the best --

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1 infection.

2 And can I ask, please, that it's put on screen  
3 INQ000348633\_11.

4 This is a PHE document looking at deaths -- well,  
5 the rate of hospital-acquired infection and indeed the  
6 deaths that may have flowed from that.

7 **A.** Yes.

8 **Q.** And to help you, they've covered the whole time and then  
9 they've covered the waves. Just looking at the whole  
10 time period, HOHA, hospital-onset, hospital-acquired.

11 **A.** Yeah.

12 **Q.** All right. And I'm not going to ask about  
13 hospital-onset, suspected -- but from -- this purpose,  
14 across the whole period there were nearly 30,000 cases  
15 of hospital-onset, hospital-acquired Covid, of which  
16 9,854 people died, 33%, and the average age of people  
17 that died was 75.

18 And if you just look at the waves. Wave 1, over  
19 8,500 cases and 3,000 deaths. And if we just look at  
20 wave 2, a far higher proportion of cases, 21,000 it  
21 jumps up to, 6,000 deaths, although the proportion  
22 overall is about a third, if I can put it like that.

23 Again, the mean age of the people dying in both  
24 waves is 75.

25 On any view, they are shocking statistics, are

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1 they not?  
 2 **A.** Absolutely.  
 3 **Q.** You said earlier this morning that hospitals are  
 4 dangerous places to be in pandemics?  
 5 **A.** Yeah.  
 6 **Q.** I suspect this is what you had in mind when you made  
 7 that observation.  
 8 **A.** Yeah.  
 9 **Q.** It might have struck many in this room as a rather  
 10 curious thing to say that the very place people go to  
 11 get better --  
 12 **A.** Yes.  
 13 **Q.** -- in fact is the place where they get infection and  
 14 may, indeed, in fact go on to die?  
 15 **A.** Yes.  
 16 **Q.** Help us, please, at what stage did you become aware of  
 17 the risks of hospital-acquired Covid?  
 18 **A.** The moment I heard that there was a new infectious  
 19 disease, January 2020.  
 20 **Q.** January -- right.  
 21 **A.** It's not like I became aware of it, it's obvious. I was  
 22 involved in efforts to reduce nosocomial infection  
 23 before Covid from other diseases. Nosocomial infections  
 24 is a very serious problem in health systems everywhere  
 25 but the NHS has a particular problem with it, if you

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1 a lead for tackling nosocomial infection. We had the  
 2 IPC guidance itself is a major -- was a major step in  
 3 tackling nosocomial infection. And then when we got to  
 4 testing, we introduced testing in hospitals as soon as  
 5 we had the tests available to do so.

6 But just to give a flavour of it. One example of  
 7 the problems that we faced and the cultural problem of  
 8 tackling nosocomial infection in the NHS is this: when  
 9 I brought in -- when we got to enough tests and we  
 10 talked about increasing testing in the NHS, some  
 11 hospitals said they did not want to test their staff  
 12 because they might find too many staff with Covid. And  
 13 my response to that is, if you have staff with Covid, we  
 14 need to know that so that they can go home and stop  
 15 infecting patients, but some hospitals refused to bring  
 16 in testing for their staff, and the NHS at the centre,  
 17 NHS England pushed incredibly hard to get testing to  
 18 everybody.

19 But the fact that somebody might say, we're not  
 20 going to test because what's that going to do to our  
 21 shift patterns if people have to go home, is an example  
 22 of, in my view, a cultural problem within the NHS that  
 23 it simply does not do enough to tackle nosocomial  
 24 infection. And I'd been worried about that from before  
 25 the pandemic and that is something that I raised

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1 think back to the MRSA scandals, et cetera.  
 2 **Q.** I'm not suggesting it solely affects Covid and we're  
 3 well aware --  
 4 **A.** But also the question -- you asked the question, "When  
 5 did you become aware?", and my answer is it wasn't like  
 6 somebody wrote me a note and said, "This is going to be  
 7 a problem", it was just like, well, obviously we are  
 8 going to have a problem with this.  
 9 **Q.** Okay. So when you became aware of the new disease  
 10 in January 2020 and ergo the risk, at the very least, of  
 11 nosocomial infection, what did you actually do to try,  
 12 as best you could, mitigate that risk?  
 13 **A.** Well, we were aware of it from the start and tackling  
 14 nosocomial infection is clearly a responsibility of the  
 15 NHS. Making sure, for instance, that the hospital PPE  
 16 guidance, as opposed to the guidance to the general  
 17 public, was precautionary, was an important part of it,  
 18 and again, these are discussions I would have had with  
 19 Simon Stevens as part of the quad process because  
 20 preventing nosocomial infection is a key responsibility  
 21 of the NHS.  
 22 **Q.** But what did you actually say to him to say, "I want to  
 23 get on top of this as best I can"?  
 24 **A.** I'm not sure I would have phrased it like that. I would  
 25 have said, "We need to tackle this". He put in place

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1 from January 2020 onwards but, again, the responsibility  
 2 for dealing with that lies with the NHS. Because you  
 3 can't -- you know, that -- tackling nosocomial infection  
 4 involves decisions that filter all the way down to what  
 5 happens on every individual ward.

6 **Q.** When you got reports that there were some hospitals  
 7 saying they didn't want to do the testing lest it reduce  
 8 their ability to staff, what did you do about it?

9 **A.** I was -- I was deeply frustrated about it. I tried to  
 10 bring in -- I had meetings with, obviously,  
 11 Simon Stevens but also Pauline Philip and Ruth May.  
 12 We -- in the end we brought in protocols to require it  
 13 but the take up of testing was piecemeal and slow within  
 14 hospitals, slower than it should have been.

15 **Q.** The Inquiry has heard evidence that in fact people  
 16 wanted the test because it might enhance the numbers of  
 17 staff because if, in fact, they weren't Covid-positive  
 18 they could come back to work. Did you hear evidence of  
 19 that, as well?

20 **A.** Yes, absolutely, that was a big part of the drive, yeah.

21 **Q.** You've mentioned there the importance of IPC measures in  
 22 trying to tackle nosocomial infection --

23 **A.** Yeah.

24 **Q.** -- and I think you're aware, Mr Hancock, that  
 25 the Inquiry had a number of spotlight hospitals that

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1 were asked about these matters. Watford, for example,  
 2 said they couldn't maintain 2 metres between bed spaces  
 3 and had to use curtains because of the layout of the  
 4 estate.  
 5 **A.** Yes.  
 6 **Q.** They didn't have ward ventilation that was appropriate,  
 7 so had to use mobile HEPA filters.  
 8 **A.** Yes.  
 9 **Q.** They didn't have separate entrances. They didn't have  
 10 waiting areas that could be segregated. They had shared  
 11 bathroom facilities that couldn't be segregated. They  
 12 didn't have enough single rooms.  
 13 **A.** Absolutely.  
 14 **Q.** Clearly the NHS estate covers, old, new, and everything  
 15 in between.  
 16 **A.** Yeah.  
 17 **Q.** For the older estates --  
 18 **A.** Yeah.  
 19 **Q.** -- how practical was it from your perspective to ask  
 20 them to rely on IPC when they had absolutely no  
 21 possibility of being able to implement half the IPC  
 22 measures?  
 23 **A.** Well, it's absolutely critical that these things are  
 24 improved. You mentioned Watford hospital, and as  
 25 an example of the things that I did to try to solve this

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1 **Q.** You've said that a number of times.  
 2 **A.** But that's because it's the answer.  
 3 **Q.** There may be many, though, that think that you as the  
 4 head of the Department of Health and Social Care, these  
 5 are appropriate questions for you to answer as well.  
 6 **A.** Yes --  
 7 **Q.** They are not suggesting -- let me just finish, please.  
 8 No one is suggesting, Mr Hancock, that you can  
 9 walk down to Watford General and hand them over a bag of  
 10 gowns or a roll of aprons, I understand that, but I do  
 11 want to ask you about the practical steps you took as  
 12 minister to ensure that these problems weren't  
 13 happening.  
 14 **A.** Yes.  
 15 **Q.** That's why I'm asking you.  
 16 **A.** Yes, I understand that but I'm giving you answers  
 17 because they are the truth. So I did all of those  
 18 things. All the way from -- I actually did go down to  
 19 an ambulance station in Deptford and personally helped  
 20 move some of the PPE kit but, obviously, me doing that  
 21 is not going to solve this problem, all the way through  
 22 to rebuilding Watford General Hospital. But the  
 23 day-to-day operational independence of the NHS means  
 24 that whilst I could do everything I could within my  
 25 remit, the responsibility for nosocomial infection

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1 and other problems, is I commissioned a new hospital for  
 2 Watford, and so Watford hospital is now being rebuilt as  
 3 part of the New Hospital Programme. So that's one very,  
 4 literally, concrete example of efforts to make this  
 5 better in the future.  
 6 **Q.** You say that -- in relation to nosocomial infections you  
 7 have been asked about any concerns that you were made  
 8 aware of regarding adequacy of ventilation in hospitals.  
 9 **A.** Yes.  
 10 **Q.** You say, "I was highly concerned about IPC in hospitals  
 11 including appropriate ventilation though this was  
 12 of course a matter for the NHS".  
 13 **A.** Yeah.  
 14 **Q.** What did you do, if anything, to ask NHS leaders about  
 15 improving ventilation in those settings, particularly in  
 16 the older estate?  
 17 **A.** Well, that would've formed part of my discussions that  
 18 I mentioned with the NHS leadership.  
 19 **Q.** But what did you actually do apart from discussing it  
 20 with them?  
 21 **A.** The NHS was statutorily independent and so in asking or  
 22 pushing them to do things, that was my responsibility.  
 23 They were responsible. That's why -- so these questions  
 24 are incredibly important and absolutely proper to ask  
 25 the chief executive of the NHS.

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1 minimisation in the NHS is a matter for the NHS, and I'm  
 2 sorry to keep coming to it, but that's because the  
 3 accountabilities were clear.

4 You know, we've heard in other parts of the  
 5 Inquiry, problems of muddled accountability. I'm being  
 6 clear about the accountability. Now, as it happens,  
 7 also, I'm not fatalistic about this either, because  
 8 I thought that that statutory independence was wrong  
 9 because I -- all I could do was push and ask, and  
 10 therefore I drafted the bill, which became the health  
 11 and social care act 2023 which revoked that statutory  
 12 independence.

13 So, in a sense, that's another answer to your  
 14 question, and certainly will help, I think, in the  
 15 future.

16 But running systems of 1.4 million people through  
 17 a filter of statutory independence is a challenge. But  
 18 I say none of this to criticise Simon Stevens who did  
 19 an absolutely brilliant job. I simply say it as  
 20 an accurate answer to your question that many of them  
 21 are -- would appropriately be directed to the person who  
 22 was accountable for taking these decisions. And he, I'm  
 23 sure, would say, rightly, that many of those  
 24 responsibilities were for individual chief executives of  
 25 individual hospitals, many of which he didn't have

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1 statutory authority to direct. And that has been  
2 changed since the pandemic as part of the Act as well.  
3 So the -- I'm simply being as clear as I can about  
4 the way that the system ran. It doesn't mean I didn't  
5 feel it. I felt it deeply.

- 6 **Q.** It's not that, but I'm sure he would say there were  
7 others under him, cells, no doubt, call them what you  
8 will, but doesn't the buck stop with you, Mr Hancock?  
9 **A.** Yeah, that's why I'm answering the questions.  
10 **Q.** Can I ask you this then, please. Was the need to  
11 improve ventilation in hospitals and healthcare settings  
12 an area of focus for the Department of Health and Social  
13 Care, not just the NHS?  
14 **A.** Yes, yes. Also -- but all I can do is repeat the  
15 situation as it was. I can only explain how the system  
16 was run.  
17 **Q.** Okay. A different, perhaps, aspect to IPC measures.  
18 Universal mask wearing was brought in on 5 June 2020.  
19 Masks for hospital staff, face coverings for visitors  
20 and outpatients. Do you think in the event of a future  
21 pandemic universal mask wearing in hospital settings  
22 should be brought in earlier?  
23 **A.** It should be brought in immediately and supplies need to  
24 be ready preferably in each hospital to make that  
25 possible.

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1 certainly older people were more at risk but there was  
2 also a greater risk of severe Covid and, indeed,  
3 mortality for people from a black, Asian and minority  
4 ethnic community?

- 5 **A.** Yes.  
6 **Q.** I think you were aware of that from about April 2020  
7 when you said there was SAGE advice given to you  
8 identifying risk factors of which gender, ethnicity,  
9 obesity and, indeed, age were mentioned?  
10 **A.** Well, there was --  
11 **Q.** Can I ask the question.  
12 **A.** Sorry, I thought --  
13 **Q.** It's all right. The question I wanted to ask you was  
14 this. You became aware of it and you said you wanted  
15 the SAGE documents to be published. Do you know whether  
16 in fact those SAGE documents were published so that the  
17 public could see the people who may be at greater risk?  
18 **A.** Yes.  
19 **Q.** All right. Christopher Whitty has told us that those  
20 from black, Asian and minority ethnic communities,  
21 particularly in the first wave, black ethnicity were  
22 people of higher risk, south Asian ethnicity at greater  
23 risk in the second wave, they were more likely to get  
24 Covid severely, infection was more likely to lead to  
25 mortality.

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- 1 **Q.** Finally in relation to this topic, you've mentioned  
2 there supplies. The Inquiry has heard a great deal of  
3 evidence about FFP3 masks not fitting a diverse range of  
4 face types, ethnicities, indeed even not fitting women.  
5 When did that particular problem come to your attention?  
6 **A.** It came to my attention at some point in the middle of  
7 the first wave, I think, or maybe a bit later than that.  
8 And -- but I in fact -- well, I attended a fit test with  
9 a number of ethnic minority nurses and saw for myself  
10 the difficulties that were caused by stock being,  
11 essentially, designed around one ethnicity.  
12 **Q.** No, I -- so you became aware of it. It perhaps matters  
13 not precisely when it was in the first wave. I'm going  
14 to ask you again. Did you do anything about broadening  
15 the types of --  
16 **A.** Yes.  
17 **Q.** What did you do about it?  
18 **A.** Again, my answer is the same. I raised this issue with  
19 the NHS.  
20 **Q.** When you left office, as far as you were concerned, was  
21 there a more diverse range of FFP3 masks available?  
22 **A.** I think so but I wouldn't be able to say whether it was  
23 fully adequate or not.  
24 **Q.** Sticking with the issue of equalities or, indeed,  
25 inequalities, I suspect. You are aware, I think, that

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1 Were you aware of those findings as a result of  
2 the PHE review in June 2020?

- 3 **A.** I was aware of this long before then, and the thing  
4 I was going to say when you asked the first part of your  
5 previous question was that the -- this wasn't just about  
6 the statistical and scientific reports whether from SAGE  
7 or from PHE. The first four doctors to die were all  
8 from ethnic minority backgrounds and several had come to  
9 the UK in order to work in the NHS. So I felt it very  
10 strongly. I saw it. And so yes, it came through in  
11 those officials reports but that PHE report came through  
12 long after this became absolutely crystal clear that  
13 this was a major problem.  
14 **Q.** You say in your statement that your understanding that  
15 Covid-19 affected people according to various  
16 characteristics of which ethnicity was one was at the  
17 forefront of your mind throughout?  
18 **A.** Yeah.  
19 **Q.** But I am going to ask you what did you actually do about  
20 that?  
21 **A.** The first thing I did was try to stop the spread of the  
22 various.  
23 **Q.** Right. Was that through the IPC measures --  
24 **A.** And lockdown.  
25 **Q.** -- as we've discussed -- and lockdown.

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1 A. Yes.

2 Q. Did you take any specific steps to address or try to  
3 address the disproportionate impact in the hospital  
4 settings on people of BAME origin?

5 A. Before the pandemic I had given a speech about  
6 institutional racism within the NHS. It is something  
7 that I was already worried about. The ability to tackle  
8 something deep-seated like that is very hard but I had  
9 raised the issue and brought in a series of measures  
10 essentially about empowering people to speak up.

11 I mean, before that in my time in government  
12 I'd been involved in this issue for instance when we  
13 did -- I introduced name-blind applications to the Civil  
14 Service. So this is an area that I care about, I knew  
15 about, and I was worried about. So I was highly alert  
16 to it when the first deaths of doctors were all people  
17 from ethnic minority backgrounds.

18 What I could -- given my responsibilities as  
19 opposed to the NHS's responsibilities, my responsibility  
20 was to make sure that people got -- that this was  
21 reduced as much as possible. The single biggest thing  
22 I could do was make sure that lockdown was strong  
23 enough. That was the best way to save lives across the  
24 board. There are a combination of sociological and,  
25 potentially, clinical reasons for this. And what the --

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1 parts of the NHS, as seen in the NHSBT."

2 A. Yes.

3 Q. Do you know what NHSBT stood for?

4 A. Yes, that's NHS blood and transplant --

5 Q. Thank you.

6 A. -- and they had recently -- it's all in the public  
7 domain -- in 2019 they had been involved in  
8 a significant -- there'd been an uncovering of racism  
9 within NHSBT.

10 Q. She says:

11 "Now could be a good moment it kick off a proper  
12 piece of work to investigate and tackle it."

13 You say:

14 "Yes, agree 100%."

15 A. Yes.

16 Q. Were you agreeing there to the systematic racism or the  
17 need --

18 A. Yes. Both.

19 Q. Thank you.

20 "Can you make that happen."

21 And Helen Whately says she would be delighted to.  
22 She's "on it."

23 Can I flash forward a year, please, to the end or  
24 nearer the end of this chain. 5 June 2020, so just  
25 before you leave office, you make reference to an E and

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1 the next stage that we took was to try to understand how  
2 much of this problem was due to -- directly due to, if  
3 you like, a different genetic response to Covid  
4 according to ethnicity and how much of it was due to  
5 sociological situation, for instance the fact that more  
6 people exposed to the public in hospitals, like hospital  
7 porters and nurses, have a higher -- a much higher  
8 proportion are -- of people giving that public service  
9 are from ethnic minority backgrounds, and that was the  
10 purpose of the PHE report, and then the further work  
11 that was done by Minister Badenoch to try to get to the  
12 bottom of it.

13 What I'm trying to say is, I was absolutely aware  
14 of this problem. It's work I had already -- it's an  
15 area I'd already done work on before the pandemic and  
16 clearly it is a significant problem that needs to be  
17 addressed.

18 Q. Can I ask you about two WhatsApps, please, that you were  
19 involved in, in a chain with Helen Whately, who was the  
20 minister for social care at the time. This is  
21 in June 2020, so it's around -- just before, I think,  
22 the publication of the PHE review. Helen Whately says:  
23 "One more thing on the NHS workforce -- I think  
24 the BAME next steps proposed are important but don't  
25 go far enough. There's systematic racism in some

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1 D glossary published by the NHS. You ask her:

2 "What do you think of this?"

3 She says:

4 "Odd, and not something the NHS should be doing  
5 -- no reason to have an NHS definition of  
6 colonialism ..."

7 She says:

8 "I hadn't seen it before. I do sense there's a  
9 gap between the approach the NHS has been taking on  
10 racism and inequality and the stance from  
11 no. 10/Kemi."

12 Who I think was the minister working on  
13 inequalities?

14 A. Minister Badenoch, yes.

15 Q. You say:

16 "Yes. Problem is there is a racism problem in  
17 the NHS. But I'm pretty sure this hard left stuff is  
18 not the way to tackle it."

19 A. Yes.

20 Q. She says:

21 "... agree. One to discuss after the recess?"

22 Now, Mr Hancock, I want to be clear about how that  
23 racism problem that you are seemingly acknowledging in  
24 those messages --

25 A. Yes.

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1 Q. -- actually played out in the healthcare system's  
 2 response to the pandemic. So not the wider issue?  
 3 A. I understand. As you can see, a year earlier we were  
 4 discussing the problem of institutional racism in the  
 5 NHS. Fast forward and one of the things the NHS has  
 6 brought out is an equality and diversity guide, which if  
 7 I remember it, had a glossary of terms that effectively  
 8 followed a hard left critical race theory ideology.  
 9 My strong view is that racism was a problem and is  
 10 best tackled by treating each individual as a person and  
 11 being -- and treating the colour of their skin the same  
 12 way as you would consider the colour of someone's eyes.  
 13 Of course you need positive support to ensure that past  
 14 barriers are removed, and -- but the problem is if you  
 15 then -- if you instead start to try to treat people  
 16 where the community they're from is more important than  
 17 their individual personal capabilities, hopes and  
 18 dreams, then you will end up making the problem worse  
 19 not better. So that is what I -- that is an explanation  
 20 of what I mean by that exchange.  
 21 Q. What I wanted to know, though, was, there may be many  
 22 wider systemic problems in the NHS but can you think of  
 23 a practical way that played out? We've looked at PPE  
 24 not being sufficiently diverse --  
 25 A. Right, so --

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1 whether there's a pandemic or not.  
 2 Q. Can I ask about perhaps an allied topic. And that is  
 3 vaccination as a condition of deployment, or VCOD, as  
 4 it's called. I see you raise your eyes there.  
 5 I just want to spend a moment or two looking at  
 6 this and we haven't, so that you know, featured majorly  
 7 on this in the evidence to date.  
 8 A. Okay.  
 9 Q. So just take your time, please, Mr Hancock. I think the  
 10 idea that there should be mandatory vaccinations for  
 11 those working in healthcare and social care settings  
 12 started to be discussed in cabinet, I think in March of  
 13 2021, and we note it's brought in in social care, and  
 14 after you left there were plans to bring it in  
 15 healthcare, all right? So some of this doesn't  
 16 necessarily involve you.  
 17 But go back to the beginning, please. Can I ask,  
 18 please, that we look on screen at INQ000092064, which  
 19 should be a Covid-O meeting minute from the 17 March.  
 20 A. 2021?  
 21 Q. 2021, yeah. All right. And it starts with obviously  
 22 bringing it in in social care but there are issues here  
 23 which will impinge upon the decision to roll it out to  
 24 NHS staff, all right? That's why I'm asking you  
 25 about it.

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1 Q. -- can you give another example how that racism affected  
 2 the healthcare system's response?  
 3 A. In who is promoted to what roles.  
 4 Q. How did that affect the response of the health system to  
 5 Covid?  
 6 A. Well, there are far, far fewer people from minority  
 7 ethnic backgrounds promoted to senior roles within the  
 8 NHS and when there is whistle-blowing by somebody from  
 9 an ethnic minority background they are not taken as  
 10 seriously in many instances. I could give examples  
 11 but --  
 12 Q. We've heard lots.  
 13 A. The solution to that is positive support from people who  
 14 may be from -- who are from backgrounds that have been  
 15 affected, but also ensuring that the system treats  
 16 everybody as an individual irrespective of the colour of  
 17 their skin and the community that they come from. And  
 18 the practical consequence of this is that there were far  
 19 more people from ethnic minority backgrounds in the  
 20 junior ranks within the NHS who are more likely to come  
 21 into contact with patients and therefore more likely to  
 22 catch Covid. And therefore there were more  
 23 hospitalisations and more deaths as a result of this.  
 24 So that's one example.  
 25 But it's something that needs to be sorted out

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1 And you can see there as you discussed VCOD in  
 2 health and social care issues settings you said that:  
 3 "... this was a moral and practical issue. The  
 4 moral case was clear, that carers should take all  
 5 reasonable and proportionate steps to keep those they  
 6 are caring for safe. There were also significant  
 7 practical questions which were important and difficult.  
 8 ... [DHSC] was proposing to bring into force the  
 9 vaccination of staff at care homes for the over 65s as a  
 10 ... first step."  
 11 All right? For you, what was the moral case for  
 12 bringing in VCOD?  
 13 A. The moral case is that -- as it's set out here, if you  
 14 are employed to care for others then you should take  
 15 reasonable steps to ensure you are not harming those in  
 16 your care. A clinically proven vaccine is a reasonable  
 17 step that should be expected. I'm not in favour of --  
 18 we're not talking about vaccinating -- requiring  
 19 vaccinations for everybody, we are talking -- I'm  
 20 talking about requiring vaccinations for all those who  
 21 then choose, through their employment, to put themselves  
 22 in close proximity with people who may be very  
 23 vulnerable to disease.  
 24 This -- as you say, this didn't come into force.  
 25 I think that's a mistake. We did -- I did bring it in

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1 in social care. I was persuaded to do social care first  
2 and then the NHS later. I regret that. We should have  
3 done it all at the same time. It should apply for flu  
4 vaccines as well and it's an irony that the very first  
5 meeting we had on Coronavirus right at the start  
6 of January 2020 was in fact a meeting about bringing in  
7 vaccination as a condition of deployment for flu in  
8 order to save lives and reduce winter pressures on  
9 the NHS.

10 **Q.** Putting aside your regret now that you didn't roll it  
11 out across both health and social care, we can see  
12 further down in the minute that you made the point there  
13 that in the NHS this was much less of an issue with over  
14 90% of those in patient-facing roles having been  
15 vaccinated, figures are lower in London but climbing,  
16 but they were lower in social care. So that's one side  
17 of the argument.

18 The minister I think for care, if we go over the  
19 page, please, addresses some of the potential  
20 inequalities issues, which is why I wanted to ask you  
21 about it. She made the point:

22 "It would be important to address the fairness of  
23 why this policy was being applied to certain carer  
24 groups and not others."

25 Go down again. The policy could create  
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1 were also from those communities, to help people feel  
2 safe.

3 The reasons for higher hesitancy amongst  
4 communities that feel -- that don't feel as connected to  
5 the authorities is widely reported and it's important to  
6 take it into account. The attitude that we had was that  
7 we shouldn't think of communities who were more hesitant  
8 as hard to reach, we should have the humility to accept  
9 that it's that the government and the authorities look  
10 more distant to some communities. And that's -- as  
11 government, that's our problem, not theirs.

12 And so there's lots of practical steps that you  
13 can then take, and all the work that Minister Zahawi led  
14 in the vaccine rollout to increase uptake amongst BAME  
15 communities could equally be applied within health and  
16 care settings.

17 Now, as it happened, the concerns over staff  
18 leaving didn't materialise. People did take the job.  
19 And it brings me back to this point that we understood  
20 that were -- there would be concerns, but that doesn't  
21 make it anything -- any less a rational policy to  
22 require people who are caring for others to protect  
23 those others as much as is reasonably possible.

24 And if you look at point (a), Helen's point here  
25 is in fact we should have been doing it for the NHS as  
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1 a challenge for the workforce where there's already  
2 significant vacancies.

3 And down again, please, to (e):

4 "Black, Asian and Minority Ethnic ... communities'  
5 hesitancy should not be underestimated and so, to  
6 mitigate this, the handing needed to be clear. The  
7 legislative proposals would feel authoritarian, so it  
8 was important to have families and trusted local voices  
9 in the sector ..."

10 So clearly a concern that it might impact on BAME  
11 communities.

12 Reflecting on the minister of care's observations  
13 there, do you agree with her statement the government  
14 needed to involve trusted local voices early on, if  
15 you're thinking about bringing in mandatory vaccinations  
16 of health and social care staff?

17 **A.** Yes.

18 **Q.** How might that in fact be rolled out, do you envisage?  
19 How do we bring in those voices?

20 **A.** Well, we actually had a lot of experience of doing that  
21 in the wider vaccination programme. For instance, one  
22 of the things we found was most effective in increasing  
23 vaccination rates amongst people from black, Asian and  
24 minority ethnic communities was to ensure that those  
25 doing the vaccinating and organising the vaccinating  
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1 well. She was saying that it might look -- why is this  
2 policy being applied to certain carer groups and not  
3 others? What she means there is: what on earth are we  
4 doing only doing this in social care? We need to be  
5 doing this in the NHS as well, where the problems,  
6 including of nosocomial infection, were, if anything,  
7 worse than in social care.

8 So, I was pushing for it for flu at the start of  
9 the pandemic. I pushed for it for both. I accepted, in  
10 the sort of practical necessity that happens in  
11 government sometimes, that it was better to do it in  
12 social care than in the NHS, and after I left they  
13 dropped it within the NHS. I think that's a mistake and  
14 it should be changed.

15 **Q.** All right. Do I take it then that in the event of  
16 a future pandemic, once there is a vaccine you would  
17 advocate for mandatory vaccinations for health and  
18 social care staff?

19 **A.** I would do that, and I would do it right from the --  
20 right from the start. You know we made vaccinations  
21 available to people in -- working in health and social  
22 care as part of wave 1, right at the start. And I would  
23 make it mandatory as soon as there is a -- enough  
24 clinically validated vaccines.

25 **Q.** Final topic, please, if I may, before our afternoon  
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1 break. Can I ask you, please, about the monitoring of  
2 deaths of healthcare workers from Covid-19. From your  
3 perspective, was any department or organisation actually  
4 monitoring the deaths?

5 **A.** Yes.

6 **Q.** And who was that, please?

7 **A.** There wasn't right at the start -- but I would -- I got  
8 individual reports and then I set up a system for  
9 monitoring that and I can't remember whether it was  
10 NHS England or PHE who put that system in place. But at  
11 my instigation that was done, yeah.

12 **Q.** There is further work, I think that you asked to be  
13 done, in relation to investigations into deaths of  
14 healthcare workers.

15 And can we have up on screen, please,  
16 INQ000474567.

17 In May 2020 you wrote to Jeremy Hunt, who was the  
18 chair of the Health and Social Care Select Committee.  
19 You'd obviously been before them. And you undertook to  
20 confirm to the committee whether it was the HSIB that  
21 should be involved in investigation of death.

22 And if we scroll down the screen, you say you've  
23 looked into the best approach and you've set in place  
24 a process for medical examiners to review the deaths of  
25 health and social care workers from Covid. Whenever the

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1 **A.** I'm not surprised that there -- if there's been  
2 a finding of underreport --

3 **Q.** It's not quite what I asked you. I asked you whether  
4 you were aware that there had been a finding --

5 **A.** There's a deep statistical answer to that question,  
6 which is that none of this reporting was accurate at the  
7 start of the pandemic.

8 **Q.** Yes.

9 **A.** And underreporting is much more likely than  
10 overreporting in these circumstances. And as a trained  
11 statistician, I'd understand that the statistics you  
12 were given are only a guide to the actual underlying  
13 truth. And so I suppose I would have taken it as read  
14 that there'd be a degree of underreporting and that that  
15 needed to be improved over time, hence putting in  
16 a system.

17 **Q.** All right. Do you think then by the time you left  
18 office there was an adequate way of knowing how many  
19 people died and, if so, whether they had in fact  
20 acquired Covid or a future disease at work?

21 **A.** I'd say we had an improved estimation process, but  
22 because of the impossibility of knowing for sure the  
23 source of an infection, in fact, it -- the numbers are  
24 unknowable, and I would caution against spurious  
25 accuracy in this example.

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1 medical examiner becomes aware of a health and social  
2 care worker having died and believes there a is reason  
3 to suspect that the staff fatality was due to  
4 Coronavirus, there will be a process to notify the  
5 employer of the deceased member of staff.

6 **A.** Right.

7 **Q.** Do you know why there wasn't any investigation process  
8 in place prior to you making this clear in the letter to  
9 Mr Hunt?

10 **A.** No.

11 **Q.** We know that in due course the Department of Health  
12 published some guidance on this process and, to cut  
13 a long story short, if I may, Mr Hancock, by 2022 the  
14 National Medical Examiner's report stated that they had  
15 looked at, I think, 474 deaths, some which will be  
16 social care, some of which will be healthcare workers,  
17 and concluded that 357 of those cases, the healthcare  
18 worker had been exposed to Covid at work.

19 The Inquiry has heard evidence that reporting  
20 through the HSC under the RIDDOR, or Reporting of  
21 Injuries, Diseases and Dangerous Occurrence Regulations,  
22 to give it its formal title, that there was  
23 underreporting.

24 Now, were you aware of underreporting through the  
25 RIDDOR process?

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1 So, for instance, the paper that you brought up  
2 earlier that had the exact number of deaths from  
3 hospital-acquired infection, you know, that -- that is  
4 the reported number. It is an estimate. Because  
5 whether somebody acquired an infection in hospital or in  
6 the community is not always clear. And I would suggest  
7 that 4 degrees of accuracy down to the individual single  
8 figure is not appropriate. There needs to be a degree  
9 of rounding in those estimates and an acceptance that  
10 sometimes you don't know where an infection has come  
11 from.

12 **Q.** No, I follow that, but the hospital-acquired -- or  
13 hospital-onset, hospital-acquired was for those people  
14 who had tested positive 15 days after their admission to  
15 hospital, and PHE were pretty certain that if you were  
16 getting tested positive 15 days in, you'd caught it in  
17 the hospital. That's why I focused not on the  
18 suspected, not on the probables, but on those where  
19 there was pretty good certainty that you'd got it in the  
20 hospital.

21 I don't want anyone to misunderstand you, are you  
22 quibbling with the figures that were provided by PHE  
23 about the number of people that caught and indeed died  
24 from it?

25 **A.** I'm not -- I wouldn't quibble. What I'd say is that, in

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1 understanding all of these things, you have to  
2 understand that there is a degree of uncertainty over  
3 all of the figures.

4 You know, we had the same with how do you measure  
5 deaths from Covid or deaths with Covid and at what point  
6 is there a cut-off from having had Covid to dying,  
7 because Covid was underreported on death certificates.

8 So all of these things, all of these statistical  
9 techniques are the -- are your -- are the best way, and  
10 we improved them over time, but they're effectively the  
11 best way of trying to measure something rather than  
12 an absolute concrete figure.

13 **MS CAREY:** Would that be a convenient moment?

14 **LADY HALLETT:** Certainly. I shall return at 3.05.

15 (2.50 pm)

(A short break)

17 (3.05 pm)

18 **LADY HALLETT:** Ms Carey.

19 **MS CAREY:** Thank you, my Lady.

20 Mr Hancock, can we discuss briefly the shielding  
21 programme. Just so that you know, we've heard from  
22 Professor Whitty and a number of others about how it was  
23 set up, who made the list, who didn't make the list.  
24 I'm not going to ask you about that, all right.

25 **A.** Yes.

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1 information.

2 "2. He agrees not to explore regulations at this  
3 stage under GDPR.

4 "3. He agrees to extend the data opt out for  
5 6 months. He has asked for more advice about if he can  
6 delay indefinitely."

7 I just want your help with that final bullet.

8 What were you trying to achieve, if I can put it like  
9 that?

10 **A.** Okay, so the four copy notices, of which one was very  
11 significantly the most important, were put in place to  
12 allow the NHS to use data more effectively and to share  
13 data through any secure platform, whereas previously the  
14 rules had -- had the effect of requiring data shared  
15 across the NHS to be done so on NHS systems. So NHS has  
16 its own email address -- email system, for instance,  
17 whereas there's perfectly adequate ones that can be --  
18 that are much better and much more secure, that could be  
19 brought in from outside.

20 So the effect of the copy notice, what we did was  
21 we wrote it on -- it ended up on two sides of A4, to get  
22 down to the front line to say: you can share data  
23 properly, effectively, so long as it's on a secure  
24 system. But it doesn't have to be according to the  
25 unbelievably complicated rules that had grown up in the

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1 **Q.** But I think one of the points that make in your  
2 statement is that there were difficulties certainly at  
3 the beginning linking data between various either  
4 government departments or computer systems to enable you  
5 to contact the individuals that were going onto the  
6 shielding list. All right?

7 And you say in your statement that you were  
8 ultimately required to issue four notices under the  
9 control of patient information regulations to help the  
10 NHS share the relevant data. Is that right?

11 **A.** Yes.

12 **Q.** All right.

13 And in the run-up to the issuing of those notices,  
14 could we have a look on screen, please, at INQ000478857.

15 13 March 2020, so just before we go into lockdown:

16 "[Secretary of State] is happy with all

17 approaches.

18 "1. He is happy [for] NHS direct" --

19 **A.** No, "happy to direct".

20 **Q.** Sorry, you're quite right.

21 "... happy to direct [NHS Direct] to collect,  
22 analyse and disseminate data to DHSC and NHSX  
23 through ..."

24 **A.** Section 254, yeah.

25 **Q.** Yes. And the notice under the control of patient

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1 past.

2 **Q.** So this was to help the shielding letters go out?

3 **A.** Yes. So with the shielding letters, that was  
4 specifically about allowing the data to be shared  
5 between DWP and the NHS.

6 And "NHSD" here is NHS Digital, who have the  
7 statutory responsibility for protection of data in the  
8 NHS.

9 **Q.** But the referencing to opting out and asking to delay  
10 indefinitely, what were you trying to achieve there?

11 **A.** Oh I wanted this new system which was going to be much  
12 more effective, and turned out to be much more  
13 effective, to be permanent.

14 **Q.** Right.

15 **A.** And it's a mistake that it was rolled back. And  
16 actually there is legislation in front of Parliament now  
17 to allow us to get back to where we were in the pandemic  
18 when the effective use of data, in a modern way, was  
19 much -- was the best it's ever been in the NHS, and then  
20 unfortunately it has sort of encroached backwards again.

21 **Q.** All right. Do you think the inability to share data  
22 easily without a copy notice hampered the ability of the  
23 healthcare system to respond?

24 **A.** Well, we put in place pretty early, so Matthew Gould,  
25 the head of NHSX, and Simon Madden, who wrote this note,

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1 did incredible work early on to spot that this was going  
 2 to be a problem and then to get across it. There were  
 3 some instances, like putting together the shielding  
 4 list, where there were -- it was a practical problem,  
 5 and so there were concrete use cases for it, but they  
 6 had spotted early enough that this was absolutely  
 7 necessary. And it went on to, for instance, underpin  
 8 the effectiveness of the vaccine programme.

9 **Q.** A number of witnesses have spoken about either paucity  
 10 or total absence of data in various respects, often in  
 11 relation to ethnicity collection and the like, and have  
 12 urged upon her Ladyship to consider making data  
 13 recommendations.

14 **A.** Yes.

15 **Q.** Do you have any data recommendation to make?

16 **A.** Oh --

17 **Q.** What is it, please?

18 **A.** Yes, please. Can I -- I'm going to answer off the top  
 19 of my head but I would be very happy to write afterwards  
 20 because it's a subject I feel very strongly about,  
 21 because I think the NHS can only operate effectively if  
 22 it had has much more modern and effective data sharing  
 23 systems.

24 **Q.** Can I ask you to focus your answer on the pandemic  
 25 response.

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1 nurse or appropriate clinician is there and a room  
 2 booked or a place booked for that to happen, that is  
 3 essentially a data issue and unless you essentially  
 4 completely free up the use of data within the NHS, we  
 5 are never going to solve that problem.

6 **Q.** Can I come back to shielding, please.

7 **A.** Yes.

8 **Q.** We know that DHSC was one of a number of departments  
 9 that fed into the shielding programme as it was rolled  
 10 out, but from the department's perspective and your  
 11 perspective as minister, did you make any steps to try  
 12 and ascertain whether the shielding programme worked in  
 13 the sense that it prevented the most vulnerable people  
 14 from becoming infected?

15 **A.** Yes, there was work done to assess the impact of the  
 16 shielding programme. There is another difficulty of  
 17 measurement here, because there was not a control group,  
 18 as in everybody who we thought needed shielding we put  
 19 into the shielding programme. We didn't hold a group  
 20 back and say we won't apply the same support to them  
 21 because then we can measure that, as would you in, for  
 22 instance, a clinical trial. That means that it is  
 23 harder to measure.

24 That emphatically does not mean that it wasn't  
 25 a success, and I've seen some paperwork put before

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1 **A.** Yes. Yes, I'll give you two concrete examples.

2 One is the collection of data for management  
 3 purposes, which we've discussed in relation to  
 4 understanding how many beds the NHS effectively has.  
 5 That system has improved a huge amount and last year the  
 6 NHS let a contract to allow for that to be done much  
 7 more widely across the NHS.

8 So, in a way, there it's: keep pushing and using  
 9 modern data better. Using data -- keep using data  
 10 better in a modern way.

11 But the area that's most important is the ability  
 12 for anybody who needs it, who has the consent to see it,  
 13 can see somebody's individual data to be able to treat  
 14 them and see all the other treatments that they've had.  
 15 That includes ethnicity data but also all of the data  
 16 that's pertinent to that treatment. And that is needed  
 17 in normal times but, by God, it's critical in  
 18 a pandemic.

19 The third area is data -- I said two, I know, but  
 20 the third is also important which is use of data  
 21 properly for the organisation of provision of services.  
 22 So, for instance, telling people when they can come.  
 23 The whole 111 First system that we talked about, being  
 24 able to turn that initial phone call into an appointment  
 25 and make sure that the medical records and the doctor or

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1 the Inquiry which implies that the shielding programme  
 2 wasn't effective. That is completely untrue. There is  
 3 no reasonable assessment of the shielding programme that  
 4 can find that if you give people support and ask them to  
 5 protect themselves from interactions with others then  
 6 they are anything but less likely to die of Covid. And,  
 7 of course, there were higher -- a higher proportion of  
 8 deaths amongst the shielded population than there were  
 9 amongst the population at large and that's because they  
 10 were vulnerable. That's who was brought into the  
 11 shielding programme.

12 **Q.** All right. You made reference there to the Inquiry  
 13 seeing some paperwork that implied the shielding  
 14 programme wasn't effective. That's not quite  
 15 an accurate representation of what Professor Snooks told  
 16 us. But can I ask you, do you think the high level of  
 17 hospital transmission, or hospital-acquired Covid,  
 18 undermined the efficacy of shielding because if you put  
 19 a vulnerable person into hospital where they're more  
 20 likely to catch it, you are thereby infecting the very  
 21 person you wanted to protect.

22 That's what she was driving at, so "untrue" might  
 23 be perhaps an unfair characterisation.

24 **A.** Well, except because you can't conclude this, therefore  
 25 it didn't save lives. That was my reading of it and is

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1 not accurate.  
 2 If that wasn't the intended interpretation then  
 3 that's good.  
 4 The answer to your question is "no". Because  
 5 without shielding, unfortunately, because of the extent  
 6 of nosocomial infection, people going into hospital  
 7 would be even more badly affected because you'd still  
 8 have the hospital-acquired infections but you'd have  
 9 more community-acquired infections. And also shielding  
 10 did mean that GPs knew which of their patients were  
 11 regarded by the data to be most likely to be vulnerable,  
 12 and therefore who they needed to give extra support to,  
 13 and protect from potential risk of infection.  
 14 So no, I don't think that hospital-acquired  
 15 infections, they were obviously a bad thing but they  
 16 didn't undermine shielding at all.  
 17 **Q.** And finally on shielding, were you involved in any  
 18 discussions about specific measures that might address  
 19 the heightened risk for the clinically vulnerable who  
 20 had to attend healthcare appointments?  
 21 **A.** The which risk? The hospital risk?  
 22 **Q.** Yes, the heightened -- I said heightened risk.  
 23 **A.** The heightened risk?  
 24 **Q.** Let me ask you go again. Were you involved in any  
 25 discussions about the specific measures that might

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1 half of all appointments have been delivered in person.  
 2 This is something that should be celebrated", but  
 3 instead the profession feels let down and demoralised at  
 4 the suggestion that they are failing their patients.  
 5 **A.** Yes.  
 6 **Q.** Had you or the department been involved in blaming, in  
 7 any way, GPs for what is perceived to be a lack of  
 8 face-to-face consultations?  
 9 **A.** No, on the contrary. I was and am a strong supporter of  
 10 virtual consultations. There were discussions in the  
 11 media about the requirement to have more face-to-face GP  
 12 appointments. I didn't subscribe to that view,  
 13 whatsoever, and in fact went out of my way to make the  
 14 case for online consultations, and still do. It doesn't  
 15 matter -- it's more important in a pandemic but it  
 16 should still be a core part of the service that GPs  
 17 provide to provide online and telephone services.  
 18 So I agreed with this -- I agreed with the thrust  
 19 of what Richard Vautrey was saying here but obviously  
 20 I didn't agree at all with the political spin that he  
 21 puts on it. And, actually, that didn't accord with my  
 22 widespread discussions with GPs on the ground, for  
 23 instance the royal college or GPs in my constituency  
 24 but, you know, the BMA GP committee is a particular  
 25 beast.

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1 address the heightened risk that clinically vulnerable  
 2 people faced when going to healthcare appointments?  
 3 **A.** Not that I can recall.  
 4 **Q.** You mentioned GPs and shielding. Clearly the rollout of  
 5 the shielding programme had another -- added a burden to  
 6 them in that regard because they had to monitor the  
 7 list. Can I ask you about a different aspect of GP  
 8 response, and I think the BMA wrote to you on 18 May.  
 9 Can we have a look at INQ000097897, please.  
 10 We're in May '21 here, Mr Hancock --  
 11 **A.** Yes.  
 12 **Q.** -- and the BMA wrote to you expressing widespread anger,  
 13 frustration and disappointment of the GP workforce and  
 14 requesting a meeting with you.  
 15 **A.** Yeah.  
 16 **Q.** And if you scroll down the screen, please, can you see  
 17 the paragraph beginning "Despite the incredible work  
 18 done by GPs"?  
 19 **A.** Yeah.  
 20 **Q.** "... and their teams over the last year to care for our  
 21 patients ... do not feel supported ... This feeling is  
 22 further exacerbated by sections of the media reporting  
 23 that practices are to blame for not seeing all patients  
 24 in face-to-face consultations. Practices have been open  
 25 to their patients throughout the pandemic, and at least

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1 **Q.** Do you think, though, that in the strong support given  
 2 by you and others to virtual consultations that led to  
 3 a perception that face-to-face appointments had been  
 4 stopped?  
 5 **A.** No, I don't think that's fair at all. There were some  
 6 media reports saying we want more face-to-face  
 7 consultations and I was saying no, we want more -- there  
 8 are too many face-to-face consultations. So I wasn't  
 9 say that at all, no.  
 10 **Q.** So although you were encouraging virtual appointments,  
 11 you were not trying to discourage face-to-face or say  
 12 that there weren't any face-to-face; have I understood  
 13 you correctly?  
 14 **A.** That's right, and the worry expressed, which  
 15 I understand, in this paragraph was a worry about, as he  
 16 puts it, sections of the media who were making this  
 17 argument and I thought that the argument that GP  
 18 appointments ought to be face-to-face and there's a sort  
 19 of values-based argument I thought that was a load of  
 20 rubbish.  
 21 **Q.** I understand that you disagree with the sentiment but  
 22 people's perception might be a different matter. Did  
 23 you hear reports of people perceiving that GPs were not  
 24 open for face-to-face consultations?  
 25 **A.** Yes, of course.

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1 Q. And what do you think caused that perception, given that  
2 you acknowledge that you heard about it?  
3 A. There was a push to have more virtual consultations and  
4 that was the right thing. So there was some push-back  
5 against a change in the right direction. If you -- but  
6 this happens often when you're trying to change  
7 something. The point about this letter is I was,  
8 essentially, in agreement with where Richard was coming  
9 from.  
10 Q. All right. In the rollout or increased use of virtual  
11 consultations, can you help with what consideration was  
12 given to those that may not be able to access either  
13 a telephone or --  
14 A. Yeah.  
15 Q. Let me finish, please -- particularly perhaps those who  
16 are unfamiliar with virtual appointments, those for whom  
17 English is not their first language, those who have poor  
18 internet connectivity, and the like, what did you do to  
19 try and address those particular impacts?  
20 A. Well, the first thing I did was increase the use of  
21 non-face-to-face and virtual appointments because  
22 increasing virtual appointments frees up space for  
23 people who want face-to-face appointments. So the  
24 argument that you put I understand, has been levelled at  
25 me many times in my enthusiasm for supporting people in

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1 available to pharmacists.

2 Also, you've got to remember that pharmacists are  
3 private businesses and outside of the pandemic of course  
4 they buy their own protective equipment in the same way  
5 that most social care providers are private businesses,  
6 and before the pandemic they buy their own equipment.  
7 So the government was not the only provider of PPE in  
8 this situation.

9 Obviously for the state-owned hospital system, the  
10 core NHS, we were, although hospitals buying their own  
11 PPE without NHS England or the central government having  
12 anything to do with it is a good thing, not a bad thing  
13 in these circumstances. So there's a balance to be  
14 struck between about who the state provides for and also  
15 how, given, we, as the state, have limited access, how  
16 that is then distributed.

17 Q. So is the answer that in times of constrained supply,  
18 community pharmacists, rightly or wrongly, were deemed  
19 to be lower in the priority for people that needed  
20 access to the PPE portal?

21 A. That is accurate. Yes.

22 Q. And another aspect of pharmacy that I want to ask you  
23 about is the life assurance scheme.

24 Now, Mr Hancock, you wanted from very early on all  
25 staff to be included in the life assurance scheme --

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1 the NHS where they are and what's convenient to them,  
2 which often means virtual appointments, but it doesn't  
3 always mean virtual appointments. There are always  
4 going to be some people who need to have a face-to-face  
5 appointment either because of the nature of their  
6 medical problem or because they may never use  
7 a computer.

8 The point is that if you have a more efficient  
9 system using modern technology you free up space for  
10 more of that rather than less. I'm totally against  
11 an online-only system whilst being very enthusiastic  
12 about the availability of online.

13 Q. Sticking with primary care, can I ask you about  
14 pharmacies, please. We have heard evidence that the  
15 national PPE supply was not accessible to community  
16 pharmacists, they couldn't get FFP3 masks, they couldn't  
17 access the PPE portal until August 2020. Do you know  
18 why there was a delay in allowing community pharmacists  
19 access to that PPE portal?

20 A. They were -- it's a very good question. The -- and as  
21 you'll know from the paperwork, I pushed for them to  
22 have that access, and eventually that happened. In  
23 a world of highly-constrained PPE availability we had to  
24 be careful to ensure it got to where it was most needed  
25 and there's a hierarchy of that. But I wanted it to be

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1 A. Yes.

2 Q. -- and you made that clear in an email, I don't need to  
3 call it up, back on 11 April.

4 A. Right.

5 Q. The scheme is then rolled out on 27 April and pharmacies  
6 in a hospital or GP setting were included but those in  
7 community pharmacy certainly felt that they were  
8 excluded and Sir Christopher Wormald didn't disagree  
9 about that. If you, back on the 11th, said, "All  
10 pharmacy staff to be included", can you help with why,  
11 when the scheme was announced, they weren't or it wasn't  
12 made explicitly clear that they weren't included?

13 A. Didn't we clear that up shortly afterwards?

14 Q. Yes, you did, but that's not what I am asking. We'll  
15 come to the clear up in a moment.

16 A. If you want the -- I'm going to give you the brutally  
17 honest answer to this with some trepidation because of  
18 our earlier discussion about accountabilities, Chair.  
19 The pharmacy contract is managed by NHS England. In  
20 order to maximise taxpayer value for money, NHS England  
21 is, by tradition, really very tight on pharmacists --  
22 I am a big supporter of community pharmacy -- and there  
23 is, therefore, inbuilt into NHS England senior  
24 management a lack of enthusiasm for giving more to  
25 community pharmacists than they absolutely have to and

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1 that's borne of the fact that their main relationship is  
2 a contractual negotiation and that, I think, is probably  
3 the reason that they did it this way.

4 But I've tried to describe that in a way that  
5 doesn't -- that is an explanation rather than trying to  
6 you know ...

7 **Q.** Can I just ask you about that. I asked Sir Chris  
8 Wormald and he said that the reason they weren't  
9 initially included was because it wasn't agreed by the  
10 Treasury, nothing to do with NHS England. Were you  
11 aware that the decision -- that all pharmacies -- and it  
12 ended up only being pharmacists and GPs in hospitals was  
13 a Treasury\_related decision? It sounded like you're  
14 saying --

15 **A.** I wasn't aware of it. But I -- in the dynamic of how  
16 hard we pushed, that will have been the end -- that will  
17 have been the last thing on the list, I would have  
18 thought, from an NHS England point of view.

19 **Q.** So -- there is a disconnect, if I can put it like that,  
20 between what he told us and what you told us and what I  
21 want to ask you about is the effect on the  
22 pharmacists --

23 **A.** Yeah.

24 **Q.** -- because clearly -- you're right, within three days  
25 you'd made it clear it was to apply to all of them, but

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1 mind and the mind of the department?

2 **A.** No, you completely misunderstood my last answer. They  
3 were absolutely top of my mind. But I couldn't  
4 necessarily drive that through the system.

5 **Q.** Well, if it's a misunderstanding then it's mine. Is  
6 your evidence, Mr Hancock, that they weren't  
7 an afterthought as far as you were concerned?

8 **A.** Not as far as I was concerned, but they evidently were  
9 as far as the system was concerned because of how that  
10 announcement came out. If you take it through the  
11 evidence that we've been looking at in the last couple  
12 of minutes, I said it should be all pharmacies.

13 **Q.** You did, yes.

14 **A.** The report -- the answer -- the formal documentation  
15 came out saying it was only the NHS pharmacies. I --  
16 once I found that out I would have been -- I would have  
17 probably expressed my frustration in Anglo-Saxon terms  
18 and said, "I'm going to sort this out" and so I got on  
19 the -- the next time I was in front of the -- in public  
20 I made clear that this was going to everybody and  
21 I would have had to fix it.

22 Now, that sort of problem is meat and drink in  
23 Whitehall, it happens all the time. And you just --  
24 it's just part of the daily life of an active minister  
25 that you have to go and fix problems all the time and

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1 we've heard evidence, particularly from the National  
2 Pharmacy Association, that even three-day wait for them  
3 was demoralising, demotivating, and they think that  
4 effectively community pharmacists are being treated as  
5 an afterthought?

6 **A.** Yeah, so my impression of the system, and if there's  
7 a Treasury element to this as well then you'll see that  
8 in the paperwork -- I wasn't aware of that or at least  
9 I don't recollect it. But you're absolutely right, my  
10 sense was also that the system was not looking after  
11 community pharmacists enough. That was my feeling too.  
12 And hence I changed it as soon as I could. But it  
13 was -- that's a -- it's -- that is a classic of how  
14 decisions get put together in those situations.  
15 You know, you become Secretary of State and you think,  
16 "My God, I'm responsible for £150 billion budget" and  
17 then you find there's all sorts of constraints on what  
18 you can do because others have different views and  
19 attitudes and this is an example of that.

20 **Q.** If your impression of the system was that pharmacies  
21 were something of an afterthought and yet you're  
22 encouraging people to go to your pharmacies to pick up  
23 medication for those that are clinically vulnerable and  
24 shielding, go there rather than going to a GP for  
25 medication, why weren't pharmacists higher up in your

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1 then take accountability for the system as a whole.

2 **Q.** Can I move on to Long Covid, please. We have heard  
3 evidence that it was known at the start of the pandemic  
4 it was likely there would be long-term effects caused by  
5 the virus even if we didn't know precisely what they  
6 were, how severe they would be and how many people might  
7 contract Long Covid.

8 **A.** Yeah.

9 **Q.** Were you made aware there would be some long-term  
10 effects even if the precise nature of the effects were  
11 not known at that stage?

12 **A.** Yes, I recall discussing this with Chris Whitty  
13 in January 2020.

14 **Q.** Right, okay. And given that it was known that there  
15 would be some, what, if anything, did you decide to do  
16 to try and work out what they were, how they could be  
17 managed, how they could be treated?

18 **A.** Yeah. So, obviously, before there were any Covid cases  
19 there was nothing that you could do about this, and the  
20 only thing you could do is try to reduce the number of  
21 Covid cases, ie bringing in a lockdown.

22 By around May/June 2020, I was aware of this being  
23 a problem, not least because it affected people close to  
24 my heart. My mother still suffers from Long Covid from  
25 that first wave. So this is very -- this is close to my

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1 heart. So in around June I convened experts and the NHS  
2 and others to try to understand what we knew by then.  
3 This, of course -- June is only two months after the  
4 peak of the first wave so people's slow recovery was  
5 only just becoming evident and the -- and then there was  
6 a whole -- we established a Long Covid clinic.

7 **Q.** I'm going to come on to those. Just to help you, in  
8 fact it was in May 2020 that you asked Sir Simon Stevens  
9 to develop plans for provision of those suffering with  
10 Long Covid.

11 **A.** Right.

12 **Q.** When you said you wanted him to develop plans for  
13 providing for those suffering, what were you talking  
14 about, financial provision, medical provision, pastoral  
15 support? What were you thinking about?

16 **A.** Yes, primarily medical provision, primarily medical  
17 provision, but across the board. So if that was  
18 in May 2020, you know, this is less than four weeks  
19 after the peak. So people couldn't have presented with  
20 Long Covid, longer than four weeks after infection. And  
21 so that will have been in anticipation of there being  
22 Long Covid as a concept, if you like. And it was  
23 definitely before there was a name "Long Covid" that  
24 I was pushing to ensure we were ready to support those  
25 who got it.

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1 simple presentation. My best understanding of it is  
2 that Long Covid is often where the neurological elements  
3 of the Covid viral impact are long-standing, are more --  
4 are a bigger thing than the immediate impact which was  
5 essentially respiratory. And neurological conditions  
6 are by their nature much more difficult to research, and  
7 so it was needed to have a cohort to study to see these  
8 broad presentations of Long Covid.

9 There's another aspect as well, which is that  
10 I thought if I just said to the NHS, "Just look  
11 after" -- you know, "Make sure you look out for  
12 Long Covid", it would have just gone into the ether and  
13 nothing would have happened, whereas if you have  
14 specific Long Covid budgets with specific dedicated  
15 clinical and other staff, and a specific budget,  
16 including a research budget, then you will actually get  
17 some action that you can -- that's trackable and you can  
18 follow.

19 **Q.** So were you actually involved, then, in saying you  
20 wanted X million, or whatever it was, spent on  
21 Long Covid research and X million on Long Covid clinics?

22 **A.** So it will have come from within the NHS budget. So it  
23 will have been -- Simon will have found the budget for  
24 it, I think and -- but -- and so his decision over  
25 exactly how much to put into it. What I was doing was

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1 **Q.** We know you set up the roundtables. I don't need to ask  
2 you about those. That detail is set out in your  
3 statement, Mr Hancock. But you did identify that  
4 further research may be needed and in particular you  
5 asked for further research on those that were not  
6 hospitalised but still got Long Covid. Why did you ask  
7 for research to be done to that cohort of sufferers?

8 **A.** Because the evidence was that the severity of your first  
9 bout of Covid was not correlated with your likelihood of  
10 long-term symptoms, my mother included, she was not  
11 hospitalised and we're four years later and she still  
12 suffers the effects. And so the early research showed  
13 that there didn't appear such a correlation between  
14 severity and longevity of the Covid problems. And so  
15 just analysing the impact of Long Covid from people who  
16 are hospitalised missed a whole load of the patients.

17 **Q.** Now, you mentioned Long Covid clinics. When they were  
18 announced or launched there was initially, I think, 40  
19 clinics in November 2020, and by June, 11 June, so just  
20 before you left office, now 80 clinics were up and  
21 running. But why were Long Covid clinics decided to be  
22 the best option for England? Can you help with that?

23 **A.** The reason is that Long Covid presents in a very wide  
24 array of ways and part of the problem with the research  
25 was, unlike Covid itself, there was not a clear and

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1 driving action on the NHS side of the fence.

2 It comes back to the discussion we've had a number  
3 of times, what do you as Secretary of State if something  
4 is an NHS responsibility? The answer is, in this case,  
5 I convened a roundtable, I pushed Sir Simon Stevens and  
6 then -- but he took the action.

7 **Q.** Right, so in this example you asked for there to be  
8 greater funding for research and clinics and you said to  
9 him, over to him, and he did it. Did you monitor to  
10 ensure he had put into place that which you had  
11 envisaged?

12 **A.** Yes, there were a series of meetings and, in fact,  
13 I visited some of the Long Covid clinics.

14 **Q.** Whilst you were Secretary of State, were you aware if  
15 there was any monitoring of the number of healthcare  
16 workers who contracted Long Covid?

17 **A.** I think there was but I haven't got the evidence in  
18 front of me.

19 **Q.** No, we're not sure that there was, actually, that data  
20 in fact --

21 **A.** If there wasn't, there should have been.

22 **Q.** Well, that's why I was going to ask.

23 **A.** Yeah.

24 **Q.** Why do you say there should have been that data  
25 collected?

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1 A. Because you'd want to know what the impact is on the NHS  
2 workforce.

3 Q. By the time you left office, do you know whether that  
4 data had been collected?

5 A. I don't know.

6 Q. Would you suggest that should be a matter for  
7 NHS England, or it should be collected --

8 A. Yeah, it's their workforce.

9 Q. All right. Does it follow from what you've said, then,  
10 that whilst you were Secretary of State you weren't able  
11 to assess the extent of absence in the health and social  
12 care system that was caused by Long Covid?

13 A. No, that would have been matter for the Chief People  
14 Officer of the NHS, Prerana Issar, who was absolutely  
15 brilliant and I do recall talking to her about this  
16 subject.

17 The other thing to say in this space is not only  
18 did I follow up with the NHS but I also received  
19 submissions from the various Long Covid support groups  
20 who felt that not enough was being done. So I knew that  
21 there was a sense that not enough was being done and  
22 I was pushing the NHS to do more, and they did do more,  
23 and opened more clinics and did the research.

24 Q. Finally this please, recommendations.  
25 If you had to give a recommendation to

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1 not been repeated since. So we should learn from them.

2 And then I suppose the third is the ability to  
3 surge. You know, we put together an ability to surge in  
4 realtime but a more considered structured plan to be  
5 able to surge NHS capacity would be valuable. You know,  
6 if there were, God forbid, a pandemic to hit tomorrow,  
7 of course we'd be able to do it better because the  
8 people involved would be able to use the learnings from  
9 last time. But if we can find ways to make that more  
10 thought through and programmatic, if you like, then that  
11 would be a good thing.

12 MS CAREY: Mr Hancock, thank you, that's all the questions  
13 I ask.

14 My Lady, there may be some time for some --

15 LADY HALLETT: Thank you, certainly, and I gather,  
16 Mr Thomas, you'd quite like to get some questions in  
17 this afternoon. And you're not attending remotely  
18 unless you are a hologram, are you!

19 Questions from PROFESSOR THOMAS KC

20 PROFESSOR THOMAS: Good afternoon, Mr Hancock.

21 Just to remind you, we've met before, I represent  
22 FEMHO, the Federation of Ethnic Minority Healthcare  
23 Organisations.

24 My Lady, just so that you can follow my  
25 questioning, I'm actually going to start with my sixth

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1 her Ladyship as to how to improve the healthcare system  
2 that is not related to lockdown, Mr Hancock, what would  
3 your recommendation be?

4 A. Well, I think in normal times having the NHS run at less  
5 than 100% capacity will increase the resilience of  
6 the -- in the NHS.

7 Q. Can I pause you there. That's a political decision as  
8 to how to fund the NHS and how they choose to run at  
9 capacity and it might be outwith her Ladyship's remit to  
10 say we should have 10,000 more beds or whatever it be.

11 A. Most of these decisions are essentially political  
12 decisions -- deciding to lock down is a political  
13 decision -- in the finest sense that politics is how we  
14 make decisions in this country at the highest level.  
15 The Inquiry is surely able to make any recommendations  
16 it should choose.

17 The second thing is about use of data. My view is  
18 that the NHS will only survive if it gets better at the  
19 use of data, and in a pandemic that's even more  
20 important. For the three -- in the three areas that  
21 I suggested and indeed research, a fourth. And I would  
22 hope there would be recommendations on that because we  
23 did, in the -- we do have this example of the COPI  
24 notices and, within the NHS, the vaccine rollout as  
25 well, as high, high quality data improvements that have

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1 question, because that piggybacks on some of the  
2 questions --

3 LADY HALLETT: Thank you.

4 PROFESSOR THOMAS: -- and I'll revert back to the order.

5 Can I just correct you, Mr Hancock, on something  
6 you said earlier. I think it's my duty to do so.

7 You said in your evidence that the first four  
8 doctors who died were doctors of colour. It was ten.  
9 It was the first ten doctors. And it's important that  
10 I correct you on that. Do you accept that?

11 A. I accept -- I'm sure that you have the evidence for  
12 that. The first four -- it was -- my point, I suppose,  
13 is an even stronger one, which is that when I saw that  
14 the first four were, I knew that there was -- we had  
15 a major problem.

16 Q. Yes. And then six follows, the next six were black and  
17 brown. Okay.

18 When we met during Module 2, we were in fact in  
19 agreement about, to use your words, the long-standing  
20 issue of racism within the NHS, which you told us was  
21 an issue that you were heavily involved in and one that  
22 you'd been concerned about well before the pandemic and  
23 you have just been speaking to Ms Carey about the speech  
24 that you gave and so on.

25 Can I ask you this. In the light of the evidence

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1 to this module from impact witnesses and experts, and of  
2 your own concern about racism within the NHS prior to  
3 the pandemic, I'm sure we can agree on this, that  
4 structural racism is likely to have been a contributing  
5 factor to the disproportionate impact on ethnic minority  
6 workers and patients. Can we agree on that?

7 **A.** Yes, we can. Yes.

8 **Q.** Mr Hancock, if that is right though, then the assertion  
9 you made earlier to Ms Carey, and I'm summarising here  
10 so forgive me because it's a summary of what you were  
11 saying, effectively that by working and trying to lock  
12 down to prevent the spread, so, you know, not  
13 specifically targeting but going for the whole, treating  
14 everyone as one mass unit, irrespective of race, that  
15 fails to address, does it not, the systemic nature of  
16 the problem? Because systemic racism operates through  
17 institutional structures, policies and practices that  
18 perpetrate unequal outcomes for minority groups.

19 Would you not agree with that?

20 **A.** I would agree with the thrust of it, but I'd say that  
21 the solution to that is to treat everybody as  
22 an individual. The solution to that is not to segregate  
23 society into communities, it is -- but it is to address  
24 precisely those -- the barriers that you talk about.

25 **Q.** But, Mr Hancock, just if I may just push back slightly  
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1 risk assessment. You approved the dilution of critical  
2 care staff ratios to manage Covid-19 patients.  
3 Question, were you aware of or seek reassurance from  
4 Simon Stevens on whether specific risk assessments were  
5 to be conducted to evaluate the impact of this decision  
6 on the safety and well-being of healthcare workers from  
7 black, Asian and minority ethnic communities who were  
8 overrepresented, proportionately, in frontline workers?

9 **A.** Well, I think it would have been impossible accurately  
10 to make that sort of assessment for two reasons. The  
11 first is, at that stage in the pandemic we didn't know  
12 what the impact was going to be, because it was  
13 a completely novel virus. And the second reason is that  
14 we had to make these decision incredibly quickly, and to  
15 hold up a decision whilst doing a full risk assessment  
16 would have led to, in my assessment, much worse outcomes  
17 overall.

18 **Q.** Mr Hancock, in hindsight would you recommend additional  
19 safeguards and measures to ensure that such decisions  
20 did not disproportionately impact black, Asian and  
21 minority ethnic healthcare workers in the future?

22 **A.** I would recommend that the disproportionate impact is  
23 taken into account in making those sorts of decisions  
24 according to what is likely to save most lives.

25 **Q.** Would you agree with this, that periodic targeted  
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1 on what you've said, respectfully.

2 You see, addressing these disparities requires  
3 tailored, equity-focused measures not a colour blind  
4 approach that ignores underlying structural barriers.  
5 Take, for example, the example that you gave earlier  
6 which, with respect, oversimplifies the problem. You  
7 will agree with this, surely, that eye colour has no  
8 historical, social or systemic impact on a person's  
9 opportunities. You will agree with that?

10 **A.** Yes.

11 **Q.** But race and colour does. Race and colour is well  
12 documented to influence people's experience and lived  
13 experience. So you can't compare the two.

14 **A.** No. Absolutely not. But I do want to live in a world  
15 where I could. And that's the point. And in fact in  
16 your -- in the earlier part of your statement just then,  
17 you said you can't be colour blind not taking into  
18 account the barriers that people face. In fact my  
19 answer was we need to remove those barriers. So I feel  
20 very strongly about this, in agreement to -- with the  
21 essence of what you're saying.

22 **Q.** All right. I'll come back on to the questions and let  
23 me see if I can get through these questions as quickly  
24 as I can.

25 I want to turn to the question of staff ratios and  
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1 reviews of frontline staff, feedback, would have been  
2 an additional safeguard and something to consider going  
3 forward?

4 **A.** Yes, and I tried to put that in place before the  
5 pandemic. In fact it was one of the things that I was  
6 working on after the speech that I mentioned in 2019.  
7 I think that's very important.

8 I mean, after all, break -- you know, breaking  
9 down the barriers that you talk about is not -- it's not  
10 a glib thing, there's a whole series of policy that need  
11 to be put in place to make that happen.

12 **Q.** Before deciding to stretch staff ratios in critical care  
13 settings, did you consult with the Chief Nursing Officer  
14 or any other senior medical advisers or NHS England  
15 about the impact and potential strain on NHS workers,  
16 what that strain would be?

17 **A.** Absolutely, yes. It was front of mind.

18 **Q.** I want to turn now to PPE.

19 In your witness statement you acknowledge  
20 challenges in the supply of PPE. Chris Wormald gave  
21 evidence to this Inquiry in Module 1 admitting that the  
22 department had stopped PPE that would be suitable for  
23 ethnic minority healthcare workers in smaller  
24 quantities. Were you aware of this?

25 **A.** I became aware of it. I wasn't aware of it at the  
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1 start.

2 **Q.** When did it come to your attention and what if any  
3 action did you take?

4 **A.** I'm not exactly sure. It will have been some time in  
5 the first half of 2020. And the action that I took was  
6 to require that the PPE we were buying was the right PPE  
7 for the workforce that we had in the NHS, which is  
8 disproportionately from an ethnic minority background.

9 **Q.** Were you aware that healthcare workers from black, Asian  
10 and minority ethnic backgrounds faced additional  
11 challenges sourcing and being provided with adequate and  
12 appropriate PPE?

13 **A.** Yes. And in fact I went to a fit test where the nurse  
14 doing the fit test was from -- was black and I could  
15 see -- physically see for myself the challenges of  
16 mask fitting. She was doing a fit test for me.

17 **Q.** Tell me this, when did you become aware of this, when  
18 did it become apparent?

19 **A.** Again, in the first half of 2020. I can't remember  
20 an exact date.

21 **Q.** What steps did you take to ensure that healthcare  
22 workers, particularly those from minority backgrounds,  
23 received adequate and high quality PPE in a timely  
24 manner?

25 **A.** Well, I gave the instruction to start buying PPE in  
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1 **Q.** Let me move on. To what extent was PPE availability  
2 monitored with specific attention to black, Asian and  
3 minority ethnic healthcare workers?

4 **A.** Well, I'm not sure it was monitored enough at the start,  
5 and that monitoring got better over time. And one of  
6 the key lessons is we need to make sure that the PPE  
7 that is stockpiled and then bought in any future  
8 pandemic fits the workforce that we have.

9 **Q.** I think we can agree on the next question, but let me  
10 put it to you in any event. We can agree that black,  
11 Asian and minority ethnic healthcare workers were more  
12 likely to be on the front line in patient-facing roles,  
13 and were disproportionately affected by a lack of  
14 suitable PPE; can we agree on that?

15 **A.** We can certainly agree on the first half of it. And  
16 there's excellent evidence from, for instance,  
17 Ben Goldacre, who did very good statistical work on  
18 this, but I also -- I also saw it for myself. I was  
19 a big champion of the workforce of the NHS and, in  
20 particular, those from ethnic minority backgrounds and  
21 also those from whatever ethnic background who'd come to  
22 the UK in order to serve in the NHS, yes.

23 **Q.** Would you also agree that there was a lack of adequate  
24 consideration for variation of facial features between  
25 ethnicities?

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1 January 2020. So it was something that I was aware of  
2 and acting on from before -- well before the pandemic  
3 hit the UK.

4 **Q.** So what happened then? Why didn't -- why were there  
5 still problems in the pipeline?

6 **A.** Well, how long have you got? I mean, there's the  
7 problems of the fact that we had a stockpile that  
8 couldn't easily be picked. The fact that the demand for  
9 PPE shot up both in the UK, when we brought in the IPC  
10 measures, but then also globally, because this was  
11 a global pandemic, buying PPE became more difficult.  
12 Even with a -- even if we'd had a stockpile twice the  
13 size, that still would have been less than 10% of what  
14 we needed over the entire pandemic.

15 So, you know, there's a whole -- there's a huge  
16 amount of detail on what I did to procure the PPE, as  
17 much PPE as we could get our hands on. And, you know,  
18 I'm -- the department's criticised for buying too much  
19 PPE, for buying too little PPE, to buying too much PPE  
20 too expensively. What we were trying to do was save  
21 as many lives as possible.

22 **Q.** Well, I think, in fairness, it was also criticised for  
23 buying the wrong PPE?

24 **A.** Absolutely. And the stockpiling having the wrong PPE in  
25 it. So all these things.

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1 **A.** Yes.

2 **Q.** And this standardised PPE was not providing -- well,  
3 I think you've already touched upon it.

4 **A.** Yes, yes, yes. Yes, I strongly agree with you.

5 **Q.** To whom and/or to which bodies would you attribute the  
6 responsibility for the lack of suitable PPE available  
7 for minority workers?

8 **A.** Well, the stockpile was managed by PHE. But they  
9 reported into the department.

10 **Q.** Let me come to my final question. And I want to be  
11 forward facing and look to lessons for the future. In  
12 the light of your firsthand experience and engagement  
13 with healthcare workers during the pandemic, what do you  
14 think can and should be done to reduce inequalities for  
15 black, Asian and minority ethnic healthcare workers in  
16 the event of a future pandemic?

17 **A.** There's so many things that need to be done.  
18 I think that the HR systems of the NHS need to be  
19 colour blind, for instance making sure that when people  
20 go for promotion that that is done on entirely on merit.  
21 I think there are practical things that can be done,  
22 like the PPE that we've talked about but including extra  
23 support, mentoring for members -- for members of the  
24 team from an ethnic minority background. But bigger  
25 than all of those things is a culture and a culture

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1 change. Because people love the NHS, and I love the  
2 NHS, we are cautious about criticising it, but this is  
3 an issue that need to be resolved within the NHS because  
4 the NHS couldn't exist without its ethnic minority  
5 workforce and doesn't do enough to support them.

6 **Q.** Can I just touch on one thing you said there, and I'm  
7 going to come back to the colour blind. Same point, you  
8 can't have a colour blind system where you have  
9 structural barriers; would you agree?

10 **A.** Yes, you've got to -- but the answer to that is to break  
11 down the barriers. That's my --

12 **Q.** So that comes first. That has to come first before you  
13 can have a colour blind system?

14 **A.** Exactly.

15 **PROFESSOR THOMAS:** My Lady, I think I'm within time.

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

17 Thank you, Mr Thomas.

18 Mr Jory, do you want to get your questions in  
19 tonight?

#### 20 Questions from MR JORY KC

21 **MR JORY:** Good afternoon, Mr Hancock, I ask questions on  
22 behalf of the Independent Ambulance Association.

23 It appears that neither the independent ambulance  
24 sector nor the College of Paramedics were consulted  
25 regarding Covid measures prior to their imposition in  
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1 **A.** Well, yes, of course the sector should be consulted.  
2 I would challenge -- even though I have my criticisms of  
3 how some things worked within the health system, I would  
4 challenge the question that practitioners were not  
5 involved in the design of much of the guidance.  
6 I think -- I'm not sure that's right. I can't answer  
7 for whether any one individual organisation was  
8 consulted for guidance that I wasn't involved in but,  
9 generally, there's a vital need to consult people on the  
10 ground, both through organisations and directly.

11 But in the case of a pandemic, often you have to  
12 bring things in much, much quicker than you would  
13 normally. So instead of a typical, you know,  
14 three-month consultation period you might convene  
15 an immediate roundtable on -- virtually, and then try to  
16 make a decision based on immediate feedback.

17 So, of course, there were -- there have to be  
18 accelerations of normal procedures and I'm very sorry  
19 I didn't reply to the letter but 20 March 2020 was in  
20 the middle of when we were bringing in lockdown so  
21 I would have been exceptionally busy.

22 **Q.** As we said, there was no criticism attached to that, but  
23 thank you very much.

24 **A.** Thank you.

25 **MR JORY:** My Lady, thank you.  
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1 early 2020. The College of Paramedics sought guidance  
2 in a letter they wrote directly to you on 20 March 2020.

3 I've got the reference for that but we don't need  
4 to perhaps look at it.

5 There was no specific response from you or your  
6 department but can I make clear, she and we attach no  
7 criticism given the circumstances at the time, but when  
8 the college did receive guidance from Public Health  
9 England this did not seem to take into account the  
10 unique challenges of working in an ambulance.

11 Now, I summarise, but I hope fairly what appears  
12 to be your general view expressed here to Counsel to the  
13 Inquiry, Ms Carey, this morning, that guidance was often  
14 created by politicians and administrators when perhaps  
15 there should have been more thought given to  
16 practitioners and clinicians.

17 So my question is this. In seeking to formulate  
18 practical measures and guidance for any future pandemic  
19 and insofar as it affects the ambulance service, would  
20 you agree that it is essential that the ambulance  
21 sector, ie those actually working at the coalface, and  
22 including the independent ambulance workers and  
23 paramedics who contributed so much in supporting the NHS  
24 during the pandemic, that they be consulted in  
25 formulating such measures and guidance?  
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1 **LADY HALLETT:** Thank you, Mr Jory, very grateful.

2 I think we'll just see if we can slip in  
3 Ms Morris.

#### 4 Questions from MS MORRIS KC

5 **MS MORRIS:** I ask questions on behalf of the Royal College  
6 of Nursing. A question about data. The rates of  
7 infection, self-isolation and death amongst health and  
8 care staff would have been key indicators of the  
9 effectiveness of the government's approach to those  
10 workers and their working conditions and therefore  
11 systematic collection of data on those matters was  
12 required. You are nodding, agreeing with me?

13 **A.** Yes.

14 **Q.** So what did you do to ensure that the government had  
15 data as to the impact of the pandemic on health and  
16 social care workers?

17 **A.** So I required the collection of that data and  
18 I publicised it. It wasn't there at the start and  
19 I made that happen. I totally agree with your question.

20 **Q.** When did you make sure it was collected?

21 **A.** It was April 2020 when the number of -- when the first  
22 significant number of deaths were starting to happen.

23 **Q.** And as to infection rates?

24 **A.** And the infection rates, of course, depended on the  
25 availability of tests, and so in the early days before  
200

1 I expanded the testing capacity very significantly, it  
 2 was -- measurement of infection rates amongst hospital  
 3 staff was much harder. But as soon as we had the tests  
 4 to do it, which was probably May 2020, we got on and did  
 5 that. But as I said, it was actually very hard to drive  
 6 the increase in testing across the NHS.  
 7 **Q.** And something that didn't require testing, measurement  
 8 of self-isolation rates. When did you introduce that  
 9 collection of data?  
 10 **A.** I don't recall the exact -- an exact date but obviously  
 11 that is also very important.  
 12 **LADY HALLETT:** Thank you, Ms Morris.  
 13 Unless there is anybody who is desperate to get  
 14 away, I think Mr Hancock has had quite a long day. Just  
 15 check there is nobody who has got 3 or 5 minutes that  
 16 they want to get in tonight.  
 17 **THE WITNESS:** I'm here as long as you like, Chair.  
 18 **LADY HALLETT:** I know, but it's been a long day. I'm afraid  
 19 we have to come back tomorrow. Too many people wish to  
 20 ask you questions, and so we have an hour and a half,  
 21 a couple of hours left I'm afraid.  
 22 So, 10 o'clock tomorrow please.  
 23 **(4.02 pm)**  
 24 **(The hearing adjourned until 10.00 am,**  
 25 **on Friday, 22 November 2024)**  
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[4] 39/7 90/16 91/7 94/2 <b>30 January 2020</b> [1] 115/1 <b>30 March</b> [2] 64/11 73/6 <b>30,000</b> [1] 100/12 <b>30,000 cases</b> [1] 132/14 <b>31 seconds</b> [1] 91/12 <b>33</b> [1] 132/16 <b>357</b> [1] 158/17 <b>358-plus</b> [1] 83/5	<b>4</b> <b>4 degrees</b> [1] 160/7 <b>4,300</b> [1] 87/20 <b>4,519</b> [1] 104/15 <b>4.02 pm</b> [1] 201/23 <b>40</b> [2] 94/8 182/18 <b>429</b> [1] 41/15 <b>46</b> [2] 75/16 75/23 <b>474 deaths</b> [1] 158/15 <b>48 hours</b> [2] 89/10 92/11	<b>5</b> <b>5 June 2020</b> [1] 141/18 <b>5 minutes</b> [1] 201/15 <b>50</b> [1] 8/4 <b>58</b> [1] 46/11 <b>59</b> [1] 41/17	<b>6</b> <b>6 months</b> [1] 163/5 <b>6,000</b> [1] 132/21 <b>6.1</b> [1] 34/8 <b>6.4</b> [1] 34/21 <b>60</b> [1] 90/17 <b>60 seconds</b> [1] 90/15 <b>60,000</b> [1] 125/3 <b>61</b> [1] 75/9 <b>62</b> [1] 75/18 <b>65s</b> [1] 152/9 <b>67</b> [1] 41/9 <b>68</b> [1] 71/23 <b>6am</b> [1] 100/4	<b>7</b> <b>7 hours</b> [1] 124/8 <b>7,000</b> [1] 87/17 <b>7,300</b> [1] 87/18 <b>75</b> [2] 132/17 132/24 <b>75 years</b> [1] 6/8 <b>78</b> [1] 87/17	<b>8</b> <b>8 months</b> [1] 116/18 <b>8,500</b> [1] 132/19 <b>80</b> [1] 182/20	<b>9</b> <b>9 am</b> [1] 98/3 <b>9 April</b> [1] 120/1 <b>9 July 2018</b> [1] 1/15 <b>9,854</b> [1] 132/16 <b>90</b> [1] 153/14 <b>999</b> [5] 90/8 99/19 100/3 100/9 105/14 <b>999 system</b> [1] 100/15	<b>A</b> <b>A4</b> [1] 163/21 <b>abandon</b> [1] 91/11 <b>abandoned</b> [6] 90/16 90/22 91/4 91/7 91/15 91/20 <b>abandoning</b> [1] 90/24 <b>ability</b> [14] 6/6 24/20 25/17 34/18 40/1 68/11 98/13 116/23 136/8 145/7 164/22 166/11 187/2 187/3 <b>able</b> [22] 2/16 5/24 26/6 29/10 40/24 67/11 75/19 93/14 101/20 115/20 130/18 131/17 137/21 142/22 166/13 166/24 173/12 185/10 186/15 187/5 187/7 187/8 <b>about</b> [205] <b>about April 2020</b> [1] 143/6 <b>about hours</b> [1] 124/11 <b>about it</b> [1] 151/25 <b>absence</b> [5] 41/19 57/14 118/2 165/10 185/11 <b>absolute</b> [1] 161/12 <b>absolutely</b> [49] 15/7 18/23 22/20 23/16 23/23 25/4 26/25 30/16 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<p><b>W</b></p> <p><b>would... [97]</b> 82/25 83/3 85/18 89/7 89/21 91/6 91/15 95/10 95/15 95/17 95/17 100/3 102/7 108/16 109/14 109/19 110/22 111/15 112/4 113/9 113/18 114/16 114/20 115/20 115/25 116/3 116/8 116/10 116/12 118/10 118/24 118/25 119/3 126/10 126/11 127/2 134/18 134/24 134/24 140/21 140/23 141/6 147/21 149/12 153/22 154/7 155/20 156/16 156/19 156/19 156/22 157/7 159/13 159/24 160/6 161/13 165/19 167/21 169/7 177/17 179/16 179/16 179/21 180/4 180/6 180/9 180/15 183/12 183/13 185/6 185/13 186/2 186/21 186/22 187/5 187/8 187/11 189/19 189/20 191/9 191/16 191/18 191/22 191/25 192/1 192/16 192/22 194/13 195/23 196/5 197/9 198/19 199/2 199/3 199/12 199/21 200/8</p> <p><b>would've [1]</b> 138/17 <b>wouldn't [11]</b> 5/24 16/20 25/5 52/12 92/12 98/7 112/15 113/6 118/16 142/22 160/25</p> <p><b>write [4]</b> 62/4 65/14 66/14 165/19</p> <p><b>writing [2]</b> 66/2 72/11 <b>wrong [8]</b> 4/21 62/22 66/6 106/19 129/22 140/8 194/23 194/24</p> <p><b>wrongly [2]</b> 45/17 175/18</p> <p><b>wrongness [1]</b> 9/23 <b>wrote [7]</b> 134/6 157/17 163/21 164/25 170/8 170/12 198/2</p>	<p>47/24 48/3 50/25 55/18 55/21 56/22 56/25 62/18 63/19 64/9 67/22 68/15 69/1 69/8 69/21 70/8 70/16 70/17 71/7 71/7 73/5 73/9 73/12 73/20 74/2 75/12 76/15 77/18 78/18 79/16 80/20 80/22 81/1 81/6 82/10 82/11 82/17 83/23 84/22 87/10 87/16 87/25 88/19 88/22 91/24 92/1 92/22 98/22 102/9 106/10 110/25 111/20 114/24 117/23 118/1 119/2 123/21 124/5 129/5 130/24 130/25 132/11 133/5 133/8 136/20 136/23 137/16 137/18 138/13 141/9 144/18 151/21 157/11 162/24 170/15 170/19 173/14 177/23 178/6 180/8 180/18 184/23 185/8</p> <p><b>year [7]</b> 10/20 10/21 10/22 147/23 149/3 166/5 170/20</p> <p><b>years [4]</b> 5/17 6/8 83/2 182/11</p> <p><b>yes [179]</b> 1/13 1/23 3/5 5/10 5/13 5/18 5/21 7/12 10/24 11/3 11/5 13/13 15/7 18/7 18/12 19/2 20/13 21/12 22/6 22/20 23/18 24/4 25/19 26/8 29/17 29/17 30/18 31/17 31/19 33/4 33/14 35/1 35/3 35/5 38/12 42/4 43/3 43/3 43/3 44/1 44/23 45/15 46/14 47/23 48/14 48/16 52/8 53/8 55/5 56/15 58/15 58/20 59/1 60/11 62/12 63/4 63/13 68/20 71/25 73/23 76/17 77/21 78/11 79/3 80/10 80/23 82/23 82/24 83/14 83/19 83/20 84/15 90/10 91/17 91/21 93/16 95/5 96/5 98/2 100/17 101/2 101/10 102/6 102/9 104/2 104/9 106/14 106/20 109/5 109/8 110/1 110/6 110/15 112/21 114/3 115/5 115/13 116/20 117/14 117/20 118/6 118/14 122/8 122/15 122/25 123/19 124/10 124/22</p>	<p>125/5 125/22 126/18 126/23 131/18 132/7 133/12 133/15 136/20 137/5 137/8 138/9 139/6 139/14 139/16 141/14 141/14 142/16 143/5 143/18 144/10 145/1 147/2 147/4 147/14 147/15 147/18 148/14 148/16 148/19 148/25 154/17 157/5 159/8 161/25 162/11 162/25 164/3 165/14 165/18 166/1 166/1 167/7 167/15 169/22 170/11 171/5 172/25 175/21 176/1 176/14 179/13 180/12 181/16 184/12 188/16 189/7 189/7 190/10 192/4 192/17 193/13 195/22 196/1 196/4 196/4 196/4 196/4 197/10 199/1 200/13</p> <p><b>yet [3]</b> 75/16 114/11 178/21</p> <p><b>you [892]</b> <b>you did [1]</b> 29/16 <b>you have made [1]</b> 1/12 <b>you know [26]</b> 8/5 8/22 11/20 15/22 22/3 23/15 27/10 31/21 33/24 56/23 60/23 61/2 62/19 85/2 121/22 129/18 130/19 136/3 151/6 158/7 161/21 171/24 177/6 178/15 181/18 199/13</p> <p><b>you wanted [7]</b> 14/18 14/19 69/22 88/16 143/14 175/24 181/12</p> <p><b>you'd [13]</b> 32/6 79/18 98/8 98/12 157/19 160/16 160/19 169/7 169/8 177/25 185/1 187/16 188/22</p> <p><b>you'd want [1]</b> 185/1 <b>you'll [7]</b> 10/7 74/18 74/25 76/7 98/25 174/21 178/7</p> <p><b>you're [34]</b> 21/25 23/17 28/9 38/5 40/15 45/13 52/10 53/19 53/22 75/18 76/12 76/16 76/18 77/4 81/25 82/1 83/1 86/19 93/9 96/18 97/19 113/5 113/16 125/2 136/24 154/15 162/20 173/6 177/13 177/24 178/9 178/21 187/17 190/21</p> <p><b>you've [23]</b> 1/14</p>	<p>10/14 22/22 34/5 38/23 50/14 62/11 82/21 83/25 98/1 102/23 105/17 129/1 136/21 139/1 142/1 157/22 157/23 175/2 185/9 190/1 196/3 197/10</p> <p><b>you: [1]</b> 109/15 <b>you: in [1]</b> 109/15 <b>your [113]</b> 1/8 1/10 2/20 7/5 9/24 10/6 10/14 10/22 11/6 11/7 11/7 11/8 11/10 11/11 11/16 13/12 13/21 15/13 17/1 18/3 18/9 22/13 22/18 23/9 24/5 24/23 25/12 28/25 37/15 38/5 39/9 43/6 47/20 48/17 48/21 49/6 53/3 53/3 53/17 53/18 57/20 61/25 62/20 67/6 67/22 70/18 72/7 76/19 78/25 79/16 82/4 83/21 85/16 86/20 87/11 87/14 88/1 92/17 96/11 97/21 107/25 108/3 108/10 114/25 117/17 118/3 119/10 122/3 123/14 129/2 131/8 131/8 131/19 137/19 140/13 140/20 142/5 144/4 144/14 144/14 144/17 151/4 151/9 152/16 153/10 157/2 161/9 162/1 162/7 163/7 165/24 167/10 169/4 178/20 178/22 178/25 179/6 182/2 182/8 182/9 186/3 188/7 188/19 189/2 190/16 190/16 192/19 193/2 196/12 197/18 198/5 198/12 200/19</p> <p><b>yourself [5]</b> 32/3 32/12 33/2 98/13 106/23</p>	<p><b>Z</b></p> <p><b>Zahawi [1]</b> 155/13 <b>Zoom [2]</b> 11/24 11/25</p>
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