

Friday, 17 January 2025

LORD ALOK SHARMA (sworn)

(10.00 am)

Statement by THE CHAIR

LADY HALLETT: Good morning. Before we -- forgive me, Lord Sharma, I just have a few words to say. Before we resume our evidence for Module 4, I wanted briefly to mention Module 1. On 18 July 2024, I published my first report for Module 1 which examined the United Kingdom's resilience and preparedness for the Covid-19 pandemic.

In the report, I set out a series of findings and recommendations which were put to the four governments of the United Kingdom: the United Kingdom Government itself, and the three devolved administrations.

I set a deadline of six months for them to respond from the date of the report's application. Yesterday, all four governments met my deadline and their responses have been published on the Inquiry's website. I will be carefully considering all of their responses in the coming days.

Thank you.

MR KEITH: Thank you, my Lady.

Could the first witness today, Lord Sharma, be sworn, please.

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quite so well.

So we're going to focus on a handful of discrete points which came within your reach in that department.

Was BEIS, as it was then known, I think it's now DSIT, the Department for Science, Innovation and Technology, responsible in part for industrial strategy, and that included science, research, innovation and the like?

A. Yes, it did.

Q. And so was your department the department that was most closely involved in the issue of research funding?

A. Yes, absolutely. So BEIS basically was the department under which UKRI sat, along with a number of other bodies. So yes, indeed, we were.

Q. I'm going to assist everybody by saying, by just observing that UKRI, is that UK Research and Innovation?

A. Yes, indeed.

Q. We must try to steer away as much as we can from acronyms.

The UK Research and Innovation, was that a non-departmental public body but which happened to be sponsored by your department?

A. Yes, indeed.

Q. I think it was launched in April 2018, so it had been in place for a while prior to the pandemic. Was it then,

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Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 4

MR KEITH: Could you commence your evidence, please, by giving us your full name.

A. Yes, my name is Alok Kumar Sharma.

Q. Thank you very much, Lord Sharma, for attending today and for assisting the Inquiry, in part through the provision of your witness statement dated 15 November 2024, INQ000474590, the truth of which you have declared to through your signature.

Lord Sharma, you were the Secretary of State for Business, Energy and Industrial Strategy in the department, the acronym for which is B-E-I-S, but I think is commonly pronounced BEIS, or was pronounced BEIS, between 13 February 2020 and 8 January 2021, a month or so after the commencement of the vaccine rollout programme.

Lord Sharma, it may help if I simply observe that the focus of this module is not to recreate forensically what happened throughout those terrible days within your department, or to recreate the processes and the systems which were deployed to deal with the vaccination and therapeutic programmes. We're focusing on learning lessons from what went well, so they can be embedded in the future, and also trying to identify what didn't go

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it may still be, the UK's largest public research funder, so not just health and social care, but across a vast range of research and development?

A. Yes, I believe so, and clearly the budgets that went for UKRI, UK Research and Innovation, came through the Department for Business.

Q. And the budget was to be measured, was measured, in the billions?

A. Yes.

Q. There are many references in the paperwork to the valuable work done by the seven disciplinary research councils in the United Kingdom, in particular the Medical Research Council -- there's another research council called Research England -- do they fall within that framework coordinated by the UK Research and Innovation body?

A. I mean, I don't know the current sort of set-up but certainly funding flowed from UKRI directly to some of the councils.

Q. There was another funding body, the National Institute for Health Research, now called the National Institute for Health and Care Research. It was traditionally headed by the chief scientific adviser, I think, in the DHSC, who was of course, then, Professor Sir Chris Whitty.

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- 1 **A.** Mm.
- 2 **Q.** Not, I should say, the Government Chief Scientific
3 Adviser, who was, of course, famously,
4 Sir Patrick Vallance, as he then was. And I think the
5 chief scientific adviser in the DHSC now is
6 Professor Lucy Chappell.
- 7 But that's another funding body which focuses,
8 does it not, on health and social care specifically.
9 Was the funding that it provided, however, something
10 that your department had a close eye on as well?
- 11 **A.** It isn't something that I was particularly focused on,
12 but obviously we had the Office for Life Sciences at the
13 time, which was a -- joint oversight from both the
14 Department for Health and the Department for Business,
15 so I suspect within the department there would have been
16 awareness of what was being done.
- 17 **Q.** Is that body one of the largest government funders of
18 medical public health and care research in Europe?
- 19 **A.** Yes, I believe so.
- 20 **Q.** Importantly was that body an integral part of the
21 research and funding that took place in the run-up to
22 the pandemic for the research that was going on at
23 Oxford University under Dame Sarah Gilbert's team which
24 of course led to the as centre vector --
- 25 **A.** Yes.

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- 1 in scientific research and support.
- 2 **Q.** And did your department also have overview of the Office
3 for Life Sciences, which is a government body which
4 promotes innovation, research and technology for work in
5 the health and social care sectors?
- 6 **A.** Jointly within the Department of Health.
- 7 **Q.** Thank you very much.
- 8 Now, it is very well known, of course, that within
9 your department there was instituted the Vaccine
10 Taskforce, the VTF. The position appears to have been
11 this, that in late March 2020 the chief executive of the
12 Bioindustry Association asked Sir Patrick Vallance
13 whether a taskforce could be instituted connected to
14 central government and out of that came Sir Patrick
15 Vallance's idea, and he must be permitted to take credit
16 for this, of course, the idea of a governmental vaccine
17 taskforce, and was that something that you were formally
18 approached about in March 2020 and which you approved on
19 the same day?
- 20 **A.** Yes, I was approached on 26 March by Sir Patrick and
21 also Sir Mark Walport and the same day I wrote to them
22 setting out my support and my department's support for
23 the VTF.
- 24 **Q.** So in very significant terms your department was the
25 father and mother of the Vaccine Taskforce, and was its

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- 1 **Q.** -- vaccine, and also, research that was going on at
2 Imperial College under Robin Shattock?
- 3 **A.** Yes, indeed, and in fact there was an initial, I think,
4 £30 million fund, Covid fund, which was made available,
5 which ultimately stood under the Department of Health in
6 terms of being able to deploy to support research into
7 Covid treatments.
- 8 **Q.** And it's important also to recognise the work done by
9 what's known as the UK Vaccine Network. I think that is
10 particularly concerned with the development of vaccines
11 and vaccine technology for infectious disease in low and
12 middle income countries, but it did also provide
13 significant funding for research and development
14 projects pre and during the pandemic?
- 15 **A.** I'm not aware of precisely what level of funding that
16 provided.
- 17 **Q.** All right. Well, you can take it from me it also funded
18 Oxford University's adenoviral vaccine research and
19 development funding -- vaccine work in 2019.
- 20 Could you also very briefly please tell us about
21 GO-Science. What is GO-Science and was that another
22 area for which your department had at least indirect
23 responsibility?
- 24 **A.** Yes, it did have responsibility for that and GO-Science
25 was obviously the Office for Science, which was involved

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- 1 creation driven particularly, in fact, by a member of
2 your department, Alexandra or Alex Jones who was the
3 director of science, research and innovation?
- 4 **A.** Yes, I mean, she played a key role.
- 5 **Q.** Thank you.
- 6 Can we just, please, have up INQ000478917.
- 7 We can see your letter to Sir Patrick Vallance, who
8 was, as I've said, the Government Chief Scientific
9 Adviser, and Sir Mark Walport, former Government Chief
10 Scientific Adviser in fact, but who also happened to be
11 the chief executive --
- 12 **A.** Yes.
- 13 **Q.** -- of UKRI, the BEIS-sponsored or managed funding
14 entity.
- 15 And we can see there that you refer in the fourth
16 paragraph to Sir Patrick Vallance having outlined his
17 plans to set up a Vaccine Taskforce and a Therapeutics
18 Taskforce to look further into what we can do. You
19 welcome it. You direct your officials accordingly, and
20 you agree.
- 21 **A.** Mm.
- 22 **Q.** Perhaps the most prominent feature of the Vaccine
23 Taskforce was its external chair.
- 24 **A.** Yes.
- 25 **Q.** Why was the Therapeutics Taskforce, which was also set

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1 up around about the same time, not chaired in the same
2 way by an external head? Can you recall?
3 **A.** I can't, for the simple reason that obviously the
4 decision was made fairly quickly, formally by the
5 Prime Minister, I think, on 13 May, that therapeutics
6 should sit outside the remit of the Vaccine Taskforce,
7 but I can certainly tell you that I believe the reason
8 the Vaccine Taskforce worked as effectively as it did,
9 was because we did have Kate Bingham, now Dame Kate,
10 I think she showed, you know, the right skills in terms
11 of scientific, but also in terms of bringing her private
12 sector knowledge into play.

13 Secondly, I do also think it's quite important the
14 fact that she reported directly to the Prime Minister.
15 I think that link to the centre was very important and,
16 you know, secondly, we had a set of people that she was
17 being supported by, many of them from within the Civil
18 Service itself, who had private sector experience, and
19 that public/private partnership I think was vitally
20 important.

21 Finally, I think the VTF worked because we were able
22 to make rapid decisions particularly on funding.

23 **Q.** Just focusing for a few minutes more on some other
24 aspects of the VTF. It's important to emphasise, isn't
25 it, that whilst it had an external chair, its external

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1 how it was run, but certainly I think the fact that the
2 VTF had a very clear mission, very focused, led by
3 someone who was incredibly "can do" and the ability to
4 make fast decisions, particularly when it came to
5 funding, I think created the success for the VTF.

6 **Q.** And so I'm driven to ask, perhaps a fairly obvious
7 question, Lord Sharma, which is this: if one recognises
8 that the most prominent features of the VTF were its
9 ability to work at faster pace, its external expertise,
10 the right combination of Civil Service experience and
11 external professionalism, and its can-do approach,
12 firstly, why aren't other bodies promulgated within the
13 government machinery in the same way, and why wasn't
14 some of the other comparable bodies like the
15 therapeutics Vaccine Taskforce set up in the same way?

16 **A.** Yeah, well, I think that is actually a key lesson that
17 I think we should be learning, is, you know, what were
18 the ingredients that made the VTF a success, and if, you
19 know, God forbid, we should face another similar
20 emergency, whether other similar bodies should be
21 constituted in the same way.

22 **Q.** Could we just look then briefly at just a couple of the
23 most important documents from around this time
24 INQ000533814 -- thank you -- dated 2 April. It's
25 a formal BEIS submission to you, the Secretary of State,

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1 advisory group and what in fact became the heart of the
2 Vaccine Taskforce was a combination of civil servants
3 and external professionals?

4 **A.** Yes, I --

5 **Q.** So it wasn't just external, there was a very significant
6 Civil Service element in particular, I think its
7 Director General Nick Elliott, Madelaine McTernan, also
8 were civil servants?

9 **A.** Yes, I think that's absolutely right, and I think it's
10 important to emphasise that whilst we had Kate Bingham
11 who came in and did an excellent job and we had external
12 support, a lot of the people involved were civil
13 servants brought in from within the different
14 departments and I think they played a really key role in
15 making it a success.

16 **Q.** And the VTF was also, as with all government departments
17 ministerially accountable to Parliament through your
18 department, of course, because it was a BEIS body?

19 **A.** Yeah.

20 **Q.** And was that one of the significant differences from the
21 Therapeutics Taskforce, as it became subsequently,
22 because that wasn't exclusively a BEIS body, was it?

23 **A.** It wasn't, and forgive me, Mr Keith, I can't really
24 comment on the Therapeutics Taskforce because I wasn't
25 involved. I know the decisions that were made around

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1 as well as your fellow ministers. The summary states
2 plainly that you'd asked Sir Patrick Vallance to
3 establish a cross-government Vaccine Taskforce. If we
4 could just look at page 2, paragraph 6, we can see there
5 the strands of work which you had directed be carried
6 out: supporting discovery of potential vaccines,
7 preparing the UK to offer itself as an expert clinical
8 testing site, reviewing the regulations ... developing
9 funding and an operational plan, and build on the UK's
10 research and development expertise.

11 I want to ask you about the second bullet point, the
12 expert clinical testing site.

13 Why, when a government is reaching out into the
14 industrial sphere and seeking to bring manufacturers on
15 board to research, develop and manufacture vaccines, is
16 it so vital to be able to offer those manufacturers, as
17 well as the British public, proper, well-funded,
18 developed clinical testing sites? Why is the need for
19 a proper platform to test vaccines so critical to the
20 willingness of manufacturers to engage?

21 **A.** Well, clearly, for any pharmaceutical treatment it needs
22 to go through a testing process through a number of
23 phases and that does involve, you know, having those
24 clinical trials and therefore making sure that you are
25 organised for that clinical testing ahead of vaccine

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1 compounds being available was vitally important. That,
2 plus, obviously, the issue on manufacturing which was,
3 again, something that we spent quite a lot of time
4 thinking about and actually putting money behind.

5 **Q.** And we'll come back to that later.

6 Why can't manufacturers do their own testing in
7 their own sites, perhaps abroad? Why is it so important
8 that the United Kingdom as a country can assist with
9 that process?

10 **A.** Well, I think there was clinical testing with a number
11 of vaccines that were used abroad --

12 **Q.** There was, yes.

13 **A.** -- as well, so I think it's not an exclusive thing for
14 the UK. But certainly from my point of view, and
15 I don't claim to be an expert on sort of clinical
16 testing, but, from my point of view, I think the pace at
17 which you can get things done, the ability to have
18 oversight over that, I suspect is probably easier if
19 you're doing that domestically, and for the government
20 to be able to help direct that, and particularly build
21 a population of people who are willing to volunteer to
22 be, you know, part of the clinical testing. That's
23 something we did, and I think people did respond to that
24 in the population.

25 **Q.** And there was in fact a Vaccine Registry?

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1 quickly as possible, hence the second objective of the
2 Vaccine Taskforce, and we can see there in the last
3 paragraph:

4 "He has a profound and deep rooted aim that the
5 world be immunised as quickly as possible."

6 So it wasn't a nationalistic -- an individual
7 country approach wasn't being taken here, there was
8 a much wider agenda.

9 **A.** No, absolutely not. And I think it was very important
10 that the UK participated in COVAX, the COVAX facility,
11 it participated in some of the other initiatives through
12 the World Health Organisation, and others. And, you
13 know, if we think about the negotiation on the
14 AstraZeneca vaccine, for instance, I mean, you know,
15 huge credit to AstraZeneca for providing that
16 effectively at cost. And so absolutely, from our point
17 of view, yes, we wanted to ensure that we were making
18 vaccines to support the population of the United Kingdom
19 but also to make sure that we were able to support
20 people in other countries.

21 **Q.** The Vaccine Taskforce, in a formal recommendation in
22 December 2020, recommended in future the creation of
23 a national vaccines agency, and Dame Kate in her own
24 book has promoted that recommendation, as indeed have
25 a number of other people, a vaccine agency that would be

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1 **A.** Indeed.

2 **Q.** And people were allowed to sign up for it and very large
3 numbers of people did --

4 **A.** Yes. I mean --

5 **Q.** -- to their credit.

6 **A.** -- hundreds of thousands signed up.

7 **Q.** Of course, the making available of vaccines was the
8 primary objective for the Vaccine Taskforce, but there
9 were two other objectives, were there not: firstly, to
10 provide vaccines globally to provide global assistance;
11 and, also, to build up resilience within the
12 United Kingdom for the future.

13 On that second point, global assistance, could we
14 have INQ000533814, page 2.

15 I think I've -- I think we've gone to the same
16 document. I'm sorry, that's my mistake.

17 Can we have INQ000330577. Thank you very much.

18 This contains a reference to a meeting with the
19 Prime Minister.

20 **A.** Yes.

21 **Q.** I want you, please, to emphasise that the government's
22 direction, very strongly and personally driven by the
23 Prime Minister, was not just about providing vaccines
24 for the United Kingdom and for its population; he was
25 extremely concerned that the whole world be immunised as

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1 largely what the Vaccine Taskforce did so successfully
2 but provide an end-to-end governance, that's to say
3 being responsible for supply chain readiness, research
4 and development, transfer and stockpiling, clinical
5 trials, all the way up to the point of delivery, which
6 obviously is for each of the devolved administrations
7 and England. Would you support that proposition, that
8 recommendation?

9 **A.** Well, I certainly think it's worth giving quite a lot of
10 thought and consideration. I guess it depends precisely
11 what the remit of such an organisation is, and how it
12 docks into government.

13 I mean, I think one of the benefits of having the
14 VTF is, yes, it had oversight but -- we brought in
15 external people but it very clearly docked into
16 government, and particularly then it came to funding
17 decisions it was important that it was close to the
18 centre.

19 And also I think it was understood that, you know,
20 the VTF would -- at some point, you know, its life would
21 come to an end, it would morph into something else. So
22 I guess the question for me is that if you have
23 a National Vaccines Agency, what I don't think you would
24 want is for it to, you know, eventually become business
25 as usual. You know, what --

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1 Q. It needs to be different?

2 A. It needs to be different. And I think what the VTF
3 brought was that sense of urgency and national wish
4 which everyone was driving towards. So I think you'd
5 give it some thought.

6 I mean, one of the things that I have set out in my
7 statement, Mr Keith, is perhaps a precursor to this, is
8 to have an external advisory body which combines
9 external experts, actually perhaps some of the folks who
10 worked on the VTF, plus ministers and civil servants,
11 meeting on a regular basis every -- throughout the year,
12 and actually scanning the horizon for what are the risks
13 from a health point of view and then effectively doing
14 an audit and looking at whether the UK actually has the
15 capability to be able to deal with those external
16 threats. Certainly from my point of view I think that's
17 one of the things that I would like to see.

18 **LADY HALLETT:** Lord Sharma, I'm sorry to interrupt,
19 yesterday, I think it was Mr Hancock who questioned the
20 need for a separate agency because he said it's the --
21 really it would be the task of the UKHSA.

22 Had you thought about whether a separate agency or a
23 separate advisory body would be necessary in addition to
24 the UKHSA -- I do hate acronyms, but anyway -- that's
25 why Mr Keith told you not to use them. Have you thought

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1 still to Parliament?

2 A. Yes, but I also think that what's important is that
3 whoever leads that body, that advisory group, should be
4 able to report directly in to the Prime Minister of the
5 day. I think that's one of the things we saw from the
6 VTF is that that direct report from Kate Bingham in to
7 the Prime Minister was actually very important.

8 Q. In her book, Dame Kate makes a number of wider
9 recommendations relating to the working of government,
10 and, if I may, I hope you'll forgive me, could I just
11 put some of the essential elements about what you
12 suggest about the benefits and demerits of working with
13 Whitehall and see whether you've got any observations on
14 them.

15 She says that she encountered too great a focus in
16 Whitehall on procedures and process and not outcomes.
17 There was a culture of underperformance, rapid rotation
18 in staff, a failure to give prominence to STEM
19 graduates, that's to say persons expert in maths and the
20 sciences, and the whole system of recruitment and Civil
21 Service staffing requires a very good look at it.

22 A. Mm.

23 Q. In the context, I should say, of something as specific
24 and perhaps as scientific as vaccines and therapeutics?

25 A. Yeah, yeah. Well, I think the first thing I'd say is

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1 about whether the UKHSA could provide this advisory body
2 and perform the task that ...

3 A. Potentially, but I think, from my perspective, the issue
4 is here is how do you ensure that we have readiness the
5 next time something like this happens. And, you know,
6 this is why I talk about the fact of having an external
7 advisory body which then effectively provides advice
8 into some of the established organisations and provides,
9 perhaps, oversight on making sure that they are working.

10 I think it's definitely worth thinking about whether
11 you create a national vaccines agency, but for me the
12 issue is if that just becomes a business-as-usual type
13 organisation, the pace that I think the VTF brought
14 perhaps wouldn't necessarily be there.

15 **MR KEITH:** If I may, it may be that by asking you whether
16 you were to promote -- you do promote a national
17 vaccines agency, I premised the question on perhaps
18 a false basis, which is that such a new body would be an
19 entirely governmental body, a quango, a -- well,
20 a departmental body.

21 What you're saying in essence, Lord Sharma, appears
22 to be that the essential feature of the VTF must be
23 maintained, which is that it has that external element
24 in it, and the external professionalism 'can-do' pace of
25 response, whilst remaining ministerially accountable

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1 that, you know, many of those people who worked on the
2 VTF were existing civil servants.

3 Q. And I've put that to you, yes.

4 A. And some of them brought external skills, as well, in
5 terms of negotiations, in terms of project management,
6 and I think that was important. I think, you know, some
7 of the points she raises around more STEM graduates in
8 the Civil Service, I think she makes the point that
9 there should be more ministers who have STEM
10 backgrounds, I think that's important. I think she
11 talks about outcomes rather than, sort of, process.
12 I think all of that is there, but, you know, and, you
13 know, we could have a long discussion about, you know,
14 the potential ways of improving the Civil Service, but
15 specifically when it came to the VTF, yes of course, you
16 know, there were occasions where you would have wanted
17 things to perhaps move faster, and certainly she's very
18 clear in her book that she did, but ultimately, I did
19 not feel that the VTF and the decisions we were making,
20 you know, ultimately, particularly when it came to
21 funding, were in some way impeded by the Civil Service
22 as it is.

23 I think she talks about the fact that one of the
24 reasons the VTF worked is because there was a venture
25 capital mindset and, actually, I think she's absolutely

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1 right about that. And yes, perhaps we should have more
2 of a venture capital mindset in government, but clearly
3 what you don't want is everyone in government to have
4 a venture capital mindset because, you know, you're
5 talking about public money, you're talking about
6 accountability and ultimately I don't think that, you
7 know, despite some of those frustrations, we -- there
8 were delays in terms of getting things done.

9 **Q.** It's very clear that one of the primary drivers for the
10 VTF's success was that their approach to procurement was
11 a risk.

12 **A.** Yes.

13 **Q.** By which I mean they were prepared to tie the government
14 into paying in advance for manufacturing capacity, in
15 advance of the clinical trials. And that obviously
16 couldn't have been done without the -- in fact, the
17 express assent of yourself, your ministers, your fellow
18 ministers, and the Prime Minister.

19 And it's obvious that not every, as you say, not
20 every government department can purchase a risk and it's
21 an extremely dangerous process. But it worked for the
22 VTF. Do you know whether or not that same mindset was
23 equally applicable to the Therapeutics Taskforce in
24 relation to which some have said: well, it didn't have
25 quite such a "can do" approach. The same principal

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1 **Q.** It was a remarkable structure, was it not?

2 **A.** Yes, it was.

3 **Q.** You were part of the ministerial panel, the draft terms
4 of reference, we can have up, please, on the page, on
5 the screen, INQ000330584. Page 1 at paragraph 2.

6 The panel of which you were part was obliged to
7 provide commercial and financial approvals for any
8 vaccine procurement contracts over 150 million. So
9 anything over that amount had to be agreed to by
10 yourself and your colleagues. Anything under had to be
11 agreed to, of course, by the civil servants in BEIS, and
12 the Vaccine Taskforce, and of course you're all
13 responsible to Parliament for this public expenditure.

14 I think your panel met eight times between August
15 and December 2020, so at a very rapid pace. Is that why
16 you say it wasn't business as usual?

17 **A.** Yes, it met eight times, I think the first time was
18 27 August and the last on New Year's Eve.

19 **Q.** The 31st --

20 **A.** 31 December 2020. And bringing together, you know,
21 senior ministers around the table, I think was really
22 important in terms of that rapid decision making. And
23 I think that -- you know, in terms of the funding
24 decisions up until that point, you know, there were
25 some, sort of, big numbers, but not at the scale that

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1 position wasn't taken at the start in relation to the
2 purchase and manufacture of therapeutics.

3 **A.** Yes.

4 **Q.** Would you agree with that?

5 **A.** Forgive me, I genuinely cannot answer that question
6 because, I mean, I had some involvement with
7 therapeutics through phase II trials on ACCORD --

8 **Q.** Yes.

9 **A.** -- but in terms of the running and the workings of the
10 Therapeutics Taskforce, that wasn't something that I had
11 any oversight or, frankly, involvement in.

12 But if I may just add --

13 **Q.** Please.

14 **A.** -- Mr Keith.

15 This issue of doing things at risk, I do think that
16 was very important and again, I think that was one of
17 the successes of both the VTF, but also actually the
18 recognition within government and the Treasury that
19 things needed to be done at risk. I mean, at the end of
20 the day we had a funding envelope of 5.23 billion.
21 I know there were frustrations in terms of, you know, it
22 taking a few weeks to sort of get established, but
23 again, I think relative to business as usual, agreeing
24 a 5.23 billion funding envelope, things actually moved
25 pretty fast.

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1 needed to be made decisions on when it came to
2 procurement of the actual vaccines, and I think it was
3 understood by everyone that actually we needed to have
4 a slightly different system to make this work. So
5 actually bringing together the Treasury, the Cabinet
6 Office, obviously the Department of Health, and the
7 Department for Business, I chaired that Ministerial
8 Investment Panel and I think, you know, that again is
9 one of the innovations we should be thinking about for
10 the future is that, you know, if we face a similar type
11 of emergency, whether right from the start in terms of
12 making funding decisions, we should have all the key
13 departments, but particularly the Treasury and the
14 Cabinet Office being part of that decision-making
15 process.

16 **Q.** And that feature to which you refer of having the
17 Treasury in that body means, of course, that they get
18 handed with the joint petard, that you have them on
19 board agreeing to this as part of the ministerial panel
20 review process as opposed to forcing BEIS, and the
21 Vaccine Taskforce, to have to go to the Treasury on
22 a case-by-case basis separately --

23 **A.** Yes.

24 **Q.** -- and ask for permission to spend vast sums of money
25 one after the other?

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1 **A.** Yes, and, I mean, initially obviously we did it on
 2 a case-by-case basis and I don't recall that there were
 3 any particular delays in terms of getting agreement on
 4 that funding but as I said, I think it was recognised
 5 that when it came to these very, very large funding
 6 decisions we needed to find a more efficient way of
 7 doing this.

8 **Q.** Another aspect of this vast public expenditure, which is
 9 of public interest, is the issue of indemnities.

10 **A.** Yes.

11 **Q.** Because, of course, all the manufacturers,
 12 understandably, sought indemnities of one sort or
 13 another. They were being forced at pace to produce
 14 vaccines for the benefit and welfare of every government
 15 and every person in the world.

16 **A.** **(Witness nodded).**

17 **Q.** They all initially, I think, sought full statutory
 18 immunity, that is to say a complete bar to being sued,
 19 which by and large is the position in the US, where
 20 there's an Act, the Public Readiness and Emergency
 21 Preparedness Act, which provides a very wide cut-out or
 22 exemption from liability. UK ministers successfully
 23 pushed that away; is that right?

24 **A.** We did, and I think it was actually recommendations by
 25 the officials and we very much accepted that, that at

25

1 **Q.** -- willingness on the part of the government to pay for
 2 the manufacturer any award or damages made against it as
 3 well as any legal costs --

4 **A.** Yes.

5 **Q.** -- in certain circumstances?

6 **A.** Yes, in certain circumstances. I mean, there were a
 7 number of carve-outs --

8 **Q.** We won't go there but it wasn't a blanket "We're going
 9 to pay the cheque" agreement, it was "We'll pay any
 10 award of costs, any award of damages, but only if the
 11 courts order it", as well as legal costs, and only in
 12 certain circumstances, or at least not in all
 13 circumstances?

14 **A.** Yes, that is absolutely right. And I would just add one
 15 other point on this.

16 **Q.** Please.

17 **A.** Obviously there was work done in terms of looking at the
 18 contingent liability for government as a result of
 19 giving these indemnities. There was also work done on
 20 what was the net benefit of having vaccines being
 21 deployed successfully, and clearly the net benefit
 22 calculations showed that it was many multiples higher
 23 than the potential contingent liabilities.

24 **Q.** But by that do you mean this: that because you're
 25 dealing with public funds, the government was obligated

27

1 the end of the day from a taxpayer perspective, it made
 2 much more sense for, you know, individual companies to
 3 come to us with their asks rather than us giving
 4 statutory immunity. And, anyway, I think giving
 5 statutory immunity would have required effectively an
 6 Act of Parliament and so that was resisted.

7 What it also allowed us, the negotiating team to do,
 8 is -- of course, there were, sort of, common indemnities
 9 given for the vaccine manufacturers but there was an
 10 ability, as a result of going down the indemnity route,
 11 to have some variations as well, and that did happen.
 12 I think that was very positive.

13 **Q.** And so that we're absolutely clear about this, the
 14 indemnities that were agreed on a case-by-case basis
 15 with each individual manufacturer by the government, in
 16 no way prevented anybody from bringing a claim against
 17 a particular manufacturer, not least under the Consumer
 18 Protection Act. The indemnity didn't and doesn't
 19 prevent access to the court and in the event of a claim
 20 being brought, it is the manufacturer who is the
 21 defendant?

22 **A.** Yes, precisely that, Mr Keith.

23 **Q.** So the indemnity took effect, in fact, simply by way of
 24 an after-the-event --

25 **A.** Yes.

26

1 to weigh up the potential contingent cost of picking up
 2 the tab for a manufacturer who loses in the court and
 3 weigh it against the overall financial advantage to the
 4 United Kingdom by having a vaccine, or vaccines, and
 5 a delivery programme?

6 **A.** Yes, and I think this issue first emerged, and I set
 7 this out in my statement, I think, when we were looking
 8 at reservations for Pfizer BioNTech, and I was presented
 9 with a calculation in terms of the contingent liability
 10 for the government, and I asked for that to be revised
 11 and for more work to be done so that we could be certain
 12 in terms of exactly what we were looking at, because
 13 that initial calculation was actually a very large
 14 range.

15 **Q.** Well, it must have been an extremely difficult task to
 16 try to quantify the financial worth to the
 17 United Kingdom of having a successful vaccination
 18 programme. I mean, that's not a straightforward task.

19 **A.** No, it's not a straightforward task but I think, you
 20 know, as the contingent liabilities were revised as a
 21 result of more information from the Department of
 22 Health, knowing that certain groups were initially not
 23 going to be getting the vaccine, I think that helped in
 24 terms of the contingent liabilities piece, and yes,
 25 I think the range in terms of the net benefit to the UK

28

1 was actually a pretty large range but nevertheless, even
2 at the lowest level, it showed that there was a net
3 benefit of very many multiples compared to, kind of, the
4 maximum exposure when it came to indemnities of the
5 government.

6 **Q.** The net benefit to the United Kingdom financially and
7 societally vastly outweighed any possible contingent
8 liability that might ever be owed --

9 **A.** Yes, absolutely.

10 **Q.** -- to a manufacturer?

11 **A.** Absolutely.

12 **Q.** Right. And those indemnities were agreed at the highest
13 level. They went to the Prime Minister, they were
14 agreed on a case-by-case basis and no doubt they were
15 the product of a great deal of thought. Do you consider
16 that the UK Government was over-generous in its general
17 approach to indemnities?

18 **A.** No, I think we were very pragmatic and I think the
19 negotiating team deserves a lot of credit for this
20 because they did push back very hard on this strategy
21 immunity which, frankly, you know, a lot of the
22 manufacturers, particularly as you said, Mr Keith, they
23 were used to that in the US with the prep Act, they were
24 very keen to push, and I think the team did a great job
25 in resisting that.

29

1 Vaccine Damage Payment Scheme, a non-compensatory
2 flat-rate scheme --

3 **A.** Mm.

4 **Q.** -- for 60% disablement or more.

5 There's a reference there to officials considering
6 options to expand the list of vaccines and to review the
7 eligibility criteria.

8 **A.** Yeah.

9 **Q.** Do you happen to know what happened to that review, and
10 also to the possibility that appears in the line below,
11 to a separate compensation, and that's an important
12 word, compensation scheme, not just a payment scheme,
13 for vaccines?

14 **A.** I think as it sets out, this was ongoing work between
15 the Department of Health and the Treasury. I mean, as I
16 understand it, and please forgive me, I mean, obviously,
17 I left at the beginning of January from my post.

18 **Q.** You did.

19 **A.** But as I understand it, obviously, Covid-19 as
20 a condition was inserted into the Vaccine Damage
21 Payments Act. I think the amount of compensation stayed
22 the same, but certainly I think one of the things that,
23 you know, reflecting on this and particularly, I think,
24 seeing some of the testimony on the impact film for this
25 module, I certainly think there is a case for us to look

31

1 **Q.** There was a paper produced for you in August 2020,
2 27 August, INQ000478999. If we could just have page 1,
3 please, firstly.

4 You were being invited to reconfirm your acceptance
5 of the general approach to government indemnities, and
6 in fact to note where things had reached in relation to
7 the draft AstraZeneca supply agreement. And we can see
8 there, in the first paragraph, the reference to
9 statutory immunity, or government-backed indemnity
10 which, as you say, the UK Government negotiated its way
11 away from.

12 We can see in paragraph 2 the reference to the US
13 Act which gives very wide-ranging immunity.

14 If we could go over the page to page 2, we can see
15 there under "Likely costs" some of the thinking relating
16 to the contingent liability figure to which you've
17 already spoken.

18 **A.** Mm-hm.

19 **Q.** We can see there was obviously a range of benefits or
20 a range of worst-case scenarios.

21 Can we then go over the page to page 3, where
22 I think there's a reference to -- yes, paragraph 12,
23 "Ministers were invited to note that the DHSC is
24 reviewing the UK Vaccine Damage Payments Act", which is,
25 as you know very well, the statute that provides for the

30

1 again at both eligibility criteria but also perhaps to
2 look at the quantum of money that would be made
3 available through this mechanism.

4 **Q.** Thank you, that's --

5 **A.** That's obviously for the future. Just to be clear.

6 **Q.** And of course it is something that ministers would have
7 to agree to and it also, of course, has a statutory and
8 Parliamentary foundation.

9 On an entirely separate subject could I please ask
10 you about the Vaccine Manufacturing and Innovation
11 Centre, VMIC.

12 **A.** Mm.

13 **Q.** You've referred to the importance of having a proper,
14 developed manufacturing -- onshore manufacturing
15 capacity in the United Kingdom, so that in the event of
16 a future pandemic there is a ready, available,
17 ready-to-go system for the manufacture of vaccines, of
18 course therapeutics, all the ancillary materials and
19 substances, the -- is it fill and finish, finish and
20 fill process?

21 **A.** **(Witness nodded)**

22 **Q.** As well as, particularly, antibodies.

23 **A.** Mm.

24 **Q.** Your department had funded, to a very considerable
25 extent, VMIC, along with the UKRI and the DHSC.

32

1 Could we have, please, INQ000506819. Thank you very
2 much.

3 We can see there a reference to VMIC, in
4 paragraph 15 a reference to the original funding.

5 **A.** Yes.

6 **Q.** 69 million.

7 **A.** Mm-hm.

8 **Q.** And then, further down -- thank you very much. And
9 then, in paragraph 16 and following, references to the
10 expectation that there would be extra capacity, that the
11 centre would be built, it would be opened by June 2021.
12 And then, in paragraph 19, further costings and further
13 funding which might be required.

14 You asked for further detail of what was likely to
15 happen and what was likely to be sought by way of
16 funding and you received a further submission, and in
17 December you were asked to approve in principle another
18 50 million or so.

19 **A.** -- 47, yeah.

20 **Q.** 47.6 million. Was that something that you approved or
21 was that decision on funding taken by another of your
22 ministers?

23 **A.** So I think at that point I delegated that to
24 Nadhim Zahawi, who was, you know, ultimately the
25 Vaccines Minister, in terms of deployment. But clearly,

33

1 **A.** Yes, absolutely right, I agree with that entirely.

2 And if I may reflect on VMIC, it was obviously
3 manufacturing but also an innovation centre. And, you
4 know, by the end of this sort of process the government
5 had invested £200 million in this facility. Clearly in
6 the autumn of 2021 the directors decided that, you know,
7 it should be sold and it was sold early on in 2022. But
8 of course, as I understand, it was then effectively
9 mothballed. And, you know, obviously I was not part of
10 the decision in selling it. If I had still been in
11 post, I would certainly have asked a lot of searching
12 questions as to whether or not it was right to sell
13 this.

14 But just reflecting on this, I think the question
15 for me is that, you know, the advantage of VMIC was that
16 there was government involvement, government investment,
17 Innovate UK had oversight. So we could, you know, to
18 use your words, "at a moment's notice" turn to that
19 facility in terms of manufacturing. And the question
20 for me is, if not VMIC, then what now, if we face
21 a similar emergency tomorrow?

22 **Q.** So we understand the position, Lord Sharma, there are
23 obviously a number of different angles and aspects to
24 the manufacture and production of vaccines and
25 therapeutics, but at the time of the pandemic there was

35

1 I supported it. I thought it was very important that we
2 build up manufacturing capacity, not just to deal with
3 vaccine manufacturing during the pandemic but obviously
4 permanently for the future as well.

5 And, Mr Keith, you showed me that email from
6 Emily Beynon earlier, from Number 10, was it the
7 Prime Minister's private secretary, and that very
8 clearly referred to the role -- some of the roles of the
9 VTF was to build up manufacturing and R&D.

10 **Q.** It's a matter of public record that the VMIC facility
11 was sold, in fact it was a separate entity. Its
12 board --

13 **A.** Yes.

14 **Q.** -- decided that, due, in fact, in the main, to market
15 conditions, it simply wasn't a going entity any more.
16 And the best way to proceed was to sell itself to an
17 overseas, international, commercial company, to try to
18 recapitalise the structure.

19 It had obviously had, by then, a great deal of
20 public money. Is it your position that it is vital that
21 that manufacturing capacity is maintained for the
22 future, that the centres are ready to go, and that they
23 are available, at literally a moment's notice, to turn
24 their manufacturing capacity to the production and
25 manufacture of vaccines and therapeutics?

34

1 a biomedical facility at Oxford.

2 **A.** Mm-hm.

3 **Q.** There was a production line run by a company called
4 Wockhardt in Wrexham which provided vaccines. There was
5 a vaccines site in Braintree. All this had to be stood
6 up --

7 **A.** Yes.

8 **Q.** -- to use a terrible expression --

9 **A.** Yes.

10 **Q.** -- from scratch --

11 **A.** Yes.

12 **Q.** -- funded at vast expense and very quickly indeed in
13 order to be able to provide the manufacturing capacity
14 which was so sorely needed?

15 **A.** Yes. And I think in terms of at Oxford Biomedica,
16 I mean certainly one of the questions I asked when we
17 got this submission on VMIC -- which showed that, you
18 know, it could be up and running a year earlier than
19 envisaged, so, you know, middle of 2021 -- I did ask
20 what could be done more immediately to get manufacturing
21 going. And I think the solution, which was I think
22 already being worked on, was to move VMIC equipment and
23 staff into Oxford Biomedica's facilities, so basically
24 in those cleanrooms, and they were used for
25 manufacturing, I think AstraZeneca, vaccines during that

36

1 period.

2 And just reflecting on one more point, I think you

3 made this issue about not just vaccines but also

4 antibodies, you know, during this period, I also

5 approved funding to acquire a manufacturing capacity

6 abroad for antibody therapies, and I certainly reflected

7 at the time that actually, you know, why is it that we

8 didn't have this capacity in the UK? And I think that

9 should be another learning from this, is that not just

10 the manufacturing of vaccines but also, as you said,

11 fill and finish, but, in addition, antibodies. If we

12 needed this tomorrow, could we actually do this in our

13 own country?

14 **Q.** That was, I think, a submission dated 24 June 2020, was

15 that the antibody manufacturing capacity at the Lonza

16 Biologics site, which is abroad?

17 **A.** I think -- yes, I think there were two, so there was an

18 initial funding ask for the AZ, AstraZeneca, antibody,

19 and then I think there was a further ask in terms of

20 Lonza, both of which were given approval.

21 **Q.** The final topic, please, is Evusheld.

22 As you told us, you left the department in

23 January 2021, and therefore you were only in post during

24 the first part of the Evusheld story which concerned the

25 advanced purchase, or the prospect of the advanced

37

1 **A.** Not at the time but obviously in preparation for this

2 Inquiry I have looked into that. If I may just sort of

3 say that --

4 **Q.** Please.

5 **A.** -- in terms -- actually, I think the compound was not

6 referred to as Evusheld at the time, I think it was

7 AZD7442, something like that.

8 **Q.** It was, and I think it was also called Project

9 Astronaut --

10 **A.** Yes, exactly, Project Astronaut. I think for me what

11 was very important in agreeing to that submission and

12 the signing of a letter of intent with AstraZeneca was

13 this was a treatment which was going to support the

14 clinically vulnerable, who wouldn't otherwise be able to

15 take a vaccine. I think that was very important for me.

16 And, I mean, you talked about Dame Kate's

17 description, in the submission it was very clear that

18 this could potentially provide protection within 24 to

19 48 hours of being administered, and I saw a great deal

20 of advantage in that. And as I said, it was supported

21 by Dame Kate but also the BIA. And initially I think it

22 was a million doses that were being proposed.

23 Obviously, as I understand, we did actually sign

24 this non-binding letter of indent, and the discussion

25 continued. Ultimately, I don't think regulatory

39

1 purchase.

2 Evusheld is a therapeutic, a medicine, which can be

3 used prophylactically --

4 **A.** Yes.

5 **Q.** -- in advance of infection?

6 **A.** Indeed.

7 **Q.** I think described, rather wonderfully, by Dame Kate as

8 "immunity in a syringe".

9 **A.** Mm-hm.

10 **Q.** As well as, of course, used to treat people who had

11 become infected and ill.

12 And in May 2020, you received a submission

13 concerning whether or not there should be a decision to,

14 in principle, buy a very large number of doses of

15 Evusheld for its use prophylactically.

16 And discussions proceeded, following your approval.

17 **A.** Mm.

18 **Q.** A non-binding letter was agreed, a letter of intent, and

19 by the winter of December 2020, the VTF was on the cusp

20 of putting to ministers and a ministerial panel an

21 agreement to actually pay money in advance for the

22 production of Evusheld.

23 You left office, as I said in January 2021. Were

24 you aware of what happened to the Evusheld advance

25 purchase thereafter?

38

1 approval came through until spring 2022, so long after

2 I had gone.

3 **Q.** Indeed.

4 **A.** Certainly the last discussion I had on this was at the

5 ministerial investment panel on 18 December where there

6 was effectively reporting to ministers which said that

7 the CMO had reflected on this particular issue and, in

8 terms of the purchase, rather than a million, perhaps

9 the level -- the maximum level should be 500,000,

10 because vaccines were being rolled out, but it was still

11 very clearly -- there was an agreement that this should

12 be purchased to support the clinically vulnerable.

13 And I think that was important -- as I've said, you

14 know, I wasn't part of the ultimate decision, and, you

15 know, there were -- the Department of Health had experts

16 who pronounced on why it shouldn't be purchased. But

17 again, for me, I think if I'd been part of that decision

18 I would certainly have asked: so what is the alternative

19 treatment that is available to those who are clinically

20 vulnerable if we are not going to buy the AZ treatment?

21 **Q.** If I may say so, you're absolutely right, in particular

22 the Chief Medical Officer, Professor Sir Chris Whitty

23 produced an advice on 10 February 2021 in which he

24 recommended against the advance purchase, and he

25 referred, as you say, not just to whether or not there

40

1 was doubt about the degree of clinical effectiveness,
2 but most importantly, the fact that the vaccine
3 programme had started, therefore there was an issue
4 about whether or not the need for a prophylactic
5 therapeutic was as great as it had been previously.

6 **A.** Mm.

7 **Q.** And also, doubts about the level of benefit that
8 Evusheld would bring about.

9 **A.** Mm.

10 **Q.** But the principal point underpinning that approach was
11 of course that there was a debate about the efficacy of
12 Evusheld, whereas in relation to vaccines, the decision
13 had been taken generically to purchase, in advance, at
14 risk without knowing anything about whether or not the
15 vaccine was even possible.

16 **A.** Mm.

17 **Q.** So it does appear on its face as if a different approach
18 was being taken generically to the purchase of
19 therapeutics?

20 **A.** I think the difference with vaccines was -- you're
21 absolutely right, Mr Keith, yes, we were purchasing at
22 a risk, but many of those candidates that we were
23 basically putting reservation orders on, vaccine
24 candidates, were already in trials, and, you know, if
25 you think, from the date that the VTF was launched to

41

1 a problem with recruitment.

2 **A.** Mm.

3 **Q.** There appeared to be quite a high measure of discord as
4 to who was going to get what funding, who was going to
5 run each of the trials, and Sir John Bell says the
6 process became overly complex, not effectively
7 coordinated or organised. And he describes how there
8 were meetings with you, or perhaps in advance of meeting
9 you in the department in which the advisory group held
10 their corporate heads in their hands, because of the
11 complexity of this process.

12 In this document headed "ACCORD new wave of trials",
13 your officials refer to a meeting that you were going to
14 have with Sir Mark Walport, CEO of UKRI, Jeremy Farrar,
15 the well-known industrialist and scientist, Sir John
16 Bell, who was intimately involved in the Vaccine
17 Taskforce -- the Therapeutics Taskforce, and Jonathan
18 Van-Tam, the Deputy Chief Medical Officer. And they are
19 discussing, or you're intending to discuss proposals for
20 the co-ordination of the new wave of Covid-19
21 therapeutic trials and the establishment of a new,
22 single-delivery framework. And over the page we can see
23 some handwritten notes which we think are yours.

24 **A.** Mm.

25 **Q.** Are they yours?

43

1 the first vaccine being administered, I think it was an
2 eight-month period, so there was an understanding that
3 the vaccines were coming and testing was going on.

4 In the case of Evusheld, I don't think phase I
5 testing started, actually, until late autumn in 2020 and
6 I think initially, as I remember from the submission, it
7 had been expected that this treatment might actually be
8 available by late autumn 2020. So I think that may have
9 been one of the reasons why a decision wasn't felt to be
10 imminent, because we still weren't clear in terms of the
11 efficacy and the testing going through the different
12 phases.

13 **Q.** I understand. As it happened, you led an oversight
14 group, you led the oversight group on what was called
15 the ACCORD phase II trial process, so in this pantheon
16 of phases from phase I to IV, this was phase II.

17 Could we have INQ000478978 up, please.

18 Before the Inquiry there are number of witness
19 statements from Professor Sir John Bell, Jeremy Farrar,
20 Professor Sir Jonathan Van-Tam among others, who say
21 that in relation to this issue of the phase II trial,
22 co-ordination by the UK Government and the funders and
23 the academic institutions which were concerned in these
24 trials, there was a lack of coherent management. There
25 were a lot of underpowered phase II trials, there was

42

1 **A.** Yes, they are indeed.

2 **Q.** "Noise with accord very unhelpful". "RECOVERY" -- that
3 is a reference to what was an extremely successful
4 phase III trial, RECOVERY.

5 **A.** Yes, indeed.

6 **Q.** Same programme, I think it may be same programme or
7 similar programme?

8 **A.** Single programme, I think. Forgive my handwriting.

9 **Q.** No, no, no, that's quite all right. You've been good
10 enough to write everything in capitals so that's helped
11 us a great deal.

12 There's a reference to funding and NIHR, the
13 National Institute for Health Research. And then you
14 say on the far right-hand side of the page "SIT in
15 BEIS".

16 **A.** Mm.

17 **Q.** So is this the positions: that it was apparent by the
18 summer of 2020 that there were going to be, well, there
19 were problems concerning the co-ordination and
20 management of this particular but really important part
21 of the clinical trial process and in particular its
22 funding and constitution?

23 **A.** Mm.

24 **Q.** Do you know whether or not the problems you identified
25 were ever resolved, because it doesn't appear as if they

44

1 were?

2 **A.** Yes. So firstly, just in terms of these notes I think

3 I would describe them as, sort of, absent-minded doodles

4 during the call of the 22nd.

5 **Q.** Lord Sharma, you don't need to justify them --

6 **A.** But I think it's important to set out, you know, that

7 this is basically what I was being told on the call, and

8 if you look at the initial summary, it talks about, you

9 know, what the oversight should be, et cetera.

10 But I think it's important to set out the history

11 a little bit on this, Mr Keith, which is that I think

12 there was some sort of question in terms of where the

13 phase II trials should sit in the first place, and this

14 was a discussion that started in March. You know,

15 ultimately, I think Sir Mark Walport was keen that they

16 sat under the UK research -- UKRI, and I was -- and this

17 ACCORD programme was formed on 14 April. I was first,

18 sort of, made aware of all of this when I was approached

19 by Number 10 towards the end of April to ask, request

20 that I chair this oversight board, because clearly there

21 were issues and they wanted someone to come and at least

22 try and bring some coherence to this.

23 We had the first oversight board meeting on 27 April

24 and I think you're absolutely right, the issues became

25 clear in terms of things not working, sort of fairly

45

1 you know, things were in play, it would sort of resolve

2 itself. But I think, you know, towards the end of May

3 it was very clear it wasn't going to. And I think then

4 at the start of June I contacted 10 Downing Street and

5 suggested that we needed to find a different way of

6 doing things and that ultimately then resulted in this

7 meeting on the 22nd bringing the key parties together,

8 and I think there is an email you will find from my

9 statement which my private office sent to Number 10

10 Downing Street on 25 June which set out that I had

11 managed to gain consensus from, you know, all of these

12 individuals who, you know, experts in their own rights,

13 and obviously, you know, a different set of

14 personalities --

15 **Q.** I was about to say: it's herding cats?

16 **A.** I would never describe something like this as, sort of,

17 herding cats. I mean, these were experts and they had

18 differing views but I think the point is that by the end

19 of June we had reached the consensus that this needed to

20 be rolled into the RECOVERY trials and that's what

21 happened.

22 **MR KEITH:** Thank you very much. That's extremely clear.

23 Lord Sharma, those are all the questions I have for

24 you. But there are number of questions from, as my Lady

25 will tell you, the Core Participants.

47

1 early on and one of the key issues, as you identified,

2 was around -- I mean, not just co-ordination but also

3 all of that leading to not enough patients coming into

4 the clinical trials.

5 **Q.** The recruitment issue?

6 **A.** The recruitment issue. And I think during that period

7 of May, I think it wasn't as if people were, sort of,

8 standing still; there were lots of plans being worked up

9 in terms of how you get more patients, how you expand

10 the hospital sites where you recruit patients, and I was

11 told that there were two key issues: one is that

12 hospitalisation rates from Covid were dropping which,

13 you know, generally is a very good thing but obviously

14 if you're looking to do this kind of clinical testing

15 that presents an issue in terms of the population that

16 you can access. And secondly, that there was a,

17 effectively a sort of competition with some of the

18 phase III trial phases as well.

19 I remember asking, and I think it says this in the

20 minutes, on 11 May we had -- we had very regular

21 meetings of this oversight group, and on 11 May, I think

22 the minutes show that I asked very clearly a number of

23 times of all the experts around the table: is there

24 anything else that they wanted government to do to fix

25 this issue? And I was told at the time that actually,

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1 **LADY HALLETT:** Mr Thomas. Mr Thomas sits over there,

2 Lord Sharma.

3 **Questions from PROFESSOR THOMAS KC**

4 **PROFESSOR THOMAS:** Good morning, Lord Sharma. Can you hear

5 me?

6 **A.** Yes, I can.

7 **Q.** In October 2020 your department published a press

8 release entitled -- sorry, forgive me, Lord Sharma.

9 I should introduce myself. I'm representing FEMHO, the

10 Federation of Ethnic Minority Healthcare Organisations.

11 I do apologise.

12 In October 2020 your department published a press

13 release titled "Ethnic minority communities and the

14 elderly called upon to bolster the fight against the

15 coronavirus". The release went on to say that

16 researchers were specifically calling on more people

17 from black, Asian and minority ethnic backgrounds to

18 take part in clinical trials for vaccines, noting that

19 they were underrepresented at the time despite being

20 disproportionately affected by Covid, and that at that

21 time, only 7% of volunteers were from ethnic minority

22 groups.

23 A further report from the Vaccine Taskforce in

24 December 2020 showed that little progress had been made

25 by the December and stated that only 8% were from ethnic

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1 minority groups which does not reflect UK demographics.

2 Lord Sharma, do you accept that there has been
3 a longstanding issue with ethnic diversity within
4 clinical trials that remains unresolved?

5 **A.** Firstly, thank you for that question. And I think
6 you're absolutely right, is that there was
7 underrepresentation in the trials from, you know, the
8 range of ethnic minority communities, and you've talked
9 about the percentages that there were, and that
10 percentage is obviously, you know, I think half of what
11 the actual proportion of ethnic minority communities in
12 the United Kingdom is.

13 At the time, I think there was effort made from the
14 VTF and others in terms of messaging to ensure that we
15 tried to get a clinical trial cohort which was
16 representative of the UK population. Clearly, as you
17 set out in the figures, that didn't happen, and I think
18 one of the learnings we should take from this is that
19 how, in future, we fix this issue.

20 Now, we had a registry at the time, there is a new
21 registry that is, I think administered by the NIHR, the
22 Department of Health. And I think one of the things
23 that we should be thinking about is how, you know, as
24 time goes on, we try and find a way of connecting with
25 ethnic minority communities and other groups that were

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1 it's important for them, for their children, for the
2 community and the wider population in the UK that they
3 are part of, you know, this kind of process going
4 forward.

5 **Q.** Can I move on to my next question, which is this: we
6 would quite like to know what steps did you personally
7 take and/or oversee to increase representation and
8 diversity in these trials for the Covid vaccines and
9 therapeutics?

10 **A.** Well, obviously, I was a part of the information that
11 went out in terms of press releases. You know,
12 ultimately I had responsibility through some of the work
13 that the VTF was doing in terms of disseminating
14 information around this issue but, you know, it was
15 a really challenging time and I think we all, sort of,
16 understand that, and in a way, this is the sort of work
17 that we ought to be doing now rather than necessarily in
18 the heat of the moment where I think people tried very
19 hard to try to make sure that we had a representative
20 cohort within the clinical trials. I don't think it was
21 for want of trying but I think, you know, you talked
22 about building trust; that's something that needs to
23 happen now, not in the middle of an emergency.

24 **Q.** Yes. Lord Sharma, I agree, for what it's worth, but can
25 I just add this: bearing in mind that there was

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1 somehow underrepresented in these clinical trials.

2 **Q.** Can I come on to that. I just want to piggyback on what
3 you've just said because during the course of this week
4 we've heard a lot of evidence so far in relation to
5 historical mistrust amongst certain communities, how
6 certain communities have been left behind. And so I
7 suppose the follow-up question is this: given the fact
8 that there was mistrust within certain communities and
9 other barriers to participation, how were these being
10 addressed?

11 **A.** So, I mean, I just want to reflect on the impact film,
12 I think it was particularly powerful, where we had
13 a doctor who was -- from the ethnic minority community
14 who talked about the fact that she obviously, as
15 a doctor, encouraged people from the community to take
16 up the vaccine, but also was someone who was then
17 volunteering to administer vaccines, and I think there
18 was a discussion as well on the impact film that mosques
19 were used as centres for vaccination, and that provided
20 a lot of confidence.

21 I think, you know, in terms of getting more people
22 from ethnic minority communities as part of that
23 clinical trial registry for the future, I think we need
24 to think about how we do that outreach now in terms of
25 going into those communities and explaining to them why

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1 historically a lot of mistrust beforehand, do you have
2 any idea why that trust hadn't been built beforehand?

3 **A.** I mean, forgive me, I can't sort of comment on, you
4 know, the work that was done in prior years when,
5 obviously, I wasn't in post. But as we've heard from
6 Mr Keith and the Chair, I mean, this is about lessons
7 and learnings for the future, so I think this is, for
8 me, this is one of the key learnings, as well: is to
9 make sure that we can stand up a clinical trial platform
10 which actually does everything from, sort of, phase I
11 onwards for the future, and making sure that we are,
12 sort of, ready to go in terms of having that
13 representative group.

14 And that clearly needs work and proactive work, and
15 I hope that's one of the things that will happen.

16 **Q.** Well, you very nicely bring --

17 **LADY HALLETT:** I think we are going to have to move on,
18 Mr Thomas.

19 **PROFESSOR THOMAS:** Yes.

20 You very nicely bring us on to my final question --

21 **LADY HALLETT:** Well, I think we've covered your final
22 question, I'm really sorry.

23 **PROFESSOR THOMAS:** So be it.

24 **LADY HALLETT:** We're so tight for time today.

25 **PROFESSOR THOMAS:** Thank you, my Lady.

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1 **LADY HALLETT:** Mr Wagner. Where have you gone? Oh, there
2 you are.

3 **Questions from MR WAGNER**

4 **MR WAGNER:** Thank you.

5 Good morning, Lord Sharma, I ask questions on behalf
6 of Clinically Vulnerable Families. I'm just going to
7 ask you about one area, if I may, which is
8 prophylactics.

9 At page 77 of your statement, you've said you're not
10 able to assess the relative prioritisation of vaccines
11 and therapeutics because your work was focused on the
12 Vaccine Taskforce and you weren't involved in
13 therapeutics, and you've also suggested you're not in
14 a position to assess the overall prioritisation of
15 pre-exposure prophylactics.

16 Now I think you have discussed briefly with
17 Mr Keith KC this morning that some prophylactics,
18 particularly antibody treatments, were included in the
19 remit of the Vaccine Taskforce; is that fair?

20 **A.** Yes, absolutely.

21 **Q.** Given that, that the Vaccine Taskforce had antibody
22 treatments in its remit, and you were the chair, how is
23 it that you, as the former chair, are not able to
24 provide a view of the relative prioritisation between
25 vaccines and prophylactics?

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1 entirely fair, in the sense that there was work being
2 done on this area. And I said, I mean, the evidence for
3 that is the submissions that came on Evusheld and
4 subsequently further submissions that came to me for
5 antibody manufacturing capacity abroad as well, in terms
6 of securing that. So there was clearly a lot of thought
7 going on on this, and, you know, obviously Dame Kate
8 when she gives evidence will, I hope, sort of say the
9 same thing. So there was a lot of thinking going on.

10 I think there is a wider issue which Mr Keith raised
11 as to what happened at the end of the day in terms of
12 the decisions on purchasing those sorts of treatments.

13 **Q.** Particularly Evusheld.

14 **A. (Witness nodded)**

15 **MR WAGNER:** Thank you.

16 **LADY HALLETT:** Thank you, Mr Wagner.

17 That completes our questions for you, Lord Sharma.

18 I've no idea if we're going to have to ask you to
19 help us again in any other module, but thank you so much
20 for your help so far.

21 **THE WITNESS:** Thank you. Pleasure.

22 (The witness withdrew)

23 **LADY HALLETT:** I shall return at 11.35.

24 (11.16 am)

(A short break)

55

1 **A.** Well, I think that the question I was asked originally
2 by the Inquiry was the comparison between vaccines and
3 therapeutics overall, and given that I wasn't
4 responsible overall for therapeutics, and neither for
5 the Therapeutics Taskforce, I didn't feel able to give
6 a view.

7 But I think if you -- if we are sort of comparing
8 sort of the vaccines work with the work on antibodies,
9 I think there was clearly work done on antibody
10 treatments to support the clinically vulnerable, and we
11 see this in terms of the, you know, agreement to fund
12 for, you know, what became known as Evusheld.

13 So I think there was thought going into this and
14 I think Dame Kate particularly was very keen when there
15 was a sort of division of labour in terms of what the
16 VTF should be responsible for. I think the -- I mean,
17 I remember from the time, and the records very clearly
18 show, that she felt that antibody treatments should be
19 part of the VTF's remit.

20 **Q.** Although they were part of the remit, would you agree
21 that, looking back, they formed a -- they sort of came
22 underneath vaccinations in terms of the prioritisation,
23 the amount of resource, the amount of creative thought,
24 all of that that went into the two different areas?

25 **A.** No, I'm not -- I mean, forgive me, I'm not sure that's

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1 (11.35 am)

2 **LADY HALLETT:** Mr Keith.

3 **MR KEITH:** My Lady, the next witness is Clara Swinson,
4 please.

5 **MS CLARA SWINSON (affirmed)**

6 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 4**

7 **LADY HALLETT:** I hope we haven't kept you waiting too long.

8 **THE WITNESS:** Not at all.

9 **MR KEITH:** Good morning. Could we commence your formal
10 evidence, please, by asking you to give your full name.

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

12 **Q.** Thank you very much for attending today, and for the
13 enormous assistance which you and your department, the
14 Department of Health and Social Care, have given to the
15 Inquiry.

16 You personally, with the assistance no doubt of your
17 departmental colleagues, have provided three very large,
18 very long witness statements, but we're very grateful to
19 you for them. Worryingly and terrifyingly, they are
20 your sixth, seventh and eighth witness statements,
21 INQ000474334, INQ000474335 and INQ000474333.

22 **A.** That's correct.

23 **Q.** Dated, all of them, September last year, but they run to
24 many hundreds or hundreds of pages.

25 But, as I say, they're extremely helpful, so thank

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1 you.

2 **A.** Thank you.

3 May I just start by expressing my deepest sympathy
4 for those who have suffered in the pandemic and continue
5 to suffer, and indeed my thanks to all of those who have
6 helped make the vaccines and therapeutics programme
7 a success.

8 **Q.** Of course.

9 By the metric of the need to protect at a population
10 level against the SARS-CoV-2 virus, the evidence appears
11 to suggest -- provisionally, of course -- that the
12 vaccine programme was an overwhelming success and,
13 perhaps to a slightly lesser degree but no less
14 importantly, the therapeutics programme brought about
15 great benefit.

16 The DHSC was one of many government departments
17 entities, people, agencies, advisory committees, who
18 helped bring that about, and it might be said to be the
19 centre of the web in terms of the vaccines and
20 therapeutics story. Therefore I'm sure you want to pay
21 tribute to all of those who contributed to that larger
22 successful outcome, but in particular your colleagues in
23 your own department, who plainly worked extremely hard
24 for a very long period of time in the aid of the
25 United Kingdom.

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1 Nadine Dorries, Lord Bethell and a number of others.
2 And plainly the DHSC had a very wide remit, it was
3 a particularly complex departmental structure which was
4 prayed in aid of the pandemic response.

5 Could we just have a quick look at some of the roles
6 that your department carried out.

7 INQ000474334, page 7, at paragraph 18. We can see
8 there you've identifying at very broad level the roles
9 of your department in: research and development;
10 amending the legislation; deployment, you led the
11 preparation for and facilitated the deployment at scale,
12 although operationally, of course, deployment was
13 largely for the NHS entities across the United Kingdom
14 as well as national public health agencies.

15 Authorisation and approval. We'll come to the
16 process by which approval and authorisation was given
17 for vaccines later.

18 The approach of prioritisation. You commissioned
19 and responded to the advice of the independent statutory
20 body the Joint Committee on Vaccination and
21 Immunisation, but it gave advice to, which ministers
22 agreed, largely, I think, in advance that they would
23 agree to, when given by the JCVI.

24 International engagement and collaboration;
25 campaigns and communications.

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1 **A.** Absolutely, I do, and, indeed, to many people, the
2 experts, independent experts, who gave voluntarily of
3 their time, and the public as well.

4 **Q.** I want to focus today on that number of discrete but no
5 less important issues in respect of which one might say
6 that it's important to embed the lessons about what went
7 well, as well as to identify those areas that didn't
8 work quite so well and in respect of which it is perhaps
9 even more important that we try to identify what can be
10 done in the future to make that process work better.

11 You are currently, and you have been since
12 November 2016, the Director General for Global and
13 Public Health at the Department of Health and Social
14 Care.

15 **A.** I was since that time -- until September of last year,
16 but I now work for the Cabinet Office.

17 **Q.** Congratulations.

18 **LADY HALLETT:** Second Permanent Secretary and head --

19 **A.** Correct.

20 **LADY HALLETT:** -- of Mission --

21 **A.** Correct, yes.

22 **MR KEITH:** I'm very sorry I haven't reflected that in my
23 opening gambit, Ms Swinson.

24 The ministers in the DHSC included, of course,
25 Mr Hancock, Mr Javid, I think Helen Whately,

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1 Perhaps over the page, if there are more -- yes.
2 Further down the page: vaccine security; vaccine uptake.
3 You obviously contributed to the identification of areas
4 where more could be done to ensure uptake and reduce
5 barriers to access across UK collaboration, interaction
6 with other vaccination programmes, holding the health
7 system to account.

8 And last, but by no means least, briefing ministers.

9 **A.** That is correct.

10 **Q.** I think the DHSC prior to the establishment of the
11 Vaccine Taskforce, was immediately instrumental in the
12 early vaccine research and the clinical trial process,
13 dealing with issues such as building capacity and
14 considering development and manufacturing. So from the
15 very word go, the DHSC was intimately involved in the
16 vaccine and therapeutic story, if I may call it that.

17 **A.** Yes, that's correct. I think the first meetings that we
18 had in January 2020 under the leadership of the CMO and
19 the Deputy CMO included the need to start work on
20 finding vaccines and therapeutics to address the new
21 virus.

22 **Q.** Was a new directorate in fact set up in the DHSC, in
23 your department, to deal with the vaccines response
24 particularly?

25 **A.** That's right. In the course of 2020 a new directorate

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1 on the overall battle plan, one on vaccines, one on
2 therapeutics, and one on the non-pharmaceutical
3 interventions that we heard a lot about. This module is
4 also -- and obviously the strategy was to find the
5 pharmaceutical interventions of vaccines and
6 therapeutics so we could move away from the NPIs.

7 **Q.** And Antonia Williams I think took on the role of being
8 the Covid-19 vaccine deployment director?

9 **A.** Correct.

10 **Q.** And you've provided some detail about the number of
11 staff and the officials who were concerned in the DHSC
12 in that directorate.

13 How many, in terms of full-time or equivalent
14 full-time staff were there in -- at various times in the
15 pandemic in that directorate, dealing with vaccines?

16 **A.** Yes, um, probably up to about 80. I don't know exactly.
17 And about the same on therapeutics. It's varied a bit
18 over time.

19 **Q.** The VTF was set up, as we've heard from Lord Sharma,
20 by BEIS, B-E-I-S. But there appeared to be some debate
21 as to whether or not that body should be accountable to
22 both BEIS and your department, the DHSC. And as we'll
23 see in a moment of course, the Therapeutics Taskforce
24 ultimately did become exclusively a DHSC-led body.

25 **A.** Yes.

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1 **Q.** In hindsight, do you think that was the right course, to
2 have the Therapeutics Taskforce in DHSC and to have
3 vaccines in BEIS?

4 **A.** Yes, I mean, the most important thing I think is that
5 they were well resourced, they had the right expertise
6 wherever they sat, but in setting up the Vaccine
7 Taskforce under the leadership of Kate Bingham from
8 May 2020, making that a task that was just vaccines not
9 therapeutics, gave a focus to that, and therapeutics and
10 antivirals were given their own focus a year later, and
11 just in terms of the steps, there was a lot to do on
12 research. There was then a lot to do on the development
13 of vaccines and therapeutics. Then on procurement. And
14 then on deployment.

15 And so the taskforces played their own role in some
16 elements of that but weren't -- the Vaccine Taskforce
17 was not end-to-end; it really focused on the
18 procurement, the development, and working with industry.

19 **Q.** Why wasn't there an external head for the Therapeutics
20 Taskforce in the way that there was, plainly, for the
21 Vaccine Taskforce, whilst at the same time later, there
22 was an antiviral taskforce which was headed by, I think,
23 an external head, Eddie Gray?

24 **A.** Correct.

25 **Q.** How did that come about?

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1 **Q.** How did that debate come about? Why did it matter in
2 which department any particular advisory body or
3 taskforce should sit?

4 **A.** Yes. So, you're right, I mean, work on vaccines and
5 therapeutics started from the beginning, it didn't await
6 the setting up of the taskforce. On the whole, the
7 system you set out, people in the system did the jobs
8 that they were already doing but at greater scale.

9 There were a few cases, and vaccines and
10 therapeutics were some, where an additional
11 organisational structure was set up because of the
12 importance of that. There was some debate, obviously,
13 on the -- as it was right at the beginning, research and
14 manufacturing are more in the business department at
15 that stage, and so it was decided by the Prime Minister
16 that the Vaccine Taskforce would be part of BEIS
17 therapeutic stage with the Department of Health and
18 Social Care as you set out.

19 **Q.** So there was a prime ministerial decision ultimately?

20 **A.** Correct.

21 **Q.** Of course the production and manufacture of therapeutics
22 involves the same scientific and innovative working
23 patterns. It obviously is intimately concerned with the
24 issue of bioresearch?

25 **A.** Yes.

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1 **A.** Well, I think at the start, whether Kate Bingham's
2 taskforce would cover both was under debate, when it was
3 decided not to, there was some debate and there was
4 definitely a lot of external input to the Therapeutics
5 Taskforce and indeed a lot of work that Jonathan Van-Tam
6 had already, the Deputy CMO, had already started. There
7 was a lot of external input, whether an external chair
8 would have changed that a lot, I don't know. I don't
9 think it made a difference to the work of the
10 Therapeutics Taskforce in its first year, which was
11 largely set up and guided by Jonathan Van-Tam and
12 I should have mentioned earlier, not just the CMO, but
13 Patrick Vallance, the GCSA, who I think made the advice
14 of the Prime Minister both for the Vaccine Taskforce,
15 and the following year for the Antivirals Taskforce,
16 that they should have an external chair.

17 **Q.** Ms Swinson, it appears to be generally recognised that
18 having an external head in the form of, as it happens,
19 Dame Kate Bingham, was a good thing. Bringing that very
20 visible external leadership had very significant
21 benefits in terms of the management of the operation and
22 the outcome of the Vaccine Taskforce. So just in
23 principle, would that not be a sensible thing in the
24 future to do in the event that a Therapeutics Taskforce
25 has to be recreated?

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1 **A.** Yes. As I say, I think the biggest difference is that
2 it has the right expertise. As we'll come on to, I'm
3 sure, the Therapeutics Taskforce in its first year or
4 first few months was largely -- the thing that would
5 have the biggest difference was repurposed therapeutics
6 that already had authorisation. So the task was
7 slightly different than starting right at the beginning,
8 where we didn't have any vaccines at all.

9 But yes, the extent of external input but also
10 a voice, as you've said, is a judgement and could have
11 easily also had an external chair.

12 The other taskforce that was set up was the testing
13 taskforce with an external chair in that year.

14 **Q.** Lord Deighton --

15 **A.** That was -- (overspeaking) --

16 **Q.** Baroness -- (overspeaking) --

17 **A.** PPE as well under Lord Deighton for -- (overspeaking) --

18 **Q.** Lord Deighton for PPE and Baroness Harding for test and
19 trace.

20 And so that we're clear, obviously the Vaccine
21 Taskforce had within itself, very able civil servants
22 who worked alongside the external professionals who had
23 been brought in.

24 **A.** Absolutely right.

25 **Q.** And the Therapeutics Taskforce, was that also

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1 be or what combination and, indeed, given there hadn't
2 been a vaccine against any coronavirus, the very expert
3 opinion thought that the chance of an effective vaccine
4 was somewhat below 10%, so they were both very important
5 from the start.

6 It was unprecedented, the speed of the development
7 of the vaccine, and so by probably the late
8 summer/autumn of that first year, 2020, it was evident
9 that an effective vaccine was much more likely, and that
10 did change the context, as we'll come on to, for both
11 other preventative treatments because there would be an
12 effective vaccine, but still really important to develop
13 the therapeutics for those who were in hospital and in
14 the community, that were both repurposed existing
15 therapeutics and novel therapeutics which did come the
16 following year.

17 **Q.** Counterintuitively and rather bizarrely, perhaps, the
18 more successful the vaccine programme was and turned out
19 to be, on one level, the more reduced the need became
20 for there to be therapeutics, because of course the
21 vaccine programme and its success reduced transmission
22 and at a population level reduced the spread of the
23 Covid-19 virus for which therapeutic treatment would be
24 needed to deal with.

25 And also, as the vaccine programme began to succeed

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1 a combination of external professionals and scientists
2 and industrialists and venture capitalists and civil
3 servants?

4 **A.** Yes, both of them were multi-disciplinary teams with
5 commercial expertise, policy expertise. For most of the
6 work with industry, that was done through external
7 advisory groups rather than paid positions in the
8 taskforce but it was the same mix of experience within
9 both.

10 **Q.** In your statement you have equally set out in relation
11 to therapeutics the roles of the -- the functions of the
12 department. Just before I show you what you've said,
13 what do you say to the suggestion that therapeutics and,
14 in particular, prophylactics and, in particular,
15 antivirals, were given any less attention by your
16 department than vaccines?

17 **A.** So, from the start, with no therapeutic and no vaccine
18 for Covid-19, both were given -- the task was to find
19 effective preventative or treatments that would mean
20 that science, as it has for almost all pandemics, would
21 give us a way out of the pandemic. And that could have
22 been a vaccine or a therapeutic or, more likely,
23 a combination of both, from the start, that's what the
24 Deputy CMO set out to do. They were both equally
25 important at that stage, we didn't know which it would

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1 at a remarkable and at such a high level, there were
2 fewer hospitalisation cases and fewer people available
3 and willing to have therapeutics tested on them anyway.
4 So there was that problem built into the success of the
5 vaccine programme.

6 **A.** There was that impact, yes, whether it was a problem or
7 not, the numbers that we needed for research, you're
8 quite right, is one reason why, in the UK, so many
9 people successfully enrolled in research in that first
10 year. Of course, the chief investigators took or
11 carried out research both in the UK but in other parts
12 of the world, and did need people who were infected with
13 the virus, at whatever point that was, in different
14 countries. So there were various trials done in other
15 parts of the world as they were in the UK for precisely
16 the reason you set out.

17 **Q.** I wasn't going to ask about trials, but you've raised
18 a point that I'll just ask you about.

19 **A.** Yes.

20 **Q.** Just a few moments ago to Lord Sharma, Leslie Thomas KC
21 put a question about the lack of diversity in the
22 clinical trials for the vaccines. But of course, what
23 hasn't perhaps been made sufficiently clear, is, there
24 may have been a lack of diversity racially and
25 ethnically in trials in the United Kingdom where

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1 I think, in very broad terms, the clinical trials for
 2 vaccines that were carried out in the United Kingdom had
 3 about a 7% ethnic minority make-up as opposed to
 4 a proper or a full reflection of the demographics of
 5 around about 13 to 15%.

6 But all the vaccines had overseas trials as well for
 7 the same product and in some countries, is this not
 8 right, there was up to an 80% ethnic or racial
 9 component?

10 **A.** Absolutely, you're correct.

11 **Q.** Because they were conducted in South Africa --

12 **A.** Correct.

13 **Q.** -- obviously where there's a very much higher proportion
 14 who are black African as opposed to white British.
 15 South American, America, and elsewhere in Europe?

16 **A.** Absolutely. So both diversity and looking where
 17 research could be done where there were higher rates of
 18 the disease, correct.

19 **Q.** Thank you. I've digressed already.

20 Bringing you back to therapeutics and your witness
 21 statement, can we have INQ000474335 at page 7. You set
 22 out there at paragraph 18 and paragraph 19 the areas in
 23 which the department was concerned on the therapeutics
 24 side: Research and development; procurement, storage and
 25 supply; funding; communications; engagement with the

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1 Public Health and in the DHSC you're obviously able to
 2 see how the system comes together.

3 **A.** Yes.

4 **Q.** In relation to vaccines, your sixth statement,
 5 INQ000474334, page 22, paragraph 20, you
 6 identify -- I'm looking at the wrong statement.

7 **A.** That's okay. Public Health England?

8 **Q.** No, it was the right reference, it's just I had the
 9 wrong statement in front of me.

10 So can we have back, please, INQ000474334, page 22.

11 Thank you.

12 Paragraph 70, there's a reference there to the
 13 UKHSA:

14 "The UKHSA is [normally] responsible for [the]
 15 procurement of vaccines for ... routine programmes."

16 But in the specific context of the pandemic, what it
 17 and the -- Public Health England agencies did, as did
 18 the public health agencies in each of the devolved
 19 administrations, was provide public health advice on all
 20 aspects of vaccination.

21 So UKHSA stood back from the role of procurement and
 22 that was largely conducted by the Vaccine Taskforce
 23 within BEIS with the assistance of the DHSC; yes?

24 **A.** Correct.

25 **Q.** There's a reference, in paragraph 71, to the Medicines

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1 science licences sector; working across the whole of the
 2 United Kingdom; international collaboration; briefing
 3 ministers and senior officials.

4 **A.** Yes.

5 **Q.** In terms of the width, any less wide than the functions
 6 in connection with the vaccination -- vaccines?

7 **A.** No, very similar and as for vaccines, most of the wider
 8 health system and the independent regulator and so on
 9 did exactly the job that they normally do for any
 10 vaccine or therapeutic, not just the C-19, but it was
 11 the same system, the Department of Health, because of
 12 the emergency situation obviously was more active in
 13 many of these than it would be normally, but it's across
 14 the breadth, from discovering and research into
 15 a vaccine or therapeutic -- therapeutics, sorry, now,
 16 through to deployment working with NHS England to get
 17 the treatments to the patients who needed them.

18 **Q.** May I just moment materially put to you each of the key
 19 bodies which you identify in your statements --

20 **A.** Of course.

21 **Q.** -- and just ask you to confirm their general -- as
 22 simply as you can, their role in the general scheme of
 23 things.

24 You're in the hot seat, Ms Swinson, because
 25 you're -- you were the Director General of Global and

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1 and Healthcare products Regulatory Agency. That's the
 2 UK regulator --

3 **A.** Correct.

4 **Q.** -- primarily responsible for authorisation and licensing
 5 of both vaccines and therapeutics. Is that an entirely
 6 independent agency, independent of the rest of the
 7 government?

8 **A.** Yes, it's an agency of the department but it is an
 9 independent regulator both in the way it assesses the
 10 safety, effectiveness and quality of drugs and vaccines
 11 before they come on to the market, with also the input
 12 of the commission of -- for health medicines, CHM, that
 13 advises it. And that is independent and regulates all
 14 medicines on the market in the UK.

15 **Q.** And in terms of its independence, what's important about
 16 what happened during the pandemic is, whilst it's an
 17 executive agency within the DHSC, formally, it gave
 18 independent advice on whether or not to license,
 19 authorise, every single vaccine and every single
 20 therapeutic that was licensed; and the way it would work
 21 was it would give independent advice which would then be
 22 formally, if you like, decided upon by one of your
 23 ministers --

24 **A.** Yes.

25 **Q.** -- called the Licensing Minister?

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- 1 **A.** Yes.
- 2 **Q.** But that in no way detracts from the fact that it was
3 absolutely for the MHRA to say whether any given vaccine
4 or therapeutic should be authorised?
- 5 **A.** Correct. It was agreed with MHRA in the summer of 2020
6 that -- under the emergency procedure and one of the
7 regulations that the same advice and work would be
8 given -- would be done within MHRA, but that decision
9 would be put to a minister. We identified a different
10 minister in the department, called the Licensing
11 Minister, to take that decision, so that it was separate
12 from the ministers who were responsible for the supply
13 and purchase and rollout of vaccines, so that there was
14 no perceived conflict between those two roles.
- 15 **Q.** And was the DHSC and the Office of the Chief Medical
16 Officer, comprising obviously the CMO and the DCMOs, at
17 pains to guarantee and ensure the continued independence
18 of the MHRA?
- 19 **A.** That is correct and that was set out both in the note of
20 the meeting that I was referring to in the summer
21 of 2020 with the then Secretary of State and the Office
22 of the Chief Medical Officer, indeed both for MHRA and
23 for other independent bodies. They were obviously very
24 interested in the progress of their work but it was --
25 in no way took away the independence and the decisions

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- 1 **A.** That's correct.
- 2 **Q.** So it actually isn't part of government in any shape or
3 form.
4 Its recommendations were, of course, concerned with
5 prioritisation.
- 6 **A.** Yes.
- 7 **Q.** Not authorisation, but the priority by which people
8 would have their vaccines made available?
- 9 **A.** Correct.
- 10 **Q.** And did you put into place a system in which although
11 the Secretary of State in certain circumstances is
12 legally bound to implement recommendations from
13 the JCVI, in the context of Covid-19, the Secretary of
14 State agreed, because it didn't fall within those
15 particular categories, nevertheless to give real weight
16 to anything that the JCVI said on the issue of
17 prioritisation?
- 18 **A.** Absolutely. The difference in this circumstance is that
19 JCVI did not consider cost effectiveness because the
20 vaccines had already been procured, but both the
21 Secretary of State and indeed it went to Covid-O, the
22 Cabinet Office-chaired cabinet committee, who agreed
23 that they would take the advice from JCVI and implement
24 prioritisation in the way that they recommended.
- 25 **Q.** And although it wasn't a matter for the DHSC, in order

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- 1 that they recommended.
- 2 **Q.** So you were constantly being informed as to progress?
- 3 **A.** Yes.
- 4 **Q.** What would have happened if those persons, civil
5 servants and external professionals, scientists,
6 academics, who were involved in procurement, in the
7 procurement of vaccines and therapeutics, the
8 manufacture of vaccines and therapeutics, the purchase
9 of vaccines and therapeutics, or their delivery, had got
10 involved in the MHRA authorisation safety processes?
- 11 **A.** So it was important we had the line between those, so
12 that in their desire to get a vaccine, that none of that
13 was influencing the proper process that MHRA took, and
14 indeed that the authorisation decisions, all of those,
15 I remember at the time, were done on a very tight copy
16 list. There were also code names for vaccines early on
17 so that people working on the -- preparing the rollout
18 did not know the exact state of the work for MHRA and
19 the authorisation that was done on an independent basis.
- 20 **Q.** Another important body, of course, and we've heard much
21 of it already, was the Joint Committee on Vaccination
22 and Immunisation.
23 If you could have page 30, please, paragraph 103.
24 In relation to the JCVI, is this not just an independent
25 but in fact a statutory body?

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- 1 to further promote the appearance and actuality of
2 independence, the actual chair of the JCVI,
3 Professor Sir Andrew Pollard, recused himself because
4 he'd had some involvement in research work in Oxford,
5 and that's why Professor Wei Shen Lim took over?
- 6 **A.** Correct, and it's exactly for that reason that I want to
7 set out my thanks both to Professor Wei Shen Lim and all
8 of the members of the subcommittee, which I think met
9 pretty much twice a week and more often when needed
10 throughout this period.
- 11 **Q.** I think they were on the phone to each other day and
12 night, 24 hours a day, it would seem.
13 Just a quick dance through the remaining bodies and
14 areas.
15 Page 33, paragraph 104. Once the vaccines were
16 procured with the great assistance of the VTF, for the
17 population as a whole, at what point did the
18 UK Government step back and at what point did the
19 remainder of the process fall within the authority and
20 the practical reach of the devolved administrations?
- 21 **A.** Yes, so once the vaccines arrived in the UK, they were
22 distributed to agreed points for each of the devolved
23 administrations, or for the Crown Territories, Overseas
24 Territories, and the Crown dependencies, as set out.
25 PHE, as was, were responsible for the logistics of

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1 that operation, and then once it was in those places,
 2 the NHS in England and in each of the other nations were
 3 then responsible for the deployment -- distribution and
 4 deployment to the vaccination centres.

5 **Q.** And in England it was the Secretary of State, your
 6 Secretary of State, Mr Hancock until June 2021, who took
 7 decisions on vaccine deployment on the advice of
 8 PH England, UKHSA as it became, NHS England --

9 **A.** Correct.

10 **Q.** -- and the Vaccine Taskforce amongst --

11 **A.** Absolutely.

12 **Q.** -- a myriad of other bodies.

13 **A.** Yeah.

14 **Q.** And in terms of the overall co-ordination, page 80,
 15 paragraph 302, even though delivery, the output of
 16 vaccines was for each devolved administration, there was
 17 in the earlier parts of this remarkably complex
 18 machinery very close engagement at all levels in respect
 19 of all aspects of research, development, procurement,
 20 manufacture, clinical trial, and authorisation?

21 **A.** That's right, across the UK, that was both done with the
 22 UK CMOs, the DCMOs, at ministerial level and at policy
 23 official. There was very closely working -- there was
 24 slightly different statutory arrangements for the JCVI
 25 for each of the bits of the UK, but they all followed

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1 drugs and makes a cost effectiveness judgement and asks
 2 the NHS to make them available. That was -- there was
 3 a different system so that was done faster in the
 4 pandemic, and that is chaired by NICE. RAPID C-19 did
 5 a very similar job to what NICE would have done, or does
 6 do, in the non-emergency time, and recommend which
 7 therapeutics should be made available to the NHS.

8 **Q.** And importantly, did RAPID C-19 have membership from all
 9 of the devolved nations including --

10 **A.** Across the UK, yes.

11 **Q.** -- all the devolved administrative bodies such as the
 12 Scottish Medicines Consortium, the All Wales
 13 Therapeutics and Toxicology Centre -- (overspeaking) --

14 **A.** As set out here, correct.

15 **Q.** So that although it was a UK body, in practice and
 16 reality, as with many of these advisory committees and
 17 bodies, they included membership from across the
 18 United Kingdom, so that to a very large extent they all
 19 became trans UK bodies?

20 **A.** Yes. And had a common approach.

21 **Q.** And a common approach.

22 The MHRA, you address at paragraph 30. I don't
 23 think we need to dwell on that except, perhaps, 30(b).
 24 The MHRA is a UK body, is it not?

25 **A.** It is.

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1 the same advice. And where there were lessons to learn
 2 or things about where the vaccine would be rolled out or
 3 changes, that was very regularly discussed.

4 **Q.** And then on therapeutics, as I've emphasised no less
 5 importantly, your seventh statement, is largely
 6 concerned with that topic.

7 INQ000474335, page 9, paragraph 23.

8 You set out something of what was the Antivirals &
 9 Therapeutics Taskforce. Was that a combined entity that
 10 brought together the Therapeutics Taskforce and the
 11 Antivirals Taskforce --

12 **A.** It was.

13 **Q.** -- in April 2022?

14 **A.** Correct.

15 **Q.** There was, paragraph 24, an advisory committee called
 16 RAPID C-19, which comprised a number of bodies but, most
 17 importantly, NICE, the National Institute for Clinical
 18 Excellence?

19 **A.** Correct.

20 **Q.** And a number of other bodies. And it took, to a very
 21 large extent, the decision as to what particular
 22 therapeutics would be not just investigated and pursued,
 23 but ultimately made available?

24 **A.** That's correct. I said that most of the system did
 25 exactly as it did before the pandemic. NICE assesses

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1 **Q.** But notwithstanding, therefore, that in terms of its
 2 authority, it extends across the whole of the
 3 United Kingdom, it also is carefully linked to NICE in
 4 England, SMC in Scotland, and the AWTTG (sic) in Wales
 5 for the purposes of its recommendations?

6 **A.** That is correct.

7 **Q.** There was a Therapeutics Clinical Review Panel, page 26,
 8 paragraph 87, which also played a role in the advice
 9 given to the -- all the UK Chief Medical Officers. So
 10 not just the Officer of the Chief Medical Officer, but
 11 in fact all four UK Chief Medical Officers about
 12 therapeutics.

13 There was another body, page 27, the UK Covid
 14 Therapeutics Advisory Panel, which gave independent
 15 advice for that earlier group on the most promising
 16 therapeutics, and then, as you have described, there was
 17 the RAPID C-19 process as well as the taskforces which
 18 were concerned with procurement and -- procurement.

19 **A.** Correct.

20 **Q.** Right. It's a complicated structure, Ms Swinson.

21 On the funding side, we've heard a bit about the
 22 funding from Lord Sharma. We're aware, of course, of
 23 the NIHR, the National Institute for Health, now Health
 24 and Care Research, the important body, the UKRI, and
 25 also the funding done by the United Kingdom Vaccines

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1 Network.

2 **A.** Yes.

3 **Q.** It's obvious that there were a number of funders. Do
4 you assess, by reference to the speed with which
5 decisions were made and the number of vaccine and
6 therapeutic trials that were funded, that that system of
7 funding worked well in January, February, March,
8 April 2020?

9 **A.** Yes. So on research funding I think it did work well.
10 I'd say two things about it. One, that you've referred
11 to, is that decisions that were taken before 2020 were
12 very important, so the base of the clinical networks and
13 research infrastructure in the UK, and indeed relatively
14 small amounts of investment that made a big difference
15 into the capabilities that the UK had and the
16 development of the AstraZeneca vaccine at Oxford were
17 already in place, and then when the pandemic had
18 started, coordinating that, issuing an urgent public
19 health call, and being able to fund and coordinate the
20 trials in the spring of 2020, that was incredibly
21 important, and I think worked well.

22 **Q.** Just pausing there. A great deal of research had
23 already been done on M -- messenger ribonucleic RNA
24 vaccine technology, so although two, I think, of the
25 Covid-19 UK vaccines were based on mRNA technology and

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1 epidemic potential, particularly in low- and
2 middle-income countries and funded research into what
3 was then a MERS, so it was a coronavirus, the
4 coronavirus vaccine platform which was then -- and had
5 had some early clinical trials, which was then able to
6 pivot to the new coronavirus, the novel coronavirus,
7 that had been found.

8 **Q.** Indemnities. Entirely separate subject, please.

9 **A.** Yes.

10 **Q.** Taking it briefly, because we've heard from Lord Sharma
11 on the general topic of indemnities already.
12 You were directly concerned with drafting
13 submissions to the Secretary of State seeking authority
14 for the general approach taken by the UK Government --

15 **A.** Yeah.

16 **Q.** -- both in general terms to indemnities but also in
17 respect of each of the contracts.

18 **A.** Yes.

19 **Q.** Was the nature and the style of the indemnity in each
20 case negotiated with each manufacturer separately?

21 **A.** I believe so. It was the responsibility of the Vaccine
22 Taskforce with very significant commercial expertise,
23 and I think it's not unusual in an emergency situation
24 to have these types of indemnities. They advise the
25 ministerial panel, which was the Minister for --

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1 were new vaccines --

2 **A.** Yes.

3 **Q.** -- the technology had been around for some time and had
4 been funded and gone into; is that correct?

5 **A.** I think you would need someone more technical but
6 I think they are the first mRNA vaccines at all, so it
7 was known as a theoretical approach to vaccines that was
8 being developed and that became --

9 **Q.** But the technology, the research, had been going on for
10 some time?

11 **A.** That's correct.

12 **Q.** Secondly, the Oxford AstraZeneca vaccine based on an
13 adenoviral virus, a chimpanzee virus --

14 **A.** Yes.

15 **Q.** -- known as a vector virus, again, that had been in
16 play, not, obviously, for the purposes of the
17 coronavirus virus that we were dealing with, but it had
18 been in play, the technology had been in play for
19 a while, and that had been funded for some time already
20 by these various elements in the United Kingdom
21 government.

22 **A.** Yes, so the UK Vaccine Network was funded from our
23 overseas aid budget, it had been established after
24 lessons learned from the Ebola outbreak chaired by
25 Sir Chris Whitty, it identified viruses of pandemic or

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1 Secretary of State for Health, and for Business, as well
2 as ministers from the Cabinet Office, and Treasury,
3 about those decisions, and we also advised our Secretary
4 of State, as set out, when the UK Government takes on
5 indemnities, there's also an obligation to inform
6 Parliament, which we did following those submissions and
7 whenever we deployed a vaccine, updated those
8 liabilities to Parliament.

9 **Q.** The overall approach to indemnities was put to and
10 agreed by the Prime Minister, given the significance and
11 the amount of public money concerned.
12 Why was the DHSC involved in this issue when it was
13 BEIS and the Vaccine Taskforce that were leading on the
14 negotiations? Or were you involved because your
15 Secretary of State, Mr Hancock, was on the ministerial
16 panel?

17 **A.** Yes, I think a few reasons. That is certainly one of
18 them. I think it might have formerly reported to both
19 departments from 2020 -- later in 2021 and for the
20 relevant accounting officer, which at the start was in
21 BEIS but then transferred to DHSC, that's the issue
22 I talked about, about ensuring that spend was regular
23 and proper and indemnities could be informed to
24 Parliament.

25 **Q.** Well, when you were briefing your Secretary of State, as

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1 is the way with government, you put a handful of
2 hypothetical questions and answers to him, for his
3 consideration, by way of trying to foresee what sorts of
4 questions the public might ask about what had been
5 agreed by the UK Government. And one of the questions
6 which you invited his approval for, in terms of alerting
7 him to what might be said by sectors in the public, was
8 "Why are you letting big pharma get away with the
9 delivery of a potentially unsafe vaccine by protecting
10 them from civil liability?"

11 In general terms, were the indemnities agreed by the
12 UK Government designed to, or did they, protect the
13 manufacturers from actually being sued in the courts by
14 individual claimants?

15 **A.** No, they were very specific, and I think it was common
16 across most international countries that at the time we
17 were procuring it was normal, we had -- so it's rare,
18 but, for example, we had done the same in the H1N1 swine
19 flu pandemic, to -- at that time, to offer a limited set
20 of liabilities to the manufacturers that the
21 UK Government would take on.

22 **Q.** So there was no overarching statutory immunity to the
23 effect of you can't be sued?

24 **A.** Not at all.

25 **Q.** There was no guarantee or any provision given by the

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1 issues?

2 **A.** No, the rigour was exactly the same. As you said, it
3 was the speed that allowed, instead of waiting for the
4 entire bundle of information to come to the MHRA that
5 would take number of weeks or months, that the MHRA
6 assess the information as it was given to them, the
7 rolling review as you called it, which meant that by the
8 time the final phase III trials had been completed, and
9 the advice, they'd already looked at what had come
10 earlier. It was exactly the same level of scrutiny and
11 data required for its assessment of safety and
12 effectiveness.

13 **Q.** So was there any reduction, as the DHSC saw it, in the
14 amount of time dedicated to clinical trials, or the
15 number of participants in those trials, or the time
16 taken by the MHRA to look at the data and the outcome of
17 all those trials?

18 **A.** No, it was running various assessments and indeed trials
19 that, in normal times, might run one after another. It
20 was being able to run those concurrently where it was
21 possible. It was -- also meant that the MHRA, if they
22 had any kind of technical questions about the form in
23 which something had been given, they would talk directly
24 and make sure they understood it, rather than it being
25 a kind of a slower to and fro on -- between the MHRA and

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1 UK Government generally limiting access to the court.
2 It was only about agreeing to pay in the event that
3 a manufacturer lost in the civil courts, on a claim
4 perhaps under the Consumer Protection Act, by way of
5 reimbursing the manufacturer for any award of damages
6 made against it and any legal costs, in certain
7 circumstances?

8 **A.** Yes, I think that's right. BEIS and the VTF would be
9 best placed, but that's roughly right.

10 **Q.** All right.

11 Moving on to the authorisation process.

12 **A.** Yes.

13 **Q.** It's well known that, in relation to the vaccines
14 authorisation process, instead of waiting, which is
15 usually the position, to the end of all the phase I,
16 II and III clinical trials for all the data to be given
17 to the MHRA as part of an application of authorisation,
18 the MHRA agreed to receive the data as soon as it became
19 available.

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

21 **Q.** A rolling review.

22 Was this course that was adopted something of
23 concern to the DHSC on account of whether or not it
24 would give rise to perhaps unfounded concerns about the
25 degree of rigour or attention being paid to safety

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1 the company, so that they were able to make the
2 assessments as quickly as possible.

3 The quality and the standard of that assessment was
4 exactly the same. It was the speed and being able to do
5 things concurrently that was different.

6 **Q.** Bluntly, the MHRA picked up the phone constantly, at all
7 times of the day and night, to say: "What's going on?"
8 Or "What about this?" Or "Where is that document?"

9 **A.** Exactly.

10 **Q.** "What does it amount to?"

11 Rather than just waiting in a delphic silence --

12 **A.** Yes.

13 **Q.** -- till the end of the process, at the point at which
14 they would be asked to give authorisation and have all
15 the material dumped on them?

16 **A.** Exactly right.

17 **Q.** On the topic of safety, remaining on this topic, the
18 paperwork shows, the documents show that the DHSC was
19 very closely connected to the general debate about the
20 absolute importance of having the MHRA made aware of any
21 safety concerns or issues or side effects appearing from
22 the clinical trial process, as well as the no less
23 important obligation to keep the public and the
24 clinicians and doctors and professionals informed.

25 Is this, in reality, a very complex structure? Are

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1 there a number of different ways in which the MHRA
2 studies vaccines and therapeutics, and of course this
3 system applies to both vaccines and therapeutics, for
4 side effects, for suspected unexpected serious adverse
5 reactions? And also a no less complex structure by
6 which it puts all information into the public domain?

7 **A.** Yes. Now I know you're hearing directly from the
8 MHRA --

9 **Q.** We are.

10 **A.** -- but the -- their assessment is both of the trial
11 data, so that is both laboratory data and trials in
12 humans, and their assessment of that. When they come to
13 authorise, they set out any precautions or things that
14 need to be said in the patient information leaflet.
15 They also look at the quality of the actual drugs, so
16 they will do regulatory checks at the manufacturers,
17 that they batch test each batch of the vaccine before it
18 comes onto the market to make sure that what is being
19 provided is as they were set out on paper. So that's
20 the second tranche.

21 Then, as you say, after deployment they also do
22 surveillance and monitoring of any side effects that are
23 reported, any other real life data, so that they are
24 also able to then amend any of the conditions under
25 which they've marketed the product.

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1 Jonathan Van-Tam, knowing what they were doing, the
2 safety signals, which I think MHRA confident always
3 reported as soon as they had information --
4 communicating risk to the public in terms of any change
5 that's happened is a complicated thing to do, so when
6 there were changes on the AstraZeneca vaccine and then
7 on the Pfizer BioNTech, working closely so that MHRA,
8 the JCVI and, if required, the Deputy Chief Medical
9 Officer, could set out that information not just in
10 writing and on the website, as you've said, but in
11 a press conference or whatever was needed, that was
12 brought together if it needed to. So it wasn't just
13 from one individual organisation.

14 **Q.** Let me put it another way. Did you or your team or your
15 officials or your colleagues ever have a situation in
16 which they became aware of a specific safety risk or
17 a condition or a suspected adverse reaction in relation
18 to any of the Covid-19 vaccines which didn't
19 subsequently, following examination by the MHRA and the
20 Commission on Human Medicines and panoply of government
21 agencies, reach the public domain?

22 **A.** No.

23 **Q.** Prioritisation. It's obviously a matter for the JCVI
24 primarily, because you've described how your Secretary
25 of State agreed in advance to accept recommendations

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1 **Q.** And in terms of the conditions, there are formal routes
2 by which the public are kept informed through a document
3 known as a summary of product characteristics, also the
4 patient information leaflets.

5 But the DHSC was obviously aware that the MHRA had
6 a number of different routes by which it kept the public
7 informed in addition. So there were weekly publications
8 of information from the Yellow Card system?

9 **A.** Yes.

10 **Q.** There was something called a drug analysis profile
11 published regularly in respect of every vaccine, and
12 changes made to the medical bible, the Green Book, as
13 well as press releases, publications, and the like?

14 **A.** Yes, all of those ways.

15 **Q.** Was there ever a time in which you, as the Director
16 General of that directorate, or the Secretary of State,
17 or any of the DHSC ministers, perceived that there was
18 information about side effects or the safety or the
19 overall safety, or any kind of suspected -- because
20 obviously you don't know whether or not a condition is
21 associated with the vaccine, associated with the virus,
22 or coincidental -- but any suspected condition was not
23 being put into the public domain?

24 **A.** So, in terms of MH being in close contact with MHRA and
25 the experts, also via the Chief Medical Officer and

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1 from the JCVI, but did the DHSC differ significantly or
2 did it depart significantly from the general approach
3 agreed by the United Kingdom, which was that the
4 priority list had to be based on the essential clinical
5 feature that the oldest were the most vulnerable and had
6 to be vaccinated first, along with care home workers who
7 looked after them?

8 **A.** No. JCVI put out their initial assessment or
9 prioritisation early on in 2020. There were some new --
10 that became more -- it was an iterative process about
11 exactly what the groups were, but it remained roughly
12 the same. We were not concerned about that.

13 There was, I'd say, two things: there was quite
14 a lot of debate, I mean publicly and around government,
15 about whether different occupations or there should be
16 a different way of looking at it, other countries also
17 sometimes did different things so why that was the case.
18 But the JCVI always looked at the clinical
19 vulnerabilities, it was set out in that way, and I think
20 any of the questions put to them addressed that, that
21 age was by far the biggest predictor of serious disease.
22 So I'd say that, in terms of the process.

23 I'd also say that, you know, there were concerns
24 about how people would react, the population as a whole,
25 to the prioritisation. I'd say because the rollout was

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1 so quick -- you know, if it had been going on for months
2 and years I think there would have been more debate but
3 because it was offered, you know, by Easter to all the
4 over-fifties and those clinically vulnerable and then to
5 all adults being offered a vaccine really by -- within
6 seven or eight months, I think it also meant that people
7 were confident that not just the prioritisation was
8 correct, but also that the NHS would get through that
9 very quickly and everyone could take up their offer of
10 a vaccine.

11 **Q.** And in an overall sense, I think the priority groups
12 were all offered, at least vaccination, in every country
13 in the United Kingdom by, well, four dates in March and
14 April?

15 **A.** Yeah, it was an amazing achievement.

16 **Q.** It is self-evident that with respect to a virus which
17 kills the elderly first and most quickly, and therefore
18 makes them the most vulnerable, that any consideration
19 or prioritisation should probably focus on the elderly.
20 But did the DHSC and the JCVI also have recourse to
21 mathematical modelling which established that if you
22 offer vaccines to the older age groups first, you will
23 inevitably end up reducing the total number of deaths
24 which will be suffered by the United Kingdom?

25 **A.** Absolutely. So the policy intent given to JCVI was to
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1 was still age-stratified that, by and large, the advice
2 that the DHSC received was that the age approach had to
3 be maintained?

4 **A.** Yes. There were a number of other factors, as you set
5 out. They were very carefully considered by JCVI and
6 others, including our Moral and Ethical Advisory Group.
7 The assessment of the clinical vulnerability was that
8 age was by far the biggest predictor and so therefore,
9 for people in different occupations, different settings,
10 they would have access to the vaccine according to age
11 order, unless they had a health condition that put them
12 in groups 4 or 6, or priority groups 4 or 6 of the JCVI.

13 Care home workers and healthcare workers had been
14 considered and were prioritised in groups 1 and 2 from
15 the start.

16 **Q.** And we'll look at that with Professor Lim.

17 Presumably the advice that you received was that if
18 you vaccinate those who are most at risk in terms of
19 morbidity or mortality, those who literally will die
20 first if they're not vaccinated, and the quicker you get
21 through those cohorts, the quicker you'll get to the
22 point at which transmission across the country as
23 a whole is reduced and the risks to everybody are
24 indirectly reduced. Is that the thinking?

25 **A.** Yes, for vaccine effectiveness, you both look at the
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1 reduce mortality and morbidity as quickly as possible.
2 In doing that, they've had access to epidemiology,
3 clinical information, also modelling. This came into
4 its own also when they looked at the dosage interval
5 early on and decided that the best way to protect the UK
6 population was to get as many people their first vaccine
7 dose, rather than -- and prioritising that within the
8 window above second doses.

9 **Q.** You've mentioned the difficult issues of whether or not
10 you interpose particular occupations.

11 **A.** Yes.

12 **Q.** Put them further up the priority list or put them into
13 the priority list. And we'll ask other witnesses of the
14 pressures that were brought to bear from particular
15 sectors to have their members vaccinated as a priority.

16 But more widely than that, were there quite acute
17 ethical issues concerning the need to prioritise the
18 vaccination of those who worked in jobs that can't be
19 done at home: persons in ethnic minority communities,
20 I don't know -- younger adults. There were some quite
21 difficult issues to be resolved. Did the DHSC seek
22 advice from its advisory group MEAG, the Moral and
23 Ethical Advisory Group, on these issues?

24 **A.** It did, yes.

25 **Q.** And do we take it from the fact that the priority list
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1 impact on the severity of the disease as well as
2 transmission, and that changed a bit over time with the
3 different variants and the different vaccines, but being
4 able to offer the vaccine to reduce mortality, reduce
5 the risk of hospitalisation by a very large percentage,
6 I think about 80%, both reduced the pressure on
7 hospitals, it saved lives, thousands of lives, in that
8 first year and subsequently, and indeed, brought down
9 the peaks of the waves of the virus.

10 **Q.** There was a particular issue concerning prioritisation
11 and you've referred to it already, and that was
12 cohort 6, priority group 6. That cohort, that group had
13 in it a footnote or a reference to carers. And an issue
14 arose as to whether or not, in group 6, unpaid carers
15 should be approached on the basis that they were to be
16 included in the definition of sole or primary carer --

17 **A.** Yes.

18 **Q.** -- to which cohort 6 footnote or text referred?

19 **A.** (Witness nodded).

20 **Q.** Ms Swinson, the material does appear to make plain that
21 government at some stage, and at some point, was
22 concerned that if the definition of carer was expanded
23 over much, it would mean too many people being given
24 priority vaccination. At the same time, you're
25 obviously concerned to ensure that the prioritisation
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- 1 groups followed as swiftly as they possibly could. How
2 do you assess that problem was -- how well was that
3 problem resolved by the DHSC?
- 4 **A.** Yes. So when JCVI recommended cohorts, or groups to go
5 into the priority 6, there was then detailed work in the
6 department and in the Green Book, as you've referred to,
7 about the definition of those groups, so defining them,
8 how to define a healthcare worker, how to -- a carer.
9 There were some ways that that was done that were
10 straightforward, for example being in receipt of Carer's
11 Allowance. There was also a carers register. And
12 I think what then also happened so that people who
13 hadn't -- who weren't registered in that way, if they
14 were the main carer of someone who would be at great
15 risk of Covid-19, that could also be agreed through
16 primary care through your GP surgery.
- 17 So defining that cohort and exactly who had
18 eligibility was carefully considered, and the
19 definitions were put in the Green Book.
- 20 **Q.** In hindsight, do you think the government took a too
21 narrow view of the definition of carers? The upshot was
22 that a very large number of unpaid carers did not
23 receive prioritisation -- prioritised vaccination in
24 cohort 6.
- 25 **A.** Yes.

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- 1 that there was continued confidence that it was being
2 done in a fair -- the rollout was operating in a fair
3 way.
- 4 **Q.** There was a considerable diminution and reduction in
5 confidence amongst that cohort because of this -- and it
6 was a problem. There was a real issue as to whether
7 unpaid carers would get prioritised. Do you think --
- 8 **LADY HALLETT:** Can I just interrupt -- I'm so sorry. Keep
9 that train of thought, Mr Keith.
- 10 Just going back to you said that you could go to the
11 local vaccination centre if you thought you ought to be
12 given some priority. But did people know that? I don't
13 think I realised that if I -- actually, I think I was in
14 one of the groups that got the jab quite early, but I
15 don't think people knew that, did they?
- 16 **A.** I was referring, really, to the operational flexibility
17 that centres did have, at the end of the day, for
18 healthcare workers. JVT has set out in his statement,
19 for example, when he was vaccinated. The fair and
20 agreed rollout was through the JCVI age cohort, and
21 I think there were very many, you know, big campaigns
22 about -- both publicly when you were eligible, but also
23 through emails and texts and other ways.
- 24 **LADY HALLETT:** Have you still got that thought, Mr Keith?
25 I hope you haven't lost it.

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- 1 **Q.** Was that not an error?
- 2 **A.** I don't know the numbers, but obviously you were offered
3 a vaccine both -- or the offer was both to sets for
4 carers but it would also be age-related, so, you know,
5 a relatively elderly carer for -- caring for an older
6 parent would also have access to the vaccine through the
7 age route, and I think -- I don't remember it being
8 a large issue, but locally it may well have been and
9 people should have talked to their vaccine centre.
- 10 JCVI did set out that there was operational
11 flexibility, so if someone had gone for vaccination with
12 their carer and there was a spare vaccine, because we
13 were very much looking to minimise wastage at the end of
14 the day, there were other ways to make sure that you
15 could get the vaccine.
- 16 **Q.** The DHSC was concerned -- it was involved because
17 although prioritisation was for the JCVI, the JCVI would
18 reach out to the rest of the government when there were
19 problems about the meaning to be given to the text --
- 20 **A.** -- (overspeaking) -- yes.
- 21 **Q.** -- or the priority groups, or how operationally it was
22 to be put into practice. Was that why the DHSC was
23 engaged?
- 24 **A.** Yes, I think that's right, and for both cross-government
25 but also the response from the public, it was important

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- 1 **MR KEITH:** No, I hope so.
- 2 I was going to ask you -- thank you very much.
- 3 Do you think that the problem of identifying who or
4 what type of carer would fall within a particular cohort
5 next time, and obviously the great probability is that
6 the next pandemic and the next viral outbreak will or
7 will probably hurt the elderly and those who need care
8 more than most, do you think there's an argument for
9 reform by way of having a permanent register for carers,
10 whether paid or unpaid, so that in the teeth of a crisis
11 the government can simply say, "Well, we know how many
12 people we're dealing with, we can identify the cohort,
13 this will enable us to take a view as to whether or not
14 they should be prioritised easily"?
- 15 **A.** Yes, it's obviously easier to define a cohort when that
16 list already exists, which is the case for healthcare
17 workers. It was the same for careworkers, where we
18 asked employees -- employers, to make sure that all of
19 their employees, because there wasn't a register of paid
20 careworkers, as, you know, unpaid carers can be a large
21 cohort, those in receipt of Carer's Allowance are
22 largely unpaid. That's a large number. If there was
23 a way to maintain and to define -- a lot of work was put
24 in at the time, but for any group that needs to be
25 defined, if there is an existing register it makes it

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1 simple. And if not, depending on the next -- what the
 2 circumstances would be, I'm sure there would be other
 3 groups that we will need to define at the time.

4 **Q.** Well, you say a lot of work was done but the truth is
 5 there was no agreement or no decision made to try to
 6 draw up a register, therefore the public had no means of
 7 registering their involvement as an unpaid carer, and
 8 therefore, nobody knew how many people they were dealing
 9 with and nobody knew whether they were entitled to
 10 prioritisation --

11 **A.** I don't know --

12 **Q.** -- if they were an unpaid carer.

13 **A.** Yes, I don't think it would have been no one but yes,
 14 I'm sure there were people, and I've seen the -- on the
 15 estimates of how big each cohort was, and how fast we
 16 could get through the cohorts, there were, you know,
 17 best efforts for what those numbers would be.

18 **Q.** You got there in the end because of course the
 19 prioritisation process reached everybody in the end, and
 20 then everybody, whatever age, got vaccinated --

21 **A.** Yes.

22 **Q.** -- or was offered a vaccination. But this was
 23 a particular cohort.

24 In order to address the concerns and needs of
 25 particular Core Participant groups in this Inquiry, was

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1 And your Secretary of State wrote in May 2021
 2 formally requesting advice on the vaccination of
 3 children and young people, and obviously it was a matter
 4 for which he was seeking the view of the JCVI. You,
 5 I think personally, wrote again on 23 June. The JCVI,
 6 however, didn't respond until 5 July 2021, and they gave
 7 their quite complex view as to whether or not children
 8 and young persons aged 12 to 17 should be vaccinated?

9 Do you know why there was that delay? For those
 10 persons who were in vulnerable households or who were
 11 immunocompromised or clinically extremely vulnerable or
 12 clinically vulnerable, they were greatly concerned at
 13 the issue of whether or not children would be vaccinated
 14 in an attempt to reduce transmission. There appeared to
 15 have been some delay. Do you know why that was?

16 **A.** So the evidence for children was -- came later than it
 17 did because they hadn't been involved in the clinical
 18 trials, it wasn't authorised for under-16s, I don't
 19 think, right from the start, or definitely wasn't.
 20 There was evidence by the spring of 2020, particularly
 21 from the United States and some other places where that
 22 could be properly taken into account, and, as you've
 23 referred to, the JC -- what happened, I think, for the
 24 under-18s is there were a number of steps, it was an
 25 iterative process, so first of all for the 16 to 18s,

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1 particular consideration also given, through the
 2 prioritisation process, but also in terms of operational
 3 responses, to the needs of migrant people, homeless
 4 people, members of the prison population, and, in
 5 particular, whether or not there should be a carve-out
 6 for them specifically within the overarching
 7 prioritisation process? So it was -- everybody was
 8 thought about even if an exception wasn't made,
 9 ultimately?

10 **A.** Yes, JCVI looked at very many bits of evidence. There's
 11 correspondence, I know, that you have made available
 12 about their assessments for both homeless people and
 13 prison workers. And all of that was carefully
 14 considered and taken into account in the groupings, that
 15 they continued to evolve depending on the evidence.

16 **Q.** In relation to children, we're going to target our
 17 questions, in fact, to the JCVI and also the CMO and
 18 DCMO, because they're the ones who gave advice on it.

19 **A.** Yes.

20 **Q.** But as it happens, in cohort 6 were also adults
 21 aged 16-65 who were in an at-risk group, and therefore
 22 the DHSC wrote to the JCVI seeking advice in
 23 March 2021 on the topic of universal vaccination, so
 24 a widening out of the vaccination delivery programme for
 25 all under-18s.

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1 then for those 12 to 15 with health conditions. From
 2 that letter, the universal offer for the 16 to 18s
 3 I think was recommended in the July, but for the
 4 12 to 15s, that advice then came later in -- at
 5 September, which I'm sure you'll come on to.

6 So I think it's not so much that there was a delay
 7 in the answer; it was that the answer came in a number
 8 of steps according to the evidence, and where JCVI were
 9 confident to recommend adding children to a universal
 10 programme.

11 **Q.** Was the DHSC more concerned in the issue of vaccine
 12 uptake, and in the process for vaccine uptake, than it
 13 would normally have been concerned with in respect of
 14 routine immunisation?

15 **A.** I mean, I would -- DHSC are concerned about vaccine
 16 uptake on the childhood programmes and the impact that
 17 that has, but clearly, in 2021, the government had set
 18 out the roadmap out of lockdown and out of the
 19 restrictions. One of the tests in that was vaccine
 20 uptake because it was one of the things that would give
 21 confidence to reopen society, remove many of the social
 22 restrictions and so on. So there was definitely a very
 23 strong interest in uptake, both for the protection of
 24 individuals, the reduction of mortality, but also for
 25 the impact on society and the economy.

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1 **Q.** To what extent did the DHSC and other bodies such as the
2 CMO, DCMO, NHS, Public Health England and so on, and the
3 VTF, consider, and if so how frequently did they
4 consider, how to ensure the barriers to access and
5 inequalities of healthcare service did not prevent the
6 uptake of vaccines which were being offered?

7 I mean, was this something which you majored on, was
8 this something you paid attention to? Were there daily
9 meetings? Tell us how it worked.

10 **A.** Yes, absolutely. So it was known before the pandemic,
11 so we knew when we were planning the campaigns that in
12 all likelihood, because of our experience on routine
13 programmes, that uptake in some groups would be much
14 harder, there would be harder-to-reach groups. There
15 were, by the time, I mean, we had daily meetings,
16 I think from November with the Secretary of State, and
17 that covered a range of things on supply, on deployment,
18 and increasingly on uptake. There was Dr Nikki Kanani
19 who was appointed in NHS England around uptake for those
20 in harder-to-reach groups, and that was a very frequent,
21 if not daily, conversation, and the vaccine uptake plan
22 was published in February 2021, that set out the
23 approach to that.

24 I can say a bit more about the overall approach or
25 I'll wait --

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1 a clear pronouncement by your department that it was
2 absolutely vital to make sure that everything that could
3 possibly be done would be done, to ensure that the
4 barriers to access and inequalities were reduced. Why
5 was this not put first and foremost, right at the front
6 before you even got going with delivery?

7 **A.** I mean, the times when we published documents, as you
8 say, both in January and February, that was covered, it
9 was definitely part of the discussions and the Secretary
10 of State had asked NHS England to be ready from
11 1 December to deploy vaccine. Everyone involved in the
12 delivery of vaccines, and NHS England and directors of
13 public health would know that different groups needed
14 particular different approaches, even when there was a
15 universal offer. So I don't know if I can point to
16 anything in a DHSC document, public document, before
17 then, but it was definitely considered right from the
18 start of deployment.

19 **Q.** INQ000256951 is, I think, a Public Health England report
20 which you may have commissioned but certainly it came to
21 you and it was actually published right at the end of
22 December --

23 **A.** December, yes.

24 **Q.** -- 2020, so on the cusp of January. If we could just
25 have a quick look at page 10, paragraphs 2, 3 and 5,

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1 **Q.** I'll come on to that in a moment.

2 We're going to try to not use phrases like
3 "harder-to-reach" because of the connotation that there
4 are groups who put themselves beyond reach.

5 But could you, please, have a look at the vaccine
6 uptake plan, INQ000087230, of February 2021.

7 **A.** Yes.

8 **Q.** So within a couple of months of the programme
9 commencing.

10 If we look at page 3 briefly -- this is obviously
11 a public document -- we can see that you say, and this
12 is a departmental document, or at least Mr Hancock said,
13 six paragraphs down:

14 "We need to ensure that everyone feels that the
15 vaccine is for them. For some groups of the population
16 the intention to vaccinate is lower ... [We need] to
17 make sure that all our communities are protected, this
18 Vaccine Uptake Plan sets out our approach."

19 The vaccine programme had already started. There
20 was a Vaccines Delivery Plan published also by the
21 department --

22 **A.** Correct.

23 **Q.** -- I think a month before, on 11 January?

24 **A.** That's correct.

25 **Q.** But there doesn't appear before January to have been

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1 we'll see that it was well known to the department that
2 there were very, very real difficulties with the data
3 systems surrounding the identification of inclusion
4 health groups, persons who had protected
5 characteristics, certain ethnic minority groups, in
6 particular Gypsy, Roma or Traveller communities, or
7 being a migrant or refugee, because, bluntly, as this
8 makes plain, data on certain health groups and protected
9 characteristic groups is variably collected. There's
10 very little data in GP systems relating to the Gypsy,
11 Roma or Traveller communities or homeless people or
12 refugees, and there's no easy central data system which
13 collates information on everybody.

14 Just at a very high level, the department was
15 obviously aware of the difficulties, therefore, of
16 trying to find out the lie of the land.

17 **A.** Yes.

18 **Q.** Over the course of the six months, the first six months
19 in 2021, as the vaccine was being delivered, was it
20 actually in any way possible to get on top of these data
21 problems? Were they too embedded, too complex, just too
22 difficult to resolve, so that actually, even by the end
23 of the prioritisation process, nobody really knew how
24 many people were in these communities and how best they
25 could be identified?

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1 **A.** So, as a number of witnesses have set out, the situation
 2 before a pandemic is likely to be the one that you're in
 3 in the pandemic, and, you know, for groups that were not
 4 registered with a GP, there are a range of things the
 5 department did, none of them by themselves make -- would
 6 mean that everyone was counted or included, but -- for
 7 example, you didn't -- being clear that you didn't have
 8 to be registered with a GP to receive a first dose, to
 9 encourage registration. For example, the homeless at
 10 this time I think were in emergency accommodation, so
 11 being able to -- that was -- we were able to -- or local
 12 immunisation teams were able to reach those probably
 13 more easily than at some other time. So for some groups
 14 it might be easier, for others it might be harder, but
 15 the advice that -- and this kind of report would also go
 16 to JCVI on the types of things to consider, the types of
 17 things that local services could do. As I say, none of
 18 them were a kind of one thing you could do to reach all
 19 of these people but a range of things were necessary, so
 20 that we could be as clear as possible that everyone was
 21 eligible for a vaccination.

22 **Q.** It's obvious, Ms Swinson, that much was done by way of,
 23 for example, using local trusted figures?

24 **A.** Yes.

25 **Q.** Reaching out through the press and social media, setting
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1 confidence, and actually, the -- we did very -- there
 2 was a lot of data, there were surveys on the reasons
 3 people might not -- or the barriers to uptake, that you
 4 need to address: confidence; you need to address
 5 convenience, so there were very many different routes to
 6 getting a Covid vaccine than normal vaccines; and you
 7 need to address complacency, whether people think that
 8 they need the vaccine.

9 And you need to do action on all three of those in
 10 order to drive up the rates as far as possible.

11 **Q.** And they're all very difficult issues --

12 **A.** They're difficult things to do.

13 **Q.** And it's a very complex sphere.

14 There was in England a vaccines equality committee,
 15 there was an equity committee in Wales.

16 **A.** Yes.

17 **Q.** There was also an equalities committee within the
 18 vaccines directorate in Scotland.

19 Did the DHSC have any sort of advisory committee,
 20 comprising members of the ethnic minorities or disabled
 21 people's groups or GRT or migrant or homeless
 22 representatives, who could say to you, "Look, this is
 23 our community, we know how best you can go about this"?
 24 Was there any sort of structure or advisory committee
 25 that was set up by you that would have helped you?
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1 up the Community Champions scheme -- I think your
 2 department funded it to the tune of about £25 million in
 3 January 2021 -- in order to try to improve or increase
 4 take-up. But the appearance is that there were a number
 5 of, I suppose, peripatetic or discrete or separate
 6 methods used?

7 **A.** Yes.

8 **Q.** But none of them were really very effective in terms of
 9 increasing trust, reducing distrust, and getting the
 10 message out there in a way that made people want to take
 11 up the offer of a vaccination.

12 The problems with our data systems, with our
 13 somewhat fragmented society, were too great for the
 14 government to be able to overcome in those six months of
 15 getting vaccinations out there. Is that a fair summary?

16 **A.** I think that the -- the approach -- there was no --
 17 you're right, there was no one way to say: this is the
 18 way to reach all of these groups. I think there's
 19 a number of things, like the Community Champions -- you
 20 know, there was a number of different schemes or
 21 approaches that would each make a little bit of
 22 difference that you had to add up in order to make the
 23 biggest difference over the course of the year. The
 24 approach overall, as I think set out in the uptake plan,
 25 is based on the WHO evidence that you need to address
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1 **A.** You refer to the NHS England equalities committee, we
 2 didn't set up a separate committee but there were DHSC
 3 members of that committee, and both through the daily
 4 meetings that Nikki Kanani and others came to, was
 5 often -- I mean, uptake was a regular -- and the quality
 6 of the data and the speed of the data we had about
 7 rollout was incomparably better to previous --

8 **Q.** What had come before.

9 **A.** -- rollouts so that you could -- it doesn't answer the
 10 question entirely or the issue entirely, but you could
 11 say which are the groups, which are the regions, which
 12 are the towns, even down to ward level, where you could
 13 ask, or NHS England could ask their local communities
 14 and directors of public health to focus.

15 **Q.** But at the top level --

16 **A.** Yes.

17 **Q.** -- the NHS's vaccines equality committee had, for
 18 example, no representative from disabled people's groups
 19 or organisations, and not every sectorial group or, to
 20 use the terrible terminology, the health inclusion
 21 groups, were represented on that committee, were they?

22 **A.** I don't have a full list but I'm sure you're correct.

23 **Q.** Probably not.

24 **A.** Yeah.

25 **MR KEITH:** My Lady, we won't finish before lunch, I'm
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1 afraid, but -- I've used this phrase before -- we are in
2 the final furlong. Could you consider rising for lunch
3 and we'll conclude this witness shortly after lunch.
4 **LADY HALLETT:** No more final furlongs, Mr Keith.
5 I'm sorry, we had hoped to finish you before lunch,
6 Ms Swinson, and I appreciate the next witness is also
7 from Cabinet Office, so we seem to be denuding Cabinet
8 Office today, but we will finish you quite shortly after
9 lunch, I hope. And I will now break and come back at
10 2.00, please.

11 (1.02 pm)

12 (The Short Adjournment)

13 (2.00 pm)

14 **LADY HALLETT:** Mr Keith.

15 **MR KEITH:** Ms Swinson, may we move on to a new topic, that
16 of mis- and disinformation, and have up INQ000502085.

17 This is a recommendation, or a submission -- if we
18 go to page 1 -- to the permanent secretary, Secretary of
19 State --

20 **A.** The parliamentary secretary. They're --

21 **Q.** Parliamentary secretary, sorry. Parliamentary secretary
22 and Secretary of State, concerning planned
23 cross-government communications on vaccination,
24 including work being undertaken to enhance vaccine
25 confidence and tackle misinformation.

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1 vaccination or were being put off it.

2 There's a reference further down the page to the
3 need for further research, for surveys, to understand
4 motivations and barriers.

5 And over the page, in fact page 5, please,
6 paragraphs 13 to 17.

7 Page 5, paragraphs 13 to 17, the submission says
8 this:

9 "13. Research has shown that rebutting each
10 individual narrative is not as effective as ensuring
11 that individuals have access to the best quality
12 information ...

13 "14. Most individuals that share misinformation are
14 well-meaning ..."

15 If you attack them, there's a risk of alienation.

16 So the position appears to have been reached by the
17 government generically that the best way to deal with
18 high and increasing levels of mistrust and to deal with
19 dis- and misinformation, is not to try to engage with it
20 specifically on each specific point or myth or trope or
21 observation that's being made in the public domain but
22 just to keep on plugging the corporate line, if you
23 like, try to get out there and repeat facts and figures
24 and the objective reality of what you're trying to say.

25 Do you think that was effective as an approach,

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1 In general terms, was the issue of tackling dis- and
2 misinformation something that was exclusively for the
3 DHSC, or was this a cross-government issue and included
4 Cabinet Office, DHSC and its Counter Disinformation
5 Unit, the NHS no doubt, PHE, and perhaps other bodies?

6 **A.** Yes, it was. As the government lead, it was the
7 Department of Culture, Media and Sport, and the Cabinet
8 Office led the communications hub and all those you
9 mentioned would have been involved in some way.

10 **Q.** If we go to page 2 we can see obvious references to
11 research showing quite considerable levels of concern
12 about levels of trust, distrust, vaccine hesitancy. And
13 at paragraph 6, this:

14 "To alleviate concerns, information on how COVID-19
15 vaccines are deployed and tested, including their safety
16 and efficacy, must be communicated clearly to the
17 public. It is crucial to understand and address factors
18 that may affect COVID-19 vaccine acceptability in ethnic
19 minority and lower-income groups."

20 So the starting point is the government, although
21 this is only a DHSC document, could not have been aware
22 of -- of the need to deal with misinformation and
23 disinformation and particularly the related issue of
24 trust and distrust, and the degree to which particular
25 sectorial groups were being prevented from taking up

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1 bearing in mind that all the evidence now suggests that
2 levels of distrust are higher than ever, levels of
3 vaccine hesitancy are higher than ever, and that trust
4 in government and the NHS in particular appears to have
5 dropped.

6 **A.** So, based on the evidence and the research we had,
7 misinformation, I think we did need to address head on
8 people's concerns. They were related to the safety of
9 the vaccine, so it was important that we proactively
10 responded to that, whether certain groups were at risk,
11 and concern about side effects, for example. So we put
12 that in the kind of misinformation camp.

13 I think on disinformation -- and as this set out,
14 largely done for good reasons and questioning -- it's
15 a very much smaller percentage of people who are
16 proactively putting out disinformation. I think on that
17 we took the approach that you said not to engage in a --

18 **Q.** Turf war?

19 **A.** -- something that was -- that had been set out, so
20 that's the approach that we took. There are much
21 smaller rates of disinformation, actually, in the UK
22 than in quite a lot of other countries, but as you say,
23 trust in the vaccine programme was related to the
24 position before the pandemic and now about overall trust
25 in government.

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- 1 **Q.** Realistically was there much that could be done about
2 that? You could keep on getting the facts and figures,
3 the position about safety --
- 4 **A.** Yes.
- 5 **Q.** -- about side effects, about the opportunities for
6 delivery, acceptance of vaccines, out there, but is
7 there a step or a limit to what you can do and in
8 practical terms, did you reach that point?
- 9 **A.** So I think it varied according to groups. So the data
10 would show, for example, I think in the Bangladeshi
11 population there was a big increase in confidence in
12 trust, whereas for some other groups, that didn't
13 improve as much overall. In fact, at the generic level,
14 2020 compared to 2021, positive sentiment went up to 96%
15 on the vaccine. Obviously, the generic figures hide
16 a myriad of different groups and reasons, some of which
17 were effectively addressed and some of which weren't.
- 18 **Q.** Do you think more progress would have been made, do you
19 think the outcome would have been better, if there'd
20 been more use of local figures, community champions,
21 trusted figures, that just the governmental back had
22 been put further into trying to use representatives of
23 each particular community better and appeal through them
24 to their communities?
- 25 **A.** Yes, that is definitely again what the research shows,

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1 in the wider healthcare community, as a result of the
2 second proposal, which never came to pass, but the
3 consultation process by which it was going to be
4 introduced in a wider sense.

5 If we just have a look at INQ000497213, we can see
6 that in January 2022, so about a month and a half or
7 just over a month before the plug was pulled in relation
8 to the expansion of the VCOD policy to the wider
9 healthcare sector, the Secretary of State and Minister
10 for Care and Mental Health, was that Helen Whately?
11 I forget.

- 12 **A.** At that time, yes, pretty sure.
- 13 **Q.** You're asked to note the most recent public health
14 evidence on vaccine effectiveness in relation to VCOD,
15 to note the emerging evidence of vaccine effectiveness
16 against Omicron, and the implication on the VCOD policy.
- 17 If we look at pages 3 to 4, paragraphs 20 to 32,
18 you'll see that the thrust of this submission was that
19 in terms of deploying a VCOD policy to the wider care
20 sector and to frontline healthcare workers, the benefit,
21 that is to say the prospect of increasing vaccination
22 rates, appear to be less clear because of course the
23 transmission was ending -- Omicron was making some
24 vaccines less effective, and it was going to be a great
25 deal harder to push rates up even further than they were

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- 1 that for communities where trust in government is low,
2 it shouldn't be government giving the message. So it's
3 exactly community champions working in local areas,
4 I think quite a lot was done on that, maybe it could
5 have been started a bit earlier, the community champions
6 campaign that you talked about, that was the approach in
7 order to obviously do some things nationally, but local
8 communities, local religious groups, local voluntary
9 groups, to use them, where they were happy to take that
10 message into their communities as a more trusted voice.
- 11 **Q.** So more could have been done at the micro level in terms
12 of appealing through local and community-trusted figures
13 to various sectors, cohorts and communities?
- 14 **A.** I'm sure more could have always -- could always be done,
15 and it's an issue now with local communities for take-up
16 of other vaccine campaigns.
- 17 **Q.** Now, of course, to some extent "sow and ye shall reap".
18 We heard expert evidence yesterday about the increased
19 levels of distrust and hesitancy, and there's a knock-on
20 effect, of course.

21 One -- another angle to this, another aspect of it
22 is the policy of vaccination as a condition of
23 deployment because the evidence appears to show there
24 was a considerable backlash, both in the care sector
25 where the first policy was actually introduced, and also

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1 already. And the demerit, the downside of the policy,
2 became clear that from the first VCOD policy there'd
3 been a considerable backlash, had there not?

- 4 **A.** [No audible answer]
- 5 **Q.** So was it your department's position in the end, in fact
6 I think on 1 March, that it ultimately wasn't worth the
7 candle?
- 8 **A.** So I think what happened through the Omicron wave is
9 that the evidence changed on whether the -- to what
10 extent the vaccine protected the individual against
11 transmission and in addition to severe disease, and the
12 policy case for introducing this policy was that it
13 would affect transmission to those at risk. Obviously,
14 that was a controversial thing at the time and different
15 things were weighed up but that was the policy, the
16 rationale.
- 17 **Q.** Sure.
- 18 **A.** When it became clear through the research on Omicron
19 that the vaccines were not nearly as effective on
20 transmission, that policy case was no longer -- no
21 longer held, and so it was both withdrawn in the care
22 home sector and not brought into force for all other
23 health and care settings.
- 24 **Q.** It became apparent to the DHSC also, didn't it, that as
25 a result of the first policy, the care home worker

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1 policy and the imposition of VCOD on them, a very large
2 number of people had left the sector? People had walked
3 away because they didn't want to be vaccinated. And you
4 were also aware by this time of the considerable degree
5 of backlash. People took the view that it was a matter
6 for their individual decision as to whether or not they
7 should be vaccinated, and this appears, the policy
8 appears to have led to an increase in distrust and
9 hesitancy.

10 But hindsight is a wonderful thing. Would you, next
11 time round, go straight away, as you did during the
12 Covid pandemic, for VCOD in relation to care home
13 workers, if that was the most vulnerable area and the
14 area most affected by a pandemic?

15 **A.** Yes. I mean, it was a political decision to weigh those
16 things up, and for the personal freedoms against the
17 protection of those most vulnerable. That debate would
18 happen again, depending where politically the ministers
19 took those -- that choice. I think that it was clear
20 when it was introduced, and through the public
21 consultation, that not everyone supported the policy,
22 but ministers and, indeed, Parliament in agreeing the
23 regulations, put that in place.

24 In terms of care home workers, there are a range of,
25 where -- anecdotally and in survey evidence, I think, it
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1 possible that would be obviously very interesting.
2 There's evidence on different countries, both for
3 vaccination for flu, for other things, that WHO also
4 brings together.

5 It's a mix of factors. I think the professional
6 expectation on healthcare workers, and indeed on care
7 workers, we also see through the annual flu campaigns,
8 and rates are not as high in those groups as they are
9 for the others at risk.

10 **Q.** The Vaccine Damage Payment Scheme next.

11 **A.** Yes.

12 **Q.** The Inquiry is obviously well aware that the payment
13 scheme is not a compensation scheme.

14 **A.** Correct.

15 **Q.** It's also something that has a statutory foundation, so
16 it's a matter for Parliament, and also it's something on
17 which -- it requires intense ministerial oversight. So
18 ultimately, questions on the remit and the scope of the
19 scheme must be for ministers, because it involves the
20 payment of public monies.

21 Your statement makes plain that obviously, with the
22 arrival of Covid, Covid-19 as a trigger disease for the
23 severe disablement, which must established, was added by
24 statutory instrument. The £120,000 payment, not,
25 I emphasise, a compensatory payment, but a flat rate
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1 was a reason given for leaving the sector. It did drive
2 rates up to over 90% as it was a legal requirement but
3 it was also, in choosing to leave that sector, there's
4 a number of reasons -- on pay, it was also when the
5 economy was opening up again, so there's a lot of
6 movement between social care, hospitality, retail, so
7 there was a whole range of reasons of which this -- it's
8 very hard to disentangle.

9 **Q.** Very. And of course, the devolved administrations
10 didn't pursue VCOD, none of them did. England was the
11 only country that did in relation to that first policy.

12 **A.** Care homes.

13 **Q.** Care homes. And their rates of uptake were not
14 significantly lower than England's. So it's very hard
15 to say, at the end of the day, whether or not it worked
16 and whether or not we've created a beast for the future
17 in terms of distrust and hesitancy and so on.

18 Would one way of trying to find or fight our way
19 through that particular thicket be to understand better,
20 firstly, how many people did leave the sector as a
21 result of the policy, and, secondly, to what degree does
22 a policy such as mandatory vaccination harm us in the
23 long run in terms of willingness to take a vaccine?

24 **A.** Yeah, I mean, I'm not sure whether it's an answerable
25 research question in retrospect but if that were
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1 payment, was introduced in July 2007.

2 **A.** Yes.

3 **Q.** And with the onset of Covid and with the obvious
4 explosion in applications, the body responsible for
5 dealing with these applications, the NHS Business --

6 **A.** Services Authority.

7 **Q.** Business Services Authority, thank you, increased its
8 membership. I think it has about 80 or more now members
9 of staff now working on it.

10 The documentation which your department has
11 provided -- let's have a look at INQ000411744 -- dated
12 June 2022, makes plain that your colleagues and
13 ministers considered -- page 2 -- changes to the scheme.
14 There was a proposal, perhaps, to increase the £120,000
15 flat payment, which, is this right: if a claimant
16 establishes a 60% disablement, and also that the
17 disablement is causally the result of the vaccine, and
18 obviously the Covid vaccine is a prescribed vaccine --

19 **A.** Yes.

20 **Q.** -- they get the lump sum of 120,000?

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

22 **Q.** There isn't a sliding scale?

23 **A.** That's correct.

24 **Q.** There was a debate about lifting that amount because it
25 had last been updated in 2007, and there was a debate
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1 also about actually sliding scales in terms of the
2 disablement which had to be established, the degree of
3 disablement, in order to receive a payment.

4 There was obviously a fair bit of thought given into
5 whether or not the scheme should be changed, bearing in
6 mind that if it was changed, you would then have to
7 backdate -- you'd have to top up any claims which had
8 already been made.

9 But what happened? We see very little in the
10 paperwork about the outcome of this consultation
11 process, internal consultation process. There weren't
12 any changes made, it would seem, to the rate or the
13 threshold, or the 60% disablement categorisation.
14 Nothing happened. Is that the sum of it?

15 **A.** Certainly in this time period, yes, advised the
16 Secretary of State on the current position and the
17 options. As you've said, they would be matters for
18 ministers to ask to take forward. I know there has been
19 a lot of focus on improving the efficiency of the scheme
20 so that those who have applied get a result, and so
21 there's been focus on that, but the ministers haven't
22 taken a decision on any of those points, as far as I'm
23 aware.

24 **Q.** Was a decision taken not to pursue the recommended
25 policy options identified at box 3, (c)(i) and (ii), or
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1 But --

2 **A.** Yes, the scheme is still operating in the statutory way
3 that you set out with -- on those three bases. There
4 have been no changes.

5 **Q.** So despite these very obvious problems which were being
6 brought to your attention, the scheme has not been
7 altered in any shape or form since, in fact, the raising
8 of the threshold to £120,000 in 2007?

9 **A.** That's the factual position, yes.

10 **Q.** Thank you.

11 Two final topics, please. Just to go back to the
12 subject of clinical trials, in particular phase II
13 trials for therapeutics, Ms Swinson.

14 I asked you some questions about the degree of
15 management and co-ordination concerning the phase II
16 trial process for therapeutics, and the Inquiry is aware
17 of the ACCORD process, the evidence in writing from
18 Professor Sir John Bell, Professor Sir Jonathan Van-Tam,
19 and Professor Farrar about what appeared to them to be
20 quite a high level of dysfunctionality and lack of good
21 planning in terms of trying to bring some order to the
22 proliferation of phase II trials. There were a lot of
23 them, there were different funders, they had different
24 numbers of recruits, of participation.

25 And Charlotte Deane, from the UKRI, has put in her
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1 is it that no decision has in fact been made at all?

2 **A.** Looking at the date, I mean, obviously there have been
3 a different number of different secretaries of state,
4 and I think this was just before -- whilst
5 Sir Sajid Javid was still in post, and he resigned
6 shortly afterwards, so I don't know if -- I'm sure you
7 would have had the paper of any response to this
8 submission, but there hasn't been a response asking the
9 department to implement any of those potential changes.

10 **Q.** But we haven't seen a document one way or the other as
11 to whether or not a decision was made, or, if it was
12 made, as it must have been, if it was made, to decline
13 the recommendation. But the upshot is the same: there
14 were no changes made to the scheme, were there, in 2022,
15 despite the explosion in the number of applications.
16 And of course, as you were well aware, very real issues
17 being raised with the department about: quantum, the
18 amount; the speed with which applications were dealt
19 with; the causation threshold; and the issue of
20 graduated payments, if at all.

21 I don't want to ask you your views on them because
22 it's a departmental policy issue, and it will be for
23 my Lady to determine what, if anything, should be done
24 about the scheme, and of course for Parliament to take
25 a view on it in due course.
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1 statement for the Inquiry this:

2 [As read] "The main lesson to learn is that in the
3 case of a national emergency the UK should have access
4 to a national platform that can deliver integrated,
5 coordinated and comprehensive [that this say covering
6 phase I to III clinical trials] so that there is
7 a UK-wide structure that can select potential
8 interventions, direct resources and coordinate to ensure
9 rapid approvals and trial set-up."

10 Would you agree?

11 **A.** Greater co-ordination for the clinical trials, I do
12 agree on. I don't know much detail about the ACCORD
13 platform, though I've read the statement you refer to.
14 And I know that the technical report from the UK CMO and
15 others points to greater success in phases III and IV
16 than I and II.

17 **Q.** Yes.

18 **A.** So I would agree with that. I would just say in terms
19 of the platform trials, of which RECOVERY is the most
20 well known, the way that those were set up, recruited
21 to, and the impact that those trials had were truly
22 world-leading, saved a million lives, the first output
23 on dexamethasone, in June 2020. So there were a range
24 of trials and as also the technical report sets out,
25 having them adequately, having enough people in the
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1 trial so they can read out and have an impact is
 2 obviously very important. I think the ones you're
 3 referring to were ones where -- or the concerns were
 4 that they were never adequately recruited so that they
 5 could read out and make a clear read out on whether the
 6 things they were testing were effective or not.

7 **Q.** You'd make, if I may observe, a very fine politician.
 8 There's a reference there to dexamethasone, and there's
 9 no doubt the RECOVERY trial had a number of
 10 groundbreaking results, including dexamethasone, but you
 11 were aware, and we've got evidence from Lord Sharma on
 12 this, that the advisory group that he had advising him
 13 on therapeutic, in particular phase II trials,
 14 corporately held its head in its hands at some of the
 15 confusion and the lack of co-ordination around about the
 16 clinical trial process.

17 Would you agree that it was plain that a higher
 18 degree of co-ordination and management was required?

19 **A.** As we're talking about therapeutics, I wanted to point
 20 to the one bit of UK -- I mean, world-leading research.
 21 There were a range of platforms I don't know well
 22 enough --

23 **Q.** All right.

24 **A.** -- but there were certainly some that worked very
 25 effectively. I've seen the concerns about ACCORD which

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1 the DHSC. Is that something that you would support?

2 **A.** Yes, there are people much better qualified technically
 3 about what that would mean in practice, but clearly, the
 4 next pandemic will not be the same as this one, having
 5 a range of potential, on both the vaccines and
 6 therapeutics size, antivirals would be a very sensible
 7 thing. That is both about getting things into phase I
 8 trials but also having -- identifying potential viruses
 9 of pandemic potential, and then having research options
 10 on the page vaccines and therapeutics of which
 11 antivirals would be a part.

12 **Q.** And finally on this topic, we've seen reference in the
 13 Rule 9 statements to a body called the Advanced Research
 14 and Invention Agency. Can you just help us, is that
 15 a DHSC-supervised body, do you know, or something
 16 different? Or --

17 **A.** Not that I'm aware.

18 **Q.** I know acronyms in government are much beloved.

19 **A.** It's not one that I know.

20 **Q.** Is it an arm's length body? Is it an EA? What is it?

21 **A.** It's definitely not an EA -- (overspeaking) --
 22 arm's length body.

23 **Q.** All right. Evusheld, finally.

24 **A.** Yes.

25 **Q.** There are two aspects to Evusheld. The first was the

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1 were led out of UK Research and Investment and BEIS, and
 2 I have no reason to doubt them, and that better
 3 co-ordination would always be a good thing.

4 **Q.** Because the Therapeutics Taskforce and the therapeutic
 5 research and development was exclusively, thanks to your
 6 ministers, a DHSC enterprise, as opposed to the Vaccine
 7 Taskforce, which was BEIS?

8 **A.** Yes, I mean, the funding, so there's the National
 9 Institute for Health Research --

10 **Q.** Yes.

11 **A.** -- which is a billion pounds, roughly, from the
 12 Department of Health. There's very substantial funding
 13 through BEIS for trials through the UK Research and
 14 Investment, and the medical research councils that are
 15 funded through that, which are funded through BEIS.

16 **Q.** Yes.

17 The Antivirals & Therapeutics Taskforce, in its
 18 recommendations of November 2022 on the topic of
 19 antivirals --

20 **A.** Yes.

21 **Q.** -- proposed the building of a library of prototype
 22 antivirals that could be then used swiftly or pushed
 23 swiftly through the phase II and III clinical trial
 24 process on the onset of a novel pathogen. You must have
 25 been aware of that recommendation in your position at

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1 decision not to make an advance purchase or not to
 2 pursue an advance purchase, and the evidence makes it
 3 plain that Professor Sir Chris Whitty wrote to the
 4 Vaccine Taskforce, copied to the DHSC, that he couldn't
 5 recommend the buying of a large amount in advance of the
 6 Evusheld therapeutic to be used prophylactically.

7 That decision -- and I must make plain that
 8 Sir Chris Whitty's recommendation refers to a number of
 9 reasons why the landscape has changed, why there might
 10 not be a purpose to it or a sufficient purpose to it,
 11 and so on, but the decision has been roundly criticised
 12 by, in particular, Dame Kate Bingham, by Clive Dix, and
 13 numbers of other people, in particular the
 14 immunosuppressed to whom that prophylactic could have
 15 come as a great source of help. Was the DHSC aware,
 16 when the decision was made, that it left the
 17 immunosuppressed, in particular, very exposed in terms
 18 of the absence of that particular therapeutic remedy?

19 **A.** So the recommendations need to be on the basis of
 20 whether such a treatment would be effective. The DHSC
 21 was definitely aware that -- or looking for a range of
 22 treatments right across the disease path, and the
 23 immunosuppressed and those who couldn't take a vaccine
 24 were a really important group. They still -- however,
 25 the evidence base on whether a treatment would, first,

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1 be authorised by MHRA and deployable, are things that
 2 need to be taken into account and both at that point and
 3 the subsequent year, the clinical advice from RAPID C-19
 4 that we talked about earlier, to the CMO and then to the
 5 ministers, is that there was insufficient evidence for
 6 that -- for it to support procurement.

7 **Q.** But in the case of vaccines, massive at-risk advance
 8 purchasing was made in the complete absence of any real
 9 clinical data to suggest they would work, indeed in
 10 advance of the completion of clinical trials?

11 **A.** Yes.

12 **Q.** And later, when it came to the decision whether or not
 13 to authorise the purchase and deployment of Evusheld in
 14 2022 as a treatment, and that's the process, the
 15 RAPID C-19 process that you spoke of --

16 **A.** Yes.

17 **Q.** -- the decision by RAPID C-19 not to go ahead with
 18 Evusheld wasn't based on clinical data so much as a view
 19 being taken on how useful it would be, given the
 20 emergence of Omicron in particular. So Evusheld didn't
 21 receive the same fair crack of the whip as the vaccines,
 22 all the vaccines had?

23 **A.** First of all, RAPID C-19 would definitely have looked at
 24 the clinical data. As we set out in 2021, the context
 25 was different, given we had such effective vaccines.

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1 information into translated languages and at what time
 2 those measures would be.

3 **A.** I'm afraid I don't have detail about exactly what
 4 materials, but both Public Health England, or UKHSA,
 5 depending on the timescale here, and NHS England,
 6 I know, in normal business, would make available
 7 information in different languages.

8 It's obviously important for accessibility, as I've
 9 set out, but you would need to put that to Public Health
 10 England or NHS England.

11 **Q.** So you can't help me with whether those measures were
 12 taken -- in respect of translations was sufficient and
 13 successful, because that's something you can't speak to?

14 **A.** Yes, that's for other organisations.

15 **MS NAIK:** Okay. Okay, well, I think we will then have to
 16 put that elsewhere. Thank you.

17 **LADY HALLETT:** Thank you, Ms Naik.
 18 Ms Beattie, who is also just in front.

19 **Questions from MS BEATTIE**

20 **MS BEATTIE:** Thank you, Ms Swinson. I ask questions on
 21 behalf of disabilities organisations. The department
 22 published the Vaccines Delivery Plan on 11 January 2021
 23 which Mr Keith has already referred to, and that
 24 referred to directly employed personal assistants
 25 forming part of the social care workforce.

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1 There certainly were advance purchase agreements in
 2 place for some therapeutics, but you're right that the
 3 advice was not to put that in place for this treatment,
 4 and in the event, those -- our advance purchase
 5 agreements were, I think, always on the basis of getting
 6 to a conditional marketing authorisation and that
 7 happened for Evusheld in the spring of 2022.

8 **MR KEITH:** Thank you very much.

9 **LADY HALLETT:** Thank you, Mr Keith.
 10 Ms Naik, I think you've got some questions, thank
 11 you.
 12 Can you see that way?

13 **THE WITNESS:** Thank you.

14 **Questions from MS NAIK KC**

15 **MS NAIK:** Thank you very much, my Lady. Thank you.
 16 Ms Swinson, I represent the Migrant Primary Care
 17 Access Group and I just wanted to ask you a couple of
 18 questions based on what you said in your witness
 19 statement at paragraph 129. You obviously don't have to
 20 look that up but it's about translation.
 21 What you said there was that:
 22 "Translation was a priority to reach those whose
 23 first language is not English."
 24 I just wanted to know if you could elaborate on what
 25 measures were taken to disseminate public health

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1 Could we bring that up please. It's INQ000411678.
 2 We're at page 42 of the document. If we could
 3 please highlight the third paragraph towards the end,
 4 the final sentence there says that:
 5 "... it [was] vital [to] identify and reach directly
 6 employed personal assistants ... as part of our efforts
 7 to ensure full coverage of the priority 2 cohort."
 8 Just to remind everyone, that was the cohort that
 9 included frontline health and social care workers; is
 10 that right?

11 **A.** That's correct.

12 **Q.** Disabled People's Organisations are aware of concerns
 13 raised by disabled people who employ personal assistants
 14 about a lack of clarity on how to secure vaccines for
 15 personal assistants and when their staff could be
 16 vaccinated, and that they were bounced between GP,
 17 clinical commissioning group and council with no
 18 organisation taking responsibility.
 19 What, if any, guidance did the department provide to
 20 disabled people and personal assistants to facilitate
 21 vaccine access and uptake of the vaccine by personal
 22 assistants who, for disabled people, are part of the
 23 frontline social care workforce?

24 **A.** They are, and as set out here -- I think the department
 25 made clear they were part of that cohort. In terms of

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1 specific guidance for them on how to access vaccines,
 2 I think that would have been through the local NHS, and
 3 also as set out in the Green Book, it might have said
 4 more there.

5 **Q.** Well, I think the Green Book doesn't mention personal
 6 assistants at all by name.

7 **A.** Okay.

8 **Q.** Are you saying there was local NHS guidance which was
 9 directed to disabled people and personal assistants that
 10 covered this matter?

11 **A.** I'm saying that this sets out the cohort. It was an NHS
 12 operational issue for how to invite the people in those
 13 cohorts under this, and for each cohort to come forward
 14 for their vaccination.

15 **Q.** And so is your answer that there was nothing from the
 16 department itself that covered this?

17 **A.** I'm not aware of any specific guidance on personal
 18 assistants in priority 2 cohort, no.

19 **Q.** And further to that, did the department undertake any
 20 consultation with disabled people and disabilities
 21 organisations about facilitating access by personal
 22 assistants to vaccination?

23 **A.** These issues would have been covered on JCVI and part of
 24 the PSED -- the equality impact assessment, but I'm not
 25 aware of anything in further detail, and it would have
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1 last met.

2 **THE WITNESS:** Thank you very much.

3 **MS STEPHENSON:** Please could you say your full name.

4 **A.** Catherine Little.

5 **Q.** Thank you for attending to assist the Inquiry today.
 6 Could I ask you, as you may have heard with other
 7 witnesses, just to keep your voice nice and loud and to
 8 speak slowly.

9 You have produced a witness statement, INQ000474557,
 10 dated 21 October 2024. It runs to 80 pages and annexes
 11 and 220 exhibits. It is signed by you.

12 Can you confirm that you have had the opportunity to
 13 read it recently and that it is true to the best of your
 14 knowledge.

15 **A.** Yes.

16 **Q.** Thank you. I'm going to start with some background
 17 matters first.

18 **A.** Upfront, if I may, I'd quite like just to personally
 19 express my sincere sorrow for the impact that the
 20 pandemic has had on so many lives, and also just to
 21 assure the Inquiry how prominent the risk of life was in
 22 all of the considerations that we undertook in the
 23 Treasury.

24 **Q.** Thank you.
 25 Your professional background. After a career in
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1 been an operational matter for NHS England.

2 **Q.** Just to be clear, do either that advice or a PSED, does
 3 that include consultation actually with disabled people
 4 and DPO?

5 **A.** I'm not aware of consultation on the JCVI guidance in
 6 the way you set the out, no.

7 **MS BEATTIE:** Thank you, my Lady.

8 **LADY HALLETT:** Thank you, Ms Beattie.
 9 I think that completes the questions for you,
 10 Ms Swinson. I'm really grateful, I know you've helped
 11 me before. I don't know whether I'm going to be asking
 12 you to help me again, and I do understand the burden
 13 that will be placed upon your old department, and
 14 I suspect also your current department, so thank you
 15 very much for the help you've given to date.

16 **THE WITNESS:** Thank you.
 17 **(The witness withdrew)**

18 **LADY HALLETT:** I hope we haven't kept you hanging around too
 19 long, Ms Little.

20 **THE WITNESS:** Not at all.

21 **MS STEPHENSON:** My Lady, the next witness is
 22 Catherine Little.

23 **MS CATHERINE LITTLE (sworn)**
 24 **Questions from COUNSEL TO THE INQUIRY**

25 **LADY HALLETT:** Congratulations on your new role since we
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1 professional services you joined the Civil Service in
 2 2013, went on to hold senior roles in the Ministry of
 3 Justice and Defence, and then joined the Treasury in
 4 2020 as director of public spending. Is that correct?

5 **A.** The Director General of Public Spending, I apologise.

6 **Q.** I'm so sorry, I thought that was what I had said,
 7 Director General of Public Spending --

8 **A.** Apologies for correcting you.

9 **Q.** -- thank you. Can you explain what roles you have taken
 10 since that time?

11 **A.** Yes. So in October 2022 I became the Second Permanent
 12 Secretary to the Treasury, with responsibility for
 13 public spending and international matters. And then in
 14 April 2024 I became the Permanent Secretary of the
 15 Cabinet Office and the Chief Operating Officer for the
 16 Civil Service.

17 **Q.** You mention some key figures in your statement. I'm
 18 sure it's news to no one but, just to remind ourselves,
 19 Rishi Sunak was the Chancellor for the entirety of the
 20 period that we're going to be discussing today, and the
 21 other key figures you mention in your statement are
 22 Steve Barclay MP and Simon Clarke who successively held
 23 the roles of Chief Secretary to the Treasury; is that
 24 correct?

25 **A.** Yes.
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1 Q. Thank you. Within the Treasury, is it right that there
2 was a dedicated team for Covid-19 vaccines from
3 March 2020?

4 A. Yes, that's correct.

5 Q. And at all times, that Covid-19 vaccines team worked
6 closely with the Department of Health and Social Care
7 and the Department for Business, Energy and Industrial
8 Strategy, particularly closely with those two
9 departments?

10 A. Yes.

11 Q. We can't endeavour here, of course, to unpick the
12 complex web, that you set out in your statement, of
13 decision making, of requests for funding, and of
14 approvals processes and the sophisticated thought that
15 went into that and the negotiations of contract. So
16 I just want to take you through some of the headlines
17 about the approach that the Treasury took to vaccines
18 and therapeutics during the period that Module 4 is
19 concerned with.

20 The first topic I'm going to ask you about is
21 vaccine development, procurement and manufacture. You
22 explain in your statement, and I'm just going to ask you
23 to assist us a little here with the general approach,
24 ie, the approach to spending approval not in a situation
25 as the department was in during Covid.

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1 scientific approaches, each with different manufacturing
2 requirements ..."

3 Paragraph 3, that recognises that:

4 "By pooling resources and risk internationally ...
5 we can increase the global chances of success ..."

6 But the scale of investment required, it recognises,
7 is going to be substantial, there's no guarantee of
8 success.

9 If we could also turn, please, to page 7 of that
10 document. At that point, reminding ourselves it's
11 7 April, there were three candidate vaccines which will
12 have different manufacturing needs. We see there the
13 vaccine being developed at Imperial College London, and
14 then there's mention of the vaccine being developed in
15 Oxford in (b), and mention of Moderna at (c). And of
16 course we know now that whilst one vaccine at Imperial
17 College London didn't make it to approval stage, (b) and
18 (c) are what would go on to become vaccines that were
19 used in the UK.

20 A. (Witness nodded).

21 Q. Thank you, we can take that document down.

22 Whilst we know that now, is it right to say that the
23 vaccines programme was extremely unusual at the time in
24 terms of its uncertainty, and unusual in the Treasury
25 approach to spending control?

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1 Is it right that the principles that you follow, as
2 set out in your statement, are regularity, propriety,
3 value for money, and feasibility, but that that general
4 framework was applied with a great deal of flexibility
5 when it came to vaccines and therapeutics spending
6 approval?

7 A. Yes, that's correct. And to expand, if I may, the
8 principles of the managing public money framework were
9 consistent throughout. We didn't change the framework
10 in any way but we did apply one, a much higher level of
11 risk taking and secondly, we adapted and flexed it in
12 a very pragmatic way to suit the circumstances that we
13 were dealing with.

14 Q. If we might turn to some of those specific approaches,
15 funding the vaccine programme, and if we could have on
16 the screen INQ000421318, please.

17 This is Treasury officials' advice to the
18 Chancellor, advice that was accepted, regarding the
19 Covid-19 vaccine development strategy dated
20 7 April 2020.

21 If we could turn, please, to page 2, at paragraphs 2
22 to 3, perhaps to set out some of the context in which
23 your department was working:

24 "Vaccine development is high risk and poses
25 significant technical and time challenges ... several

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1 A. That is right. It was highly unusual, but our
2 overwhelming advice at the time was that it was right to
3 take a much higher risk approach, because the
4 overwhelming case for the benefits, about to public
5 health and to the economy were so significant it
6 outweighed any of the initial risks. So we advised the
7 Chancellor to invest in all vaccines that proved to be
8 promising and to explore every single opportunity at
9 this stage.

10 Q. You describe that as a three-stage approach in your
11 statement. The first is a generous commitment envelope.
12 Can you translate for us, what does that mean,
13 a generous commitment envelope?

14 A. Normally, what we would do in public spending is to
15 provide a precise amount of money for a very precise
16 outcome that the government is trying to achieve. In
17 this instance we took the view that given we really
18 didn't know what it would ultimately cost or over what
19 time frame, that we should give the maximum amount of
20 flexibility and provide a funding envelope over
21 a multi-year period that was significant enough to allow
22 the Vaccine Taskforce to operate with a significant
23 amount of freedom and pragmatism. That is absolutely
24 unheard of outside of a spending review or in normal
25 spending practice.

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1 **LADY HALLETT:** As I say, it must have gone against all the
2 instincts of you and your colleagues?
3 **A.** It did, and I think it's fair to say I expected to come
4 into the Treasury to control public spending with an
5 iron fist and I ended up spending a huge amount of money
6 and changing our risk appetite radically almost
7 overnight.

8 **MS STEPHENSON:** And that resulted, didn't it, in
9 a three-year period being covered by the envelope, and
10 by funding outside of the usual spending review period,
11 I think as you have described.

12 Second, then, the Treasury sought explicit
13 ministerial consent in respect of indemnities. Is it
14 right that ministerial consent is required for all
15 government contracts involving indemnification because
16 of the liabilities to the Exchequer?

17 **A.** Yes, and it's actually important that approvals are
18 sought from Parliament, because the contingent
19 liabilities produced by these sorts of indemnities are
20 so novel and contentious and potentially very
21 significant to public finance.

22 **Q.** I'm not going to ask you to go into the detail of any
23 individual contracts or negotiations, or the specific
24 terms, indeed, of indemnity arrangements at any point in
25 your evidence. But is it right to summarise it in this

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1 delegated approval level that's set every year by the
2 Treasury. For BEIS, that was set previously at £70
3 million pounds. We increased that to £150 million,
4 which was a bit of a judgement call as to what the right
5 level was, but we felt that having seen some of the
6 activity that was under way, that was a level that would
7 allow them to pragmatically sign up to further
8 expenditure without any further delay by coming to us.

9 **Q.** So pausing there and taking stock of that framework
10 which you've helpfully described for us in overview, are
11 there lessons that can be learned in respect of future
12 pandemics and preparedness from the flexible approach
13 adopted in the Covid vaccination development programme?

14 **A.** Yes, and we talked about two of them. The third one
15 that I would add, and I know many witnesses have talked
16 about, is the governance arrangements that we put in
17 place through the ministerial panel. In normal times,
18 spending approvals would go through a multiple
19 sequence-stage process, and in effect we streamlined and
20 collapsed all of that into one decision-making process,
21 and we would certainly repeat that again if we were in
22 the situation.

23 **Q.** Just finishing perhaps off that point about the VTF
24 ministerial panel, ordinarily, separate ministerial
25 approval would have been required for each spending

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1 way: that indemnities were agreed by the Treasury for
2 vaccine developers in which the Exchequer bore a much
3 higher share of the risk than would normally be the
4 case, in order to be successful, or in order for the VTF
5 to be successful in negotiations with developers to
6 secure contracts?

7 **A.** Yes, that's correct, and we took the view that we had to
8 take exceptional risk in order to secure those
9 commercial arrangements quickly and ahead of global
10 demand in the space.

11 **Q.** Do you think, as far as you're able to know, do you
12 think it is likely that had the UK taken a different
13 approach by not agreeing to such indemnities it would
14 have been able to secure the vaccine supply contracts
15 that it did?

16 **A.** I think it's highly unlikely that we would have been
17 able to secure those contracts given the pace of demand
18 on a global level, and pace and risk-taking were key in
19 the success of the commercial arrangements.

20 **Q.** The third and final element of the framework that you
21 set out in your statement was increasing the limit to
22 which the Treasury delegated authority to BEIS to spend
23 without specific prior approval. Can you just explain a
24 little about that and why it was different?

25 **A.** In normal times, every department has a risk-based

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1 decision by BEIS, the Treasury, and the Cabinet Office.
2 And so you describe that single decision point.

3 To be clear, it's not that the Treasury lost any of
4 their usual authority, power, final say, whatever we
5 want to term it, in those spending decisions, it's just
6 that you collaborated at that stage. Would that be
7 a correct summary?

8 **A.** Yes, that's correct. It's important to emphasise that
9 the Treasury cannot delegate its responsibilities for
10 Treasury consent for novel, contentious or repercussive
11 matters, and that is an important constitutional
12 principle in the role of Parliament and how it delegates
13 its authority to the Treasury.

14 **Q.** I want to move on now to the specifics of the Vaccine
15 Taskforce programme business case. Funding for the
16 vaccines programme between March and July 2020 was drawn
17 from a combination of funding sources on a case-by-case
18 basis. Was it considered that it was important to build
19 a more stable base of funding for the VTF, and that they
20 then made a business case for that funding base in the
21 beginning of July 2020?

22 **A.** Yes, I think we realised very early on that this process
23 of continually coming back to the Treasury was not going
24 to be an effective way of operating, and that business
25 case was specifically to justify the multi-year funding

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1 envelope.

2 **Q.** There are a number of adjustments to that business case,
3 and I'm not going to enter into the complex
4 back-and-forth of that, but just to go to the headlines
5 here, is it right that the final business case went in
6 on 29 July 2020, and that then that -- the sum that was
7 requested, which was 5.23 billion at that stage, was
8 finally settled in September, but that the VTF were
9 notified that that approval was earlier, it was that the
10 official letter, as it were, went out in September?

11 **A.** Yes, that's correct. And that's quite normal for us to
12 receive a readout from a minister, in this case the
13 Chief Secretary, to let the department know, and then
14 for us to formalise the conditions of that approval over
15 a slightly slower time. But we're talking about
16 a matter of days.

17 **Q.** You were aware that there are some concerns raised by
18 Dame Kate Bingham at the time, about the delay in this
19 process. I don't intend to go through all of those in
20 detail because, of course, the specifics of what was or
21 what was not appropriate in this pandemic may differ
22 next time, depending on the nature of any virus or
23 potential vaccines to combat it, but in terms of the
24 broad lessons we might learn from some of the concerns
25 raised by Dame Kate Bingham at the time, you're aware

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1 funding envelope, we continued to sign off specific
2 approvals and we signed off £1.3 billion worth of
3 additional specific approvals so that we could continue
4 with the momentum and the pace of the work of the
5 Vaccine Taskforce. I think it is absolutely right and
6 proper that a business case is produced. It's
7 fundamentally the record of how we are looking at
8 decision-making and the risk and benefit to the
9 taxpayer. And I think on the actual use of the Green
10 Book, this sort of view that it's quite a rigid way of
11 undertaking investment appraisal. A few things I'd say,
12 firstly the Green Book has been developed as a best
13 practice and investment appraisal over many decades.

14 **Q.** Can I just pause you there, because we have another
15 Green Book in this Inquiry.

16 **A.** Oh yes, of course.

17 **Q.** Can you just explain what the Green Book is, as you're
18 referring to it?

19 **A.** Apologies, yes, there are lots of books. The Green Book
20 from the Treasury perspective is the guidance that sets
21 out how practitioners should undertake government
22 investment appraisal for the public sector. And it is
23 seen globally as one of the most longstanding, mature
24 sets of guidance in this space.

25 There's lots of myths about the Green Book. So

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1 that concern was raised about the speed of approvals,
2 that that was raised on 22 July 2020 in a meeting with
3 the Prime Minister. And that essentially the concern
4 was that making a business case with any -- anything
5 approaching certainty about figures was very difficult
6 because, being asked to estimate quantity and cost of
7 vaccines in June or July 2020 when there was no clear
8 idea of what those figures would be was challenging, and
9 that it was rigid and consumed the VTF's time and energy
10 and caused delays.

11 Do you understand those concerns, and can you
12 explain what the Treasury's response to that was?

13 **A.** So I've obviously spoken to Kate and I talked to her at
14 the time about her concerns. I think there's a few
15 things I would say in response. Firstly, the Treasury
16 at this time was often signing off very complex material
17 amounts of public spending, often within 48 hours of us
18 receiving a case. That is an extraordinary thing for us
19 to do, given the scale of public spending and the risks
20 that were involved, and our teams worked around the
21 clock to make sure that frontline services, and in this
22 case, the Vaccine Taskforce, got as much approval as
23 quickly as possible to get resources to where it was
24 needed most.

25 Throughout the period when we were looking at the

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1 a number of witnesses have referred to there being
2 a sort of magic benefit-cost ratio or that the templates
3 were very rigid. It's not designed to be a prescriptive
4 approach, it is a toolkit of methodologies, and it
5 fundamentally sets out how you consider quantifying risk
6 and uncertainty when you are dealing with so many
7 unknowns. And I think this is very, very pertinent to
8 the Vaccine Taskforce. That is not unusual in
9 government and the public sector.

10 So it's important that when we're talking about this
11 sort sum of money, which is nearly a penny on
12 Income Tax, that we are really thinking about the
13 material risk and benefits to society, and I think it's
14 important to take a proportionate approach.

15 We're not telling departments how to do it; we are
16 giving them guidance.

17 **Q.** So are you of the view that there is another, better,
18 perhaps more scientific, less financial model, that
19 might be used in these scenarios that could be more
20 nimble, or is your position that the model that was used
21 was appropriate?

22 **A.** I don't agree with the idea that you should have
23 a scientific case. The Green Book sets out quite
24 clearly in its principles that evidence and data should
25 be used throughout, and so my argument would be that

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1 scientific evidence and data should be fundamental to
2 each of the five cases that the Green Book sets out.

3 And again, it's not designed to be a prescriptive
4 template; it's up to the owner of the decision, and in
5 this case the Vaccine Taskforce, to decide pragmatically
6 what evidence should be included and what level of
7 judgement is applied in the assumptions in the case.

8 **Q.** I'm going to move on now to ask about vaccine
9 manufacture and onshoring capabilities and the spending
10 decisions around those.

11 You explain in your statement it was recognised that
12 from the earliest weeks of the pandemic the UK needed to
13 work urgently to develop domestic vaccine manufacturing
14 capacity.

15 If we could have a look, perhaps, just to illustrate
16 the point, at INQ000421297.

17 This is a letter from Matt Hancock MP, the Secretary
18 of State at the time, to the Chief Secretary to the
19 Treasury. A little later than we've been talking about,
20 18 June 2021. If we see at paragraph 3 there, it's
21 recognised that "the UK is not alone", that there is
22 competition, as it were, out there, and the VTF has been
23 asked to "identify transformational investments which
24 will significantly strengthen the UK's long-term
25 responsiveness to future pandemics".

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1 promote, develop and accelerate new vaccine production,
2 technology and manufacturing. But the project suffered
3 significant issues and delays, to the point where it was
4 no longer commercially viable.

5 There was significant investment in the Vaccine
6 Manufacturing and Innovation Centre. Could you set that
7 out for us in summary?

8 **A.** Yes. So I think the first investment from the
9 government was undertaken in 2017, and you can see
10 a series of further investments over the course of that
11 period leading up to SR21.

12 SR21, by that point £205.7 million had been invested
13 in VMIC, and at the SR we provide a further £80 million
14 in order to complete the project.

15 **Q.** You've exhibited correspondence which explains there are
16 a number of further delays from 2021, it appears
17 associated with construction and delivery. And it
18 became apparent that it wasn't going to be useful within
19 the immediate life of the pandemic, and of course,
20 eventually, in 2022, it was sold. What was the
21 rationale from a Treasury perspective behind that sale?

22 **A.** So I think you can see from the correspondence between
23 the chief secretary and George Freeman that we were
24 actually quite concerned about the sale and the
25 potential repercussions for resilience, and we asked

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1 And if we have a look at, also, page 2, please, at
2 paragraph 2:

3 "Time is not on our side: not only can some of these
4 investments provide contributions to our vaccine
5 resilience late this year and early next, but the global
6 competition is fierce."

7 So was it clear throughout the period in which
8 spending decisions were being considered that there was
9 a real urgency over vaccine manufacture?

10 We can take that down now, thank you.

11 **A.** Yes, and I hope you can see that throughout, in all of
12 our advice and in our interactions, the resilience of
13 the UK manufacturing sector for vaccines was
14 a significant priority for the Treasury, and later that
15 year, at SR21, which took place in November, as the
16 correspondence leads to, we invested in a range of
17 different options, including the VMIC, Braintree, the
18 CPI in Darlington, and we also provided some further
19 funding to BEIS to invest in resilience in manufacturing
20 overall.

21 **Q.** If we could just talk about some of those specific
22 investments, dealing first with the Vaccine
23 Manufacturing Innovation Centre.

24 The Inquiry has already heard evidence today about
25 the fact that that was a facility that would hopefully

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1 a number of quite searching questions about whether that
2 really was the right option. So we looked at what was
3 being done to address residual vulnerabilities, what the
4 scenarios were for step-in rights and whether we would
5 lose those step-in rights, and what we would actually
6 do. We also asked BEIS to safety out all the other
7 alternative options that they had considered and to look
8 at the impact on other innovation investments that we
9 had previously provided funding for.

10 And ultimately there's a chain back and forth on all
11 of those questions. Ultimately the chief secretary took
12 the view that we had to rely on the expert views of BEIS
13 and ministers there, but there were several conditions
14 that we put on that sale, with each of those conditions
15 and issues being raised.

16 **Q.** Were the funds from the sale, are you able to assist us
17 with whether they were directed back into manufacturing,
18 so as to ensure that that investment was not lost?

19 **A.** I'm afraid I don't specifically know the answer to that
20 question.

21 **Q.** The decision -- and you may be aware of some of the
22 concerns expressed that the decision to sell was a move
23 in the wrong direction because it lost significant
24 manufacturing capacity, perhaps that is obvious, but
25 also those relationships with vaccine manufacturers that

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1 went along with it. Did the Treasury consider the
 2 impact specifically of the relationship loss in its
 3 decision making?
 4 **A.** I don't recall seeing specific evidence of that. But
 5 I think -- I can obviously see that that was the case
 6 from the information that has been provided by the
 7 department. But ultimately, our responsibility in the
 8 Treasury is -- was to provide the approval, given it was
 9 quite a novel and contentious thing to have done, and
 10 especially given the amount of taxpayer money involved.
 11 Ultimately it was up to BEIS to provide assurances and
 12 to meet the conditions that we put on the sale.
 13 **Q.** Just touching briefly on two other manufacturing
 14 investments which I think you have mentioned, Braintree
 15 and the Centre for Process Innovation. Simply to ask,
 16 do you know, are you aware of the current status of
 17 these sites?
 18 **A.** Forgive me, I don't. It's beyond the scope of my
 19 current responsibilities.
 20 **Q.** Perhaps the last important point to mention is the
 21 Moderna strategic investment. A strategic partnership
 22 was agreed with Moderna at the end of 2022. The
 23 Inquiry's understanding is that this is a ten-year
 24 partnership agreement. How does that partnership assist
 25 the UK in strengthening its domestic manufacturing

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1 "His view was that, if the clinical advice is that
 2 the vaccine doesn't work, then we should terminate with
 3 immediately effect in line with the advice."
 4 Now, I appreciate clinical advice is something
 5 entirely outside of your remit. There is in the second
 6 paragraph a desire to recover costs. And then this,
 7 which I'd like to ask you about:
 8 "Finally, he noted that it was surprising that the
 9 advice was not being shared with the [Secretary of
 10 State] BEIS and Lord Agnew, given they are members of
 11 the VTF and the advice notes that 'this is one of the
 12 two vaccines scheduled for delivery at significant
 13 volumes ...' He noted that this points to an earlier
 14 concern that there seems to have been a change of
 15 approach to engagement with the ministers and commercial
 16 experts within the VTF since the change of leadership."
 17 And he goes on to ask for some follow-up actions to
 18 be carried out in respect of that.
 19 Thank you, we can take that down.
 20 So the concern which seems to be expressed here, if
 21 we cast our minds back towards the beginning of your
 22 evidence, the very effective ministerial panel that you
 23 described, that the process for the termination of the
 24 Valneva contract had not gone through the panel in that
 25 same way. Can you help us with what the Treasury's

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1 capabilities?
 2 **A.** I'm afraid I wasn't directly involved in that strategic
 3 partnership other than the oversight of the funding that
 4 was provided alongside the deal, so I don't know the
 5 detail.
 6 **Q.** All right, I'm going to turn now to another topic, which
 7 is -- somewhat controversial at the time and a matter of
 8 importance to a number of Core Participant groups in the
 9 Inquiry, and that's the termination of the Valneva
 10 contract.
 11 Valneva was one of the manufacturers within, of
 12 course, the VTF portfolio, but its contract was
 13 terminated ultimately, never rolled out to the public.
 14 I don't need to go through with you the fine detail of
 15 this, but if we might look at an email, please, of
 16 September 2021 and if we could have on screen
 17 INQ00512911.
 18 And within page 1, we can already see, this is --
 19 thank you. In fact, could we just zoom out again so
 20 I can see -- thank you.
 21 The date on this is 10 September 2021. And it is an
 22 email representing the view of the Chief Secretary to
 23 the Treasury, Steve Barclay, about the termination of
 24 Valneva contract. The beginning of the email -- and if
 25 I could zoom back in now, thank you -- explains:

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1 understanding at the time was of the position and any
 2 concerns around that?
 3 **A.** Yes. So it's correct that it didn't go through the
 4 ministerial panel in the way that decisions of this
 5 nature normally would. We were directly approached by
 6 the Vaccine Taskforce with a recommendation to cancel
 7 the Valneva contract, and as you can see from that
 8 correspondence, the minister was quite keen that the
 9 principles of the ministerial panel were put into
 10 practice for this decision, and in -- I think that's
 11 important, given we'd spent £354 million by this point
 12 on the Valneva vaccine.
 13 I would note that we were forecast to spend an
 14 additional £590 million, and so what isn't in that
 15 correspondence directly, but is in other parts of my
 16 evidence, is that we also did look at the value for
 17 money of that decision.
 18 **Q.** Did you understand the reason for that process not
 19 having been followed?
 20 **A.** I don't.
 21 **Q.** And do you know what the outcome was, in terms of that
 22 being fixed, or followed subsequently?
 23 **A.** I recall that the information was shared as the Chief
 24 Secretary requested but I don't have any other details
 25 of what the follow-up was to that, and that process.

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1 Q. You may be aware that there was some concern, including
2 from Dr Clive Dix, that that decision at the time was
3 misguided because it might do damage to the wider
4 relationship with the pharmaceutical and bioscience
5 industry, given the decision and also the timing of it.

6 Is that something that the Treasury took into
7 account when it was involved in these discussions?

8 A. That wasn't within our role and remit, and I can
9 obviously see where Clive is coming from, but that
10 wasn't a particular issue or within the responsibilities
11 of the Treasury.

12 Q. I'm going to move on now to a different topic, and
13 that's therapeutics and in particular, at first,
14 antivirals.

15 Ultimately, the UK Government secured over
16 five million courses of antivirals to treat Covid-19 and
17 the Treasury of course approved that funding. But there
18 have been some concerns that there was less of
19 a willingness to invest in development of antivirals
20 versus vaccines. Can you explain, please, what the
21 Treasury's view, if any, was, on what ought to take
22 priority when it came to spending decisions?

23 A. Yes. So it's important to emphasise that the Treasury
24 always saw a very critical role for antivirals in the
25 response to the pandemic, especially in relation to

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1 I think it's right that we set out that balance of
2 risks and benefits in the advice that we gave to
3 ministers, and ministers ultimately concluded at that
4 stage that they didn't want to increase investment.

5 In the second phase in December, when a further case
6 is made to the Treasury --

7 Q. Can I just pause you there just to add some context.

8 But -- please continue once I've done so. But the
9 second phase was in response, was it not, to the Omicron
10 variant, and to a concern that some vaccines might not
11 be as effective against the Omicron variant, and that
12 antiviral investment needed to be increased in order to
13 guard against that?

14 A. Yes. That's correct.

15 Q. Okay, please continue. Thank you.

16 A. I suppose the additional consideration at that stage was
17 one, whether we would be able to deliver the courses in
18 time to respond to the peak of the Omicron variant which
19 was forecast to be in January in 2022. But also the
20 point you've made about vaccine escape risk and to what
21 extent there was evidence that for those who had been
22 vaccinated, this would in any way reduce the rate of
23 hospitalisation for vaccinated people. And that was
24 quite a critical part of the decision making from
25 a value-for-money perspective. And Philip Duffy, my

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1 clinically vulnerable groups and for those who could not
2 have the vaccine, and I think we stressed that
3 throughout all of our advice, and that's why we signed
4 off an envelope of £621 million at the very start of the
5 taskforce's work.

6 The two phases that follow, there are different
7 considerations at play. So in August we're approached
8 to review a business case with expenditure up to
9 £11.1 billion over a two-year period. And in effect
10 what the Treasury's advice set out was that there was
11 some benefits to the case, particularly for the public
12 health benefits that I've just alluded to, but also the
13 commercial benefits of getting ahead and attracting the
14 discounts that had been negotiated.

15 But on the other side you've got a very, very
16 significant risk of a material amount of public
17 spending, £11.1 billion pounds would have been more than
18 we were investing overall in vaccines, and we did have
19 concerns about the clinical information we had available
20 at the time about the effectiveness of antivirals, and
21 at that stage I don't think we'd undertaken peer reviews
22 of the clinical studies that were available to us. So
23 there was a very real risk that we were going to spend
24 material sums of public funding on antivirals that may
25 not ever be used or may not be effective.

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1 colleague who led on this, spoke to Jonathan Van-Tam at
2 the time to double-double-check our understanding of
3 this question of vaccine escape risk and effectiveness,
4 and I think what Jonathan says is there's quite material
5 variation in your value-for-money calculation, depending
6 on the range of results that they were seeing at the
7 time.

8 And the anticipation was that the PANORAMIC trial
9 would conclude in January and so we should continue to
10 invest in order to see the benefits of that trial and
11 hopefully to be able to meet the demands of the Omicron
12 peak. So those were the considerations.

13 Q. In terms of the business case that was submitted in that
14 second phase after the Omicron variant was of real
15 concern, the business case was submitted by DHSC and it
16 had, if you like, the backing in the sense that it was
17 supported by the department's senior clinical adviser
18 and the Office of the Chief Medical Officer. If their
19 view was that it was advisable to increase funding in
20 antivirals, was it for the Treasury to, if you like,
21 overrule or go behind that by doing its own assessment
22 of whether or not antivirals were something that ought
23 to be invested in?

24 A. So I don't recognise the characterisation of the
25 Treasury doing its own clinical assessments. The role

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1 of the Treasury is to faithfully represent the view of
2 experts and throughout the pandemic, and in normal
3 times, that is how Treasury sets out impartial,
4 professional and objective advice to ministers.

5 What is the purview of the Treasury is to set out
6 the trade-offs in public spending. And it's important
7 context that at this point -- I mentioned that, you
8 know, we're quite significantly ahead in vaccine
9 rollout. You can see that the benefits to the economy
10 are starting to take effect, and we've already spent
11 a significant amount of public funding on the vaccines.

12 At the same time we're being asked to spend even
13 more money on something that hasn't yet been proven to
14 be effective. And so I think it's absolutely right that
15 Treasury ministers are looking at the balance and
16 proportionality of public spending, especially when it
17 is such a significant sum of money.

18 So at no point does the Treasury attempt to, in any
19 way, take a clinical view. We're trying to balance the
20 proportion of public spending and whether we think it's
21 good value for money.

22 **Q.** Right. I'm going to move on now to the final matter
23 I want to ask you about, which is under the heading of
24 lessons learned and recommendations. You have already
25 referred to some of the innovative ways of working that

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1 the way in which we did governance, they're all examples
2 of applying that spending framework in a flexible way.

3 And then the consolidation of governance. I mean,
4 we would have saved many months, I believe, by
5 consolidating into a single ministerial decision point,
6 and I would repeat that immediately. And there are many
7 instances outside of a pandemic where I think there are
8 some valuable lessons to be learned.

9 **Q.** And what about things that could have gone better? Have
10 you identified any of those?

11 **A.** So I think there are a few things. Firstly, the use of
12 data, and the consistency of data, and I think the chief
13 secretary alludes to this specifically in a number of
14 different ways, but I think making sure that your data
15 is shared, open, consistent. We did very well in lots
16 of different circumstances, but really investing in the
17 quality of data in government is key.

18 Commercial skills, I think on one hand we did a very
19 good job at moving some of our most talented commercial
20 leaders to the places they were needed most, but the
21 raising of commercial skills across the whole of the
22 Civil Service is an ongoing endeavour and we've made
23 lots of strides but I very much agree with the comments
24 that Kate Bingham has particularly made around STEM and
25 commercial skills. And that happens to be part of my

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1 happened when it came to investment in vaccines and
2 therapeutics. Can you explain to us, what was the good
3 that came out of that part of the department's working
4 which you think would be beneficial to repeat should the
5 UK find itself in the same situation again?

6 **A.** We -- so I think there are three really core things.

7 One is the explicit use of risk-based judgements and
8 risk-management techniques in articulating the balance
9 of risk, how you try to quantify uncertainty and
10 benefits when making these sorts of decisions.

11 I think the fact that we very explicitly upfront
12 said that we are going to take a very high-risk
13 approach, because the benefits are so overwhelming only
14 positive, that means we are fundamentally changing
15 everything we are doing. And I think using that sort of
16 risk appetite framework in a professional way is
17 incredibly important in decision making.

18 Secondly, we talked about the flexibility of the
19 spending framework, and we've run number of lessons
20 learned on the detail of that, which I won't go into,
21 but I think it shows that you have to use the framework
22 flexibly and in a very fast and agile way, without in
23 any way undermining the important delegations that we
24 are given by Parliament for public expenditure.

25 And we've talked about the big spending envelopes,

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1 current role within the Cabinet Office and something
2 I take very seriously.

3 And then thirdly, embedding the Cabinet Office and
4 Treasury upfront into programmes. I cannot emphasise
5 how important that was. We did it well in the case of
6 vaccines, but to do it consistently I think matters. It
7 means you're developing your understanding of decision
8 making right from the start rather than trying to play
9 catch-up later on in a process.

10 And then finally, we did some very specific work on
11 how we support accounting officers, and I think there
12 are some quite technical aspects of the way in which we
13 do that, that we've documented some lessons learnt on in
14 the Treasury in particular.

15 **MS STEPHENSON:** Thank you. Those are all of my questions.

16 **LADY HALLETT:** I don't think there are any Core Participant
17 questions.

18 **MS STEPHENSON:** No.

19 **LADY HALLETT:** I'm really grateful, Ms Little. Thank you so
20 much. I am sorry we have taken two permanent
21 secretaries away from the Cabinet Office in the same
22 day. I hope we haven't caused the government to come to
23 a close.

24 Anyway, I also don't know whether I might be asking
25 for your help again. I do have other modules that may

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1 or may not be coming across your desk, so thank you in
 2 any event for of the work -- for the help you have given
 3 me so far.
 4 **THE WITNESS:** Thank you, my Lady.
 5 **(The witness withdrew)**
 6 **LADY HALLETT:** Very well, 10.30 on Monday? 10.30 on Monday.
 7 Thank you, all.
 8 **(3.23 pm)**
 9 **(The hearing adjourned until 10.30 am on Monday**
 10 **20 January 2025)**

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