1 **Tuesday, 11 March 2025**
2 **(10.00 am)**
3 **LADY HALLETT:** Mr Wald.
4 **MR WALD:** My Lady, I wonder if, before we start, I could
5 just return to the subject of a particular document
6 that I mentioned at the end of yesterday, INQ000533868.
7 I said at the time that it was necessary for us to check
8 whether there was any requirement or need to apply
9 a restriction order on that document.
10 In the event, no such need arises.
11 **LADY HALLETT:** Thank you very much.
12 **MR WALD:** Our next witness, or our first witness today is
13 Dame Emily Lawson.
14 **DAME EMILY LAWSON (sworn)**
15 **LADY HALLETT:** Welcome back.
16 **THE WITNESS:** Thank you.
17 **Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 5**
18 **MR WALD:** Please state your full name for the Inquiry.
19 **A.** My name is Emily Jane Ruth Lawson.
20 **Q.** Dame Emily, we have received two statements from you for
21 this module. I know that you provided a statement, at
22 least one statement, for a previous module.
23 **A.** Yes.
24 **Q.** In relation to this module we've received INQ000572261,
25 and INQ000531295, for which we are very grateful. Both

1 statements are signed. Could you confirm, please, for
2 the Inquiry that both statements are true to the best of
3 your knowledge and belief?
4 **A.** Yes.
5 **Q.** Thank you very much, Dame Emily.
6 Could I start, please, with a little bit of your
7 background. I am concerned, when I move on to it, with
8 that period that relates to the pandemic itself, and
9 won't be asking you questions in relation to more recent
10 professional experience.
11 Dame Emily, you have a background in academia,
12 I understand.
13 **A.** Yes, I have a PhD in molecular genetics.
14 **Q.** You worked in the biotechnology industry?
15 **A.** Yes.
16 **Q.** And you have also worked as a management consultant at
17 McKinsey?
18 **A.** Yes.
19 **Q.** And following that, you've had experience at Morrisons
20 and Kingfisher?
21 **A.** That's right.
22 **Q.** I hope to be able to seek your reflections on data, data
23 management and modelling in due course. Can I take it
24 that the experience that you've had will enable you to
25 offer reflections based on relevant experience and

1 expertise?
2 **A.** Yes.
3 **Q.** Good. Thank you for that.
4 I move now to your involvement with NHS England.
5 Between 2017 and 2020 you were employed by NHS England
6 as National Director for Transformation and Corporate
7 Operations.
8 **A.** Yes, my job title shifted once very slightly when
9 NHS England and Improvement merged, but it was
10 effectively the same role now effectively spread across
11 two different -- well, two organisations that had now
12 come together.
13 **Q.** Understood. You also held, from December 2018, a senior
14 leadership role for the joint NHS England and
15 NHS Improvement organisation?
16 **A.** Yes, I led the Joint Working Programme to bring the two
17 organisations together.
18 **Q.** And between the beginning of April and the middle --
19 beginning of April 2020 and the middle of July 2021, you
20 were the Chief Commercial Officer for NHS England and
21 NHS Improvement?
22 **A.** Yes.
23 **Q.** Moving on in time, you were seconded to the DHSC from
24 20 March 2020 to 9 November 2020?
25 **A.** Yes.

1 **Q.** And in July 2029 (sic) up until July 2021, you held the
2 post of non-executive director of SCCL?
3 **A.** From July 2019, yes, until I -- yes, that's right.
4 **Q.** How did you come to take on that role at SCCL, about
5 which we've heard a certain amount of evidence already
6 in this module?
7 **A.** Yes. So the plan that pre-existed me taking that
8 non-executive role in July of 2019 was that the
9 shareholder role in government of SCCL should move from
10 DHSC to NHS England. So in order to prepare for that,
11 but in advance of it actually happening, myself and
12 Miranda Carter took non-executive roles in the summer of
13 2019 as part of that extended handover period.
14 **Q.** I had a go at summarising what SCCL is, or was, in the
15 course of opening this module, the opening submissions
16 given then. Would you, perhaps, explain, as you
17 understand it, what is SCCL?
18 **A.** Obviously, you've got Paul Webster coming on after me
19 who will probably give a more authoritative answer, but
20 the SCCL was set up partly as a consequence of the Lord
21 Carter review of the potential opportunities for
22 efficiency in the NHS to consolidate the supply chain
23 activities and to try to take advantage of the scale of
24 the NHS in procurement. So with the idea being that if
25 you can buy on behalf of the whole NHS you will get

1 better prices for goods and services than you will if
2 it's just a single trust doing that.
3 And by that time in ... I mean, SCCL has quite
4 a complicated structure -- had, which I can give
5 a couple more sentences on if it's helpful, but
6 basically the goods and services they were providing
7 services for to the NHS were held in, I think it was 11
8 towers, and these towers were bid for by consortia of
9 other organisations, so they would then provide the
10 service of buying -- for example, one of them was about
11 food and, you know, hotel services, for example; another
12 one was about medical devices, including pacemakers, so
13 relatively straightforward things that the NHS uses
14 a lot of.
15 And they also contracted originally with DHL but
16 then switching to Unipart, I'm afraid you'll have to ask
17 Paul for the detail, but I think either in 2018 or 2019
18 they switched to Unipart who ran the warehouses that
19 then dispatched those goods and services into the NHS.
20 **Q.** We'll come on to that and we certainly will be asking
21 Mr Webster for a little bit of detail on that. But
22 during the pandemic, by way of summary, SCCL fell under
23 the control of DHSC?
24 **A.** It did, yes.
25 **Q.** We know from a previous module, Module 4, that you also

1 had an important role in relation to vaccines --
2 **A.** Yes.
3 **Q.** -- which we won't be going back to today.
4 I want to ask now -- just finally, you returned to
5 Number 10 in April 2022 up until September 2023 as Head
6 of the Prime Minister's Delivery Unit there?
7 **A.** Yes.
8 **Q.** Moving, then, to how you came to be involved in
9 procurement during the pandemic more specifically.
10 Let's start in early March of 2020. On 10 March,
11 NHS England's Chief Executive asked you to investigate
12 complaints from NHS trusts that their orders for PPE
13 were not arriving on time. That's right, isn't it?
14 **A.** Yes.
15 **Q.** And I think we can display our first document in
16 relation to this.
17 It's INQ000533074, and page 2 of it, just to get
18 a sense of the kinds of issues that were causing
19 concern. We see there that:
20 "... WMAS had placed an order for face masks ..."
21 What is WMAS, please?
22 **A.** West Midlands Ambulance Service.
23 **Q.** Thank you.
24 "... for face masks and that these have not been
25 forthcoming, and that Anthony Marsh (CEO) is escalating

1 to Simon Stevens.
2 "London reported concerns around continuing with
3 community swabbing and access to PPE.
4 "North East and Yorkshire reported that YAS ..."
5 **A.** Yorkshire Ambulance Service.
6 **Q.** "... have moved to RPE because of a lack of appropriate
7 PPE, and that Merseycare were suspending community
8 swabbing due [to] a lack of PPE."
9 And finally:
10 "South West reported that South Devon had suspended
11 due to a lack of equipment and swabs."
12 Dame Emily, what was your reaction to learning about
13 these kinds of challenges being faced by NHS trusts?
14 **A.** My reaction was to, I mean, connect to the various
15 people who were already looking at this. So this email
16 is from Stephen Groves, who is one of the leads for the
17 emergency response in NHS England, and obviously he was
18 already in communication with -- I think the email is to
19 Sarah Parker, who was part of Steve Oldfield, the chief
20 commercial officer -- in the department. So what
21 I didn't want to do was to wade into stuff that was
22 already being handled because yet another person asking
23 questions is often not that helpful. So I was glad that
24 Stephen copied me in.
25 **Q.** Let's look at the email that shows that. It's

1 INQ000533075, and page 1 of it.
2 **A.** Yes.
3 **Q.** This shows your discussion with Steve Oldfield, as
4 you've summarised for us:
5 "Got reports today of a hospital going to screwfix
6 to buy goggles."
7 Is that Great Ormond Street?
8 **A.** It is, yes.
9 **Q.** "[Hospital] struggling for PPE as well. Apparently
10 several trusts are down to 2 boxes of masks. As you
11 know, the supply of PPE is critical to staff feeling
12 safe."
13 I just wanted to ask you a point about the word
14 "feeling" there. It's not just a lack or shortage of
15 PPE that causes problems; it's the prospect of that
16 occurring in the coming days, isn't it?
17 **A.** It is, yes. You know, it was a very worrying time.
18 People could kind of see that the growth was coming and
19 particularly clinical leaders were getting emails and
20 pictures from -- and WhatsApps from Italy, which was
21 already in a, you know, really challenging position. So
22 just the emotion and the fear among staff was really
23 high. And so if you can only see two boxes of masks,
24 first of all you don't feel safe, but secondly it might
25 cause you, for example, to not wear the mask for long

1 enough because you're like, "Well, I might need it again
2 tomorrow", and then you potentially have people
3 compromising themselves because they don't feel safe,
4 not because the supply isn't actually there. And
5 I think Professor Manners-Bell talked a little bit about
6 that in his report, which I thought he conveyed really
7 well, but that was a very visceral concern.
8 And obviously in the intervening time between these
9 two emails that you've shared I've been to the
10 SCCL board meeting in Nottingham, which was on the 11th,
11 so it was exactly five years ago today, where we'd had
12 a normal board meeting and one of the non-execs and
13 I had raised issues. I then had a meeting outside of
14 the board meeting itself with Jin Sahota -- I don't
15 think with Alan Wain but definitely with Jin -- to say,
16 "Right, what is the actual response going on?"
17 So by the time of the email you're showing me --
18 this is Saturday -- I am concerned that we've been
19 raising emails, we've been writing backwards and
20 forwards, but I'm not seeing that we're changing what
21 we're doing in order to deal with this heightening
22 tension and what looks like heightening lack of supplies
23 at the trust.
24 **LADY HALLETT:** Sorry to interrupt, if you could slow down.
25 **THE WITNESS:** Sorry, yes.

1 **MR WALD:** I'll move on to the latter part of this email in
2 a moment but I pose a question about feeling safe,
3 because evidence has been given to the Inquiry up until
4 now about there being no national shortage, albeit that
5 there were some issues about distribution to individual
6 hospitals. I wanted to have your evidence on the
7 feelings that resulted, even from the prospects of
8 shortages in the coming hours or days.
9 **A.** Yes.
10 **Q.** And you've given your answer to that question.
11 **A.** Yes.
12 **Q.** Let's move on, then, to the second half of this email
13 paragraph.
14 "I thought the release of the PIPP stock would
15 relieve the pressure so not sure if it hasn't got to
16 people yet or if there are still too strong restrictions
17 on ordering and delivery at SCCL. Would you be ok to
18 write a strongly worded letter to PHE and/or SCCL saying
19 the data says there are stocks and they need to get them
20 out, and [get] back to us instantly with any issues?"
21 At this point, Dame Emily, the decision had already
22 been made to release the PIPP stockpile, but SCCL had
23 put in place demand restrictions, and so releasing that
24 stockpile had not improved the flow of stock to trusts.
25 Is that the position?

1 **A.** Yes. I mean, the whole PIPP stock hadn't been released,
2 but sort of the ability to start using it had been, but
3 it was not happening in a full flow way; it was
4 happening in a controlled way.
5 **Q.** When you say controlled, we'll move on in a moment to
6 physical problems that were encountered in distribution.
7 **A.** Yes.
8 **Q.** So that aspect of it I suspect you wouldn't describe as
9 controlled?
10 **A.** Sorry, the physical aspect of distribution from Haydock
11 into the SCCL -- (overspeaking) --
12 **Q.** Yes, the obstructions, the problems with getting
13 stockpile PPE out of the warehousing.
14 **A.** Yes, I mean, I'm happy to -- shall we -- sorry, shall
15 I wait for the question on that?
16 **Q.** Let's wait for the question.
17 **A.** Yeah.
18 **Q.** We'll come on to it in a moment.
19 Can I first understand from you the reason for PPE
20 not being shipped to trusts in the quantities needed?
21 **A.** I think there were several things going on, and
22 I appreciate you've probably heard from other people,
23 but if you don't mind it probably helps if I take
24 a second to lay this out.
25 **Q.** Please do.

1 **A.** So the PIPP stock, and there is also a second stockpile
2 not mentioned here but was material which was the
3 EU exit stockpile, which was also being released at this
4 point, the PIPP stock is held in what is effectively
5 a deep-freeze scenario in the warehouse in Haydock, run
6 by Movianto, which was subcontracted to PHE. And the --
7 you don't go into that kind of warehouse to send
8 a couple of pallets to a trust; it has to come out of
9 that warehouse into what's called the distribution
10 warehouse, which were the ones run by Unipart, and then
11 it can be dispatched to trusts.
12 Trusts couldn't order directly from Haydock, and
13 Haydock would not have been able to dispatch. You've
14 got the wrong lorries, if you like, that you can't go in
15 and pick stuff up in the same way you can from
16 a distribution warehouse. So stuff had to be moved
17 twice. And what had happened was SCCL had seen
18 a massive growth in orders not just for PPE but for
19 everything else. And that's in -- both
20 Jonathan Marron's statement and Paul Webster's statement
21 give some examples of that. And to give one example,
22 the use of FFP3s had gone up threefold by the end of
23 February in terms of how many were going out per week,
24 and if that is happening to everything that you pick,
25 that makes picking very difficult.

1 So there was a release of some stock from Haydock,
2 but PHE and SCCL were also concerned to not release that
3 all at once because it might need to last for longer.
4 So that was a controlled release into the SCCL
5 warehouses.
6 **Q.** And that is a form of demand management?
7 **A.** That is a form of demand management, yes.
8 You then had demand management at the SCCL
9 warehouses where there were caps on specific items, so
10 from 19 February there was an order limit for FFP3s,
11 from 24 February for 2Rs, two 2R masks which are the
12 fluid resistant masks, and then from 26 February for eye
13 protection, and there were then other controls against
14 orders. So if an order was more than 150% of what they
15 would normally have ordered, it was stopped, that kind
16 of thing.
17 So there were a bunch of controls going on. And
18 what, of course, the system wasn't able to see is when
19 was a trust genuinely over-ordering because they were
20 nervous, they wanted to make sure they had the stock,
21 and when did they actually need more because they were
22 treating more patients and because there was a growth in
23 demand? The system wasn't able to see that. So there
24 were tensions, kind of, all through the supply chain, if
25 you like.

1 **Q.** I assume that extremely helpful answer is one that you
2 are able to provide the Inquiry on the basis of what you
3 have gleaned since that time. You were also anxious,
4 quite rightly, to understand what the cause or the
5 causes of the problems were at the time and I want to
6 just bring up on to the screen a document that shows you
7 attempting to do that, and just ask you to the extent
8 that you've not already dealt with it in that answer,
9 whether there were any other indications here of what
10 lay behind the problems being encountered.
11 It's INQ000533076, and it's pages 1 and 2.
12 So this is actually -- your email is at the top and
13 then we've got, this is from Alan Wain.
14 **A.** Alan Wain who was the Chief Operating Officer at SCCL.
15 **Q.** Yes, and he is identifying, as he understands it, what
16 the problems being experienced were at the time. And
17 you said that it's a very helpful email, I assume that
18 you took this to be a sensible explanation of those
19 problems?
20 **A.** Is it possible to scan down a little bit?
21 **Q.** Yes, I was going to take you all the way through, but
22 starting with "Poor communications". Did that feed into
23 the problem as you understood it then or as you
24 understand it now?
25 **A.** Yes, if I could take a step back, I'm happy to do the

1 detail but just because you asked a broader question
2 a second ago.
3 **Q.** Yes.
4 **A.** I genuinely thought it was a helpful email, which is
5 what I said at the top. I also thought it didn't
6 describe the whole situation, I thought it described
7 a very clear view from SCCL of what they were
8 experiencing. It didn't go all the way to identifying
9 all of the issues and therefore we needed to do more to
10 get underneath the skin of the issues to actually solve
11 the problem, but maybe you're taking me there.
12 **Q.** Okay, well, by all means, if there are aspects of this
13 that are missing, you'll let us know now.
14 **A.** Sure.
15 **Q.** I appreciate it's not your email, but you were sent it,
16 described it as helpful.
17 **A.** Yes.
18 **Q.** But it may not have been comprehensive as well as
19 helpful?
20 **A.** That's right.
21 **Q.** Yeah. So we've got "Poor communications", actually,
22 that appears twice, as items (1) and (2). We've then
23 got "Bad behaviour from trusts".
24 **A.** Mm-hm.
25 **Q.** Is that something you would agree with? You've

1 mentioned that there were problems about understanding
2 what degree of need there was, whether people were
3 seeking more than was immediately needed because of
4 anticipated problems.
5 **A.** Yes. I mean, look, I think it signals the level of
6 tension everybody was operating with at the time but it
7 was one of my concerns, because if you -- I wouldn't
8 have described what the trusts were doing as bad
9 behaviour. The trusts were tremendously concerned to be
10 able to treat patients and to be able to keep their
11 staff safe, so I totally see from an SCCL perspective
12 that an increase of 4,500% feels absolutely outrageous,
13 I didn't feel it necessarily -- excuse me, I have
14 probably sped up again -- it didn't fully appreciate the
15 tension that the trusts were also dealing with, so
16 I thought there needed to be a balance here because if
17 we were going to solve the problem we had to solve it
18 for the whole supply chain not just for one part of it.
19 **Q.** Yes, the observation is made at (3) that during the
20 course of a single day -- "of the day, we took orders
21 for 1 million facemasks."
22 **A.** Yes.
23 **Q.** That simply shows how extreme the position was at that
24 time.
25 **A.** It does, and I think it's important to convey just how

1 many -- at this point everybody thinks this is
2 a potentially deadly disease. You don't yet know that
3 it's only elderly -- it's largely, not only,
4 obviously -- elderly people are particularly at risk of
5 getting ill so all staff feel they are putting
6 themselves on the line to come to work, and so you had
7 a massive increase in people putting 2R masks on to try
8 and protect both themselves and colleagues and the
9 patients they were treating. So again, if you're
10 running a warehouse that seems absolutely outrageous.
11 If you're running a hospital saying, actually, I want
12 more staff to wear type 2R masks, probably didn't feel
13 that extreme.
14 **LADY HALLETT:** I find it rather strange that someone should
15 describe it -- I appreciate you have disowned the
16 comment "bad behaviour" from trusts. It seems rather
17 curious to me that one part of the system is accusing
18 another part of the system who, as you say, were doing
19 their best to protect staff and patients, of bad
20 behaviour.
21 **A.** I do think this is one of the challenges that we had
22 over this period, and you mentioned that I went on the
23 board on the -- in July 2019. One of the three issues
24 that I'd flagged in my work through the autumn as
25 a non-executive, had been the relationships with trusts,

1 and trusts -- SCCL at that time felt that trusts were
2 not buying enough through them and that NHS England
3 should mandate it. And I felt that before we mandated
4 it we needed to make sure the service was really working
5 for trusts, and that they thought they were getting what
6 they needed.
7 So I think this is indicative of the fact that
8 actually, Trusts-SCCL relationships were very mixed and
9 there was a way to go to improve them and now you've
10 suddenly put this massive tension on top and that's
11 brought that out.
12 **MR WALD:** There's discussion here of limitation and demand
13 management. At this stage, were you asking SCCL to
14 increase their own buying activity?
15 **A.** SCCL had been instructed at one of the supply cell
16 meetings right at the beginning of February to increase
17 their buying. So they had both, in fact on 31 January,
18 activated the just-in-time orders that were part of the
19 PIPP stockpile and they had increased their own buying,
20 I think from 7 or 8 February. That's in the minutes of
21 the supply cell. I obviously wasn't part of it at the
22 time. So they had already started buying more.
23 **Q.** As far as you knew, was SCCL following a policy of not
24 acknowledging control measures, or in other words, not
25 telling NHS trusts about demand control measures in an

1 attempt to prevent panic buying?
2 **A.** I'm not aware either way.
3 **Q.** Okay. Now let's see what you've -- unless there's
4 anything else you wanted to remark upon with this email?
5 **A.** No, that's fine.
6 **Q.** Let's go to a part of your witness evidence. It's
7 INQ000531295 and page 9. Paragraph 38. And we can see
8 here you stating:
9 "I was concerned that SCCL was not anticipating, was
10 not planning for, and had only partial information on
11 future stocks of the amounts of PPE that would be
12 required. My concerns relating to SCCL were confirmed
13 after I had discussions with the CEO and Chair of SCCL
14 on a follow-up call."
15 What specifically made you worry that this was the
16 case?
17 **A.** Well, it's partly the email that we've just reviewed but
18 it was also multiple conversations with Jin Sahota who
19 was the CEO and Jim Spittle who was the chair over the
20 period -- I mean, I send an email on the Saturday night,
21 Alan responds on the Sunday night. We've clearly spoken
22 on the Sunday morning. I speak to Jin on Monday the
23 16th, I check back in with Steve Oldfield and say I'm
24 not sure this is enough, and then we do a joint call
25 together, Jim Spittle, Jin Sahota, and both Steve and I,

1 I think on the 18th. I'm very good on days of the week,
2 less good on dates in my extremely detailed memory of
3 what happened five years ago. And the answers often
4 came back like Alan's email. Those answers are not
5 wrong but they are also putting the onus of the problem
6 on to trusts as opposed to the fact that, clearly, the
7 distribution system is starting to fail, and at this
8 point, the thing that I found most difficult is SCCL
9 could not tell me how much additional they'd bought.
10 I knew they'd placed additional orders but they couldn't
11 tell me how much and so -- and they also had already
12 flagged to the supply chain cell they didn't know when
13 these orders would arrive. So we might have increased
14 buying but we didn't know when it would come.
15 So I didn't feel like I was getting sufficient
16 traction from SCCL that gave me confidence that
17 collectively we were going to solve this problem.
18 **Q.** These issues came to your attention in March of 2020; is
19 that right?
20 **A.** This paragraph relates specifically to those calls
21 between the Alan email on the Sunday night and the
22 conversation Steve Oldfield and I had, I think, on
23 Wednesday the 18th.
24 **Q.** Which, I think, takes us to March 2020?
25 **A.** This is all in March.

1 **Q.** This is all in March 2020?
2 **A.** This is March 18.
3 **Q.** You were the Chief Commercial Officer at NHS England and
4 a non-executive director at SCCL, weren't you?
5 **A.** I had been appointed Chief Commercial Officer,
6 I formally didn't take up the role until 1 April 2020.
7 **Q.** Is that why we perhaps detect a degree of distance
8 within your statement between yourself and the failings
9 identified? The question is, if you were
10 a non-executive director at SCCL since July of 2019, ie,
11 six months earlier, ought you not to have been aware of
12 this sooner than March of 2020?
13 **A.** So my role on the SCCL board from July, obviously there
14 was no pandemic thought of in July of 2019, was focused
15 on the safe transfer of SCCL to NHS England, which was
16 planned for sometime in 2019, probably 1 October, and
17 we, Miranda and I authored a paper to say we didn't
18 think it was ready, and it was then proposed to transfer
19 on 1 April 2020. Obviously that didn't happen either.
20 The concerns I was focused on as a NED obviously
21 first was to understand the company, and second, was to
22 understand why SCCL wasn't getting the traction with the
23 NHS that everybody thought it should have, and that, you
24 know, Lord Carter had laid out the potential for.
25 And the three issues that I focused on during the

1 autumn, one was the customer relationships, which I've
2 already mentioned; one was the whole tower structure,
3 because it was so complex, the towers were outsourced to
4 a consortium that had put the best bid offer in, and
5 some of those were NHS organisations, some of them
6 weren't. And the financial model of how the towers both
7 made the margin that they were supposed to make and
8 deliver the best possible prices was not compelling to
9 me in some places. So I did couple of deep dives with
10 tower leads to try to really understand what was working
11 and what wasn't working. So the commercial model was of
12 concern.
13 And the third, which, not just me but several other
14 non-executives raised, was that SCCL was about to embark
15 or had just embarked on a major IT transformation and
16 their IT was definitely not where it should be. But at
17 the board meeting where this was raised, the
18 conversation was both, you definitely need to do this,
19 but also, you do actually have the capacity to make this
20 happen, because this is a massive change in a small
21 amount of time?
22 So that's what I had focused on in those board
23 meetings.
24 What happens at the beginning of -- well, at the end
25 of January is I am still running the joint working

1 programme, so the two organisations only formally come
2 together on 1 April 2020. I am also running all of the
3 internal functions of NHS England including facilities,
4 estates, IT and HR. So for example, the first way I get
5 involved in the pandemic is doing things like the
6 facilities audit of trusts to make sure that the oxygen
7 supplies are going to be robust. So I have a different
8 role in February. I'm not part of the supply cell.
9 It's only part in the beginning of March when Simon
10 first asked me to look at ventilators on 6 March and
11 then at PPE at the beginning of the following week
12 that I start to fully engage in the commercial aspects
13 of the pandemic and connect with Steve Oldfield and the
14 supply cell that he set up.
15 **Q.** All right, thank you.
16 I see the stenographer is heroically coping --
17 **A.** Oh, I'm sorry.
18 **Q.** -- but if we could just reduce the pace slightly, I'm
19 sure that would make life a little easier.
20 Could we please have on the screen, please,
21 INQ000531295.
22 Now, in March 2020, also on the 18th, you were told
23 that the layout and set-up of Unipart's warehouses would
24 not allow any further increases in throughput capacity,
25 weren't you?

1 And this is the part here:
2 "Gareth and I called the CEO of Unipart."
3 **A.** Yes.
4 **Q.** "Although Unipart had already upscaled staffing in their
5 logistics centre this was insufficient to meet the
6 throughput required to meet the needs of NHS Trusts.
7 Unipart took on board the concerns raised on the call
8 and went away to carry out research on what would be
9 possible. The next day, 18 March 2020, they informed us
10 that the layout and set up of their warehouses would not
11 allow us any further increases in throughput and
12 capacity. It was becoming very clear that the existing
13 arrangements for procuring and distributing PPE would
14 not be sufficient to satisfy demand."
15 What was the problem with the layout of these
16 warehouses?
17 **A.** So it's not a problem in peacetime but all supply chains
18 and warehouses, as again Professor Manners-Bell lays out
19 in his report, have been leaned out over the last
20 20 years to deal with just-in-time supply. So they
21 don't hold --
22 **LADY HALLETT:** Leaned out?
23 **A.** So the concept of just in time, so you only have as much
24 as you need for a very short period, which means that
25 the warehouses don't need to be very big because you can

1 always rely on more stock coming from either
2 a deep-freeze-type warehouse like Haydock or from
3 overseas.
4 So on average, again, I think it'd be -- SCCL would
5 have a more accurate number, but SCCL warehouses would
6 hold about three weeks of stock of items that moved
7 relatively fast, like PPE. And they weren't designed to
8 hold large stocks and they weren't designed to scale up,
9 because trusts would order when they needed it, it would
10 arrive within 24 or sometimes 72 hours. So there just
11 fundamentally wasn't the capacity in those warehouses to
12 stretch. They weren't sitting there with large amounts
13 of space empty.
14 **MR WALD:** Is it just a feature of the size of the warehouses
15 or was it, as we see in this paragraph, a problem about
16 the layout, a problem about the doors that open and
17 close at a warehouse?
18 **A.** I think the doors problem was one of the issues at
19 Haydock that they couldn't -- that it opened onto
20 a particular platform which only certain lorries could
21 come up. I don't remember a particular issue with the
22 doors at Unipart. But the conversation -- Unipart had
23 already doubled their staffing in the week before, and
24 that's -- I remember John saying that to Gareth on this
25 call, and he said, "Look, we've already doubled."

1 And Gareth said, "Look, it's going to need to be
2 eight times next week."
3 And he said, "Right, okay, let me think about that."
4 And then he came back the following day to say,
5 "Look, there is nowhere to go, there isn't -- you can't
6 fundamentally change the layout of a warehouse and you
7 can't put eight times as many people in."
8 Sorry, I realise I keep speeding up.
9 Because you just can't physically fit the people and
10 the, you know, the -- sorry, I don't have the technical
11 language -- but the pick-ups, et cetera, they won't be
12 able to get round the warehouse. So there was nowhere
13 to go in the existing system, we'd maxed it out.
14 **Q.** But you're right that Professor John Manners-Bell deals
15 with just-in-time contracts.
16 **A.** Yes.
17 **Q.** We've heard some evidence about just-in-time contracts,
18 and the problems that they experienced in a global
19 pandemic, last week also. Given that the PIPP stockpile
20 was designed to be used in an emergency, what would need
21 to change in order that that stockpile could be used?
22 What was available for quick use at scale if necessary?
23 **A.** You mean in March 2020 or now?
24 **Q.** Looking forward.
25 **A.** Looking forward.

1 **Q.** Extracting lessons.
2 **A.** Thank you. So I -- the store -- sorry, I'm just going
3 to go back a second because I want to be really clear
4 that we're talking about two different types of
5 warehouses.
6 The PIPP stock is being held in a warehouse which is
7 not designed to ship directly to customers, and that is
8 entirely sensible. That stock is held for long periods
9 of time. We can come back to stock rotation and how do
10 we make it more robust, but there was not a fault with
11 that warehouse. What we needed was an ability to get
12 stock out of that warehouse into a warehouse where it
13 could be broken down. So, instead of, I don't know, it
14 would be the wrong number, but a million masks, you can
15 break it down into the hundred thousand that a trust
16 actually needs, along with the gloves the trust needs,
17 the masks, et cetera. Things are picked off of a shelf
18 of masks, picked off of a shelf of gloves, et cetera,
19 which would be in a different part of the warehouse, and
20 you create the right package that the trust has asked
21 for. That can only be done in a distribution warehouse.
22 So this is not a fault of the PIPP warehouse stock;
23 it was that we'd already scaled up to an extent the
24 supply chain had not been planned for.
25 The scale problem was with the Unipart warehouses

1 which were not just holding PPE; they were holding
2 everything else. They were holding pacemakers and
3 tubing and, as Alan said to me at the time, custard
4 powder. And all of the -- hospitals needed other
5 things. They didn't just need PPE. So it was apparent
6 to me on the 18th, when I got that call back from
7 Unipart, that the answer could not be in scaling the
8 existing system further. We had to put new dedicated
9 capacity into the distribution chain.
10 Sorry, so you asked me a forward-looking question
11 and I've just answered the past, so just let me come
12 back to it.
13 For the future, again, this is where I think SCCL
14 has some brilliant plans that it would be helpful to ask
15 them about, but the ability to scale the distribution
16 next time is built into the forward planning of SCCL
17 through a combination of call-off contracts where you
18 can agree that you will now contract with a new
19 warehouse, with a new set of truck drivers, et cetera,
20 to build out the supply chain very quickly. So they've
21 planned for that in the way that they are running things
22 now.
23 **Q.** All right. Given the problems that were being
24 experienced back in March 2020, you made a request for
25 military aid for civil authorities, didn't you? A MACA

1 request?
2 **A.** I did, yes.
3 **Q.** And Brigadier Philip Prosser, who is now a Major
4 General, was assigned to assist.
5 **A.** Yes.
6 **Q.** We'll come back to Brigadier Prosser in a few moments
7 and we'll hear from him directly in week 4 of the
8 hearings in this module. I want to now turn to
9 distribution for social care more specifically.
10 For social care, rather than being given free
11 supplies like an NHS trust would get, the system was
12 PIPP stock being released to wholesalers who then sold
13 into the social care market. We gather that from your
14 witness statement paragraph 153e.
15 Is that what was happening?
16 **A.** Yes, there had already been one release to the social
17 care providers I think the previous week before I got
18 involved.
19 I just want to pick up something in your question.
20 Trusts were not getting free PPE at this point; they
21 were ordering PPE which they would have to pay for.
22 The -- taking the costs out of the system came later.
23 **Q.** So did it come at the same time for NHS trusts and for
24 social care?
25 **A.** I don't think so, no, but I don't have that detail in my

1 head, I'm afraid. I'm happy to get back to you on that.
2 **Q.** Do you think that NHS trusts got it for free before
3 social care did? Or do you not know?
4 **A.** I don't think they got the same quantity of supply but
5 there was a drop of PPE to local resilience for, again,
6 the first week of March -- again, it's before I got
7 involved -- that wouldn't have been charged for. So
8 social care was able to get PPE from a range of places,
9 including the usual wholesalers and through the local
10 resilience fora.
11 **Q.** The reason for my question, you say at paragraph 153e,
12 the same paragraph, that:
13 "This proved insufficient, so social care were later
14 set up to access supplies via the new distribution
15 system."
16 **A.** They were, yes.
17 **Q.** From which I inferred, perhaps incorrectly, that there
18 had already been such an arrangement with NHS trusts; is
19 that not the case? Do you want to remind yourself of
20 your 153e?
21 **A.** Yeah, I'm just looking at it now.
22 So a range of approaches were set up very quickly to
23 deliver to social care. So the first which was
24 organised between the department and MHCLG was to use
25 the local resilience fora, and indeed, in my first

1 couple of weeks running this, I remember having
2 conversations with a couple of leaders of local
3 resilience fora to understand what their needs were,
4 what they were getting, what they were not getting.
5 This was not an established part of the pandemic
6 plan; it was something that was set up on the spot when
7 everybody realised there was a problem.
8 What we established through April, working with the
9 local resilience fora, is that this was quite
10 insufficient for social care. There's a lot of very
11 small suppliers in social care, and they were not able
12 to out-compete big suppliers in the wholesale market
13 when the wholesalers had kit and it was very inefficient
14 for them to get it from the LRFs, so we set up the
15 e-portal which we started commissioning at the beginning
16 of April, and it was tested with social care towards the
17 end of the month and then rolled out more broadly over
18 the summer.
19 **Q.** Inefficient because, amongst other things, the
20 procurement of that PPE had to be done at the existing
21 market prices in a very volatile market, sometimes, at
22 considerable mark-ups?
23 **A.** So social care would have been buying from two different
24 sets of wholesalers, one were the wholesalers who were
25 getting stock from PHE via the PIPP stock, and

1 I believe, but that would be a question for PHE, that
2 that was price controlled. They weren't allowed to do
3 a massive mark-up. And then the others was in the open
4 market, where yes, the price pressures would have been
5 immense.
6 **Q.** Would it be sensible, in the event of a future pandemic
7 that called for emergency procurement, that the social
8 care sector should receive free PPE centrally supplied
9 throughout the period of need?
10 **A.** I think having a distribution system that works for all
11 of the different -- well, the 58,000 customers that
12 ended up getting PPE through the parallel supply chain
13 retaining the ability to do that would be hugely
14 important. Primary care obviously also desperately
15 needed PPE and were very, very small, and so it was
16 an efficient way, which is why we set up the e-portal.
17 I think the pricing thing is a slightly different
18 question about what you would do in another pandemic --
19 **Q.** Do you have a view?
20 **A.** -- whether it was free or not.
21 **Q.** Can you offer a view about that?
22 **A.** I haven't actually thought this one through in advance,
23 unlike a lot of the other questions. I think it was the
24 right thing to do at the time, because the market prices
25 were horrible at times, although actually came down

1 quickly. And it made no sense for the whole, you know,
2 multiple providers across the UK and the devolved
3 authorities to be bidding against the same manufacturers
4 and the same wholesalers. And if you were going to buy
5 as a government, then recharging people made no sense.
6 I think, again, I'm probably not the right person to
7 ask the question, but the plan if the PIPP stock had
8 been able to do what it was intended to do, which is to
9 get through the first few weeks of the pandemic, by
10 going via wholesalers rather than distributing for free,
11 then you wouldn't have needed it. But we needed
12 different PPE and we needed more of it than had been
13 expected so we were in a different situation with
14 regards to pricing.
15 **Q.** All right. Well, we'll hear from other witnesses today
16 who might be able to assist us with that point.
17 **A.** Yes.
18 **Q.** You mentioned the Parallel Supply Chain. I want to ask
19 you a bit about the establishment of that supply chain.
20 We've heard a little bit about it before. Over the
21 weekend of 20 to 22 March, Brigadier Prosser was part of
22 discussions, along with yourself, about whether the SCCL
23 could cope with PPE storage, processing, and
24 distribution. That's right, isn't it?
25 **A.** Yes.

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1 **Q.** And you concluded that it could not cope, and was it at
2 this meeting that the recommendation was made that the
3 DHSC should set up the Parallel Supply Chain or
4 PPE Cell?
5 **A.** There were actually -- sorry, I will get back to the
6 question but just to set the scene.
7 **Q.** Do you want to give an answer to the question and then
8 set the scene? Was it at this meeting or at some other
9 meeting?
10 **A.** We didn't call it the Parallel Supply Chain, and we
11 didn't know, the weekend of 21 March, that we were
12 setting up any kind of organisation. We were trying to
13 solve the problems that we saw in front of us. So there
14 was already something called the PPE Cell which was one
15 of five supply cells that were reporting to Steve
16 Oldfield's overall supply structure. So we were part of
17 that.
18 **Q.** Let's not get, sort of, distracted by labels.
19 **A.** Okay.
20 **Q.** What we're talking about is an in-house government from
21 scratch supply chain, call it what you like. But that's
22 what I mean. Was it at that meeting or over that
23 weekend that the idea for that came --
24 **A.** I think that is the genesis of the Parallel Supply
25 Chain.

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1 **Q.** Yes.
2 **A.** And it's not just distribution; it's all aspects of
3 that.
4 **Q.** And you wanted to set the scene a bit. Do you still
5 want to do that before I ask a follow-up question?
6 **A.** Why don't you ask the follow-up --
7 **Q.** Okay, I'll do that.
8 In hindsight, do you believe it would have been
9 possible to resource SCCL to be able to continue to
10 procure and distribute PPE throughout the pandemic
11 rather than creating something afresh, something brand
12 new?
13 **A.** No.
14 **Q.** No. And why is that?
15 **A.** One of the main principles of anybody who focuses on
16 delivery, like me and, indeed, like Phil Prosser, is
17 that you start from what you've got, because building
18 something new is always going to be much harder than
19 making what you've got work. And I felt, before Phil
20 arrived, and Phil then absolutely took his team through
21 it specifically on distribution -- and we can come back
22 to buying -- that we had reached the limits and, in
23 fact, gone beyond the limits of the existing system and
24 there were different challenges for the different things
25 that SCCL was doing. So we'd covered in great deal the

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1 fact that we had maxed out the warehouse and shipping
2 capability of Unipart that was running the distribution
3 on behalf of SCCL and the NHS.
4 The buying, there had been a discussion during the
5 week previous with Gareth Rhys Williams. Jin Sahota had
6 written a paper that I think was also co-authored by
7 David Wathey, who was part of the supply cell reporting
8 to Steve Oldfield, to say, "Right, we're going to need
9 to buy differently, what should that look like?" And
10 the proposal that I became aware of that weekend was
11 that SCCL would continue to buy from their existing
12 suppliers, which made total sense, they were set up on
13 their system, but because they couldn't easily add new
14 suppliers to their system and because there were real
15 concerns about the contractual basis on which SCCL
16 operated, we needed, if we were going to buy from new
17 suppliers, to set them up separately. So that was what,
18 in Jin Sahota's paper, he called them wave 2 suppliers.
19 So that morning of Saturday, 21 March, I set up four
20 teams. The first was downstairs on the second floor of
21 Skipton House, was Phil Prosser, the army, SCCL I think
22 partly on the phone, working through: can you do
23 anything else to the distribution chain or are you going
24 to need to do something different?
25 In one room on the sixth floor with me you had some

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1 of Gareth's additional commercial -- members of the
2 commercial team looking at all of the offers that had
3 come in and saying, "How do we start to catalogue and
4 triage and build a system to track those?"
5 In another room you had Melinda Johnson from the
6 department, Preeya Bailie from NHS England and
7 a consultant from Baringa looking at our process and
8 trying the current SCCL process and seeing if we could
9 streamline it because it was considered to be very --
10 overly complex, so how could we run something that was
11 robust and smoother?
12 And in the final room was Hannah Bolton who had come
13 with the commercial team from the Cabinet Office, where
14 I said, "Look, while we're looking at this whole long
15 list of things and your colleagues are trying to figure
16 out how we catalogue them and how we triage them, can
17 you start looking at some specific deals and figuring
18 out what characterises a deal that might actually be
19 robust? Is it big enough? Is it the right stuff?"
20 We can come back to this.
21 **Q.** I was just coming on to that.
22 **A.** So you're right, therefore, to ask me the question: that
23 was the genesis of the Parallel Supply Chain. I didn't
24 know it that morning.
25 **Q.** And all the while, offers were coming in thick and fast?

1 **A.** Yes.
2 **Q.** And they needed to be triaged, and you've explained how
3 you tasked various teams for that work. You say in your
4 statement that there was an urgent need for some form of
5 prioritisation and tracking of those offers.
6 **A.** Yes.
7 **Q.** Now, you said that with your experience of modelling,
8 data management, you might be able to offer reflections
9 on how that could be done, or could be optimised. Do
10 you, with the benefit of hindsight, have any reflections
11 on how that task could have been done or perhaps should
12 in the future be done in a more efficient way than
13 occurred during the pandemic?
14 **A.** Sorry, are you -- could you just do the beginning of the
15 question again, please?
16 **Q.** Yes. Offers were coming in thick and fast.
17 **A.** Yeah.
18 **Q.** You identified an urgent need to prioritise offers?
19 **A.** Yes.
20 **Q.** We've heard quite a lot of evidence now about the High
21 Priority Lane, about alternative models, the rapid
22 response team, the webform, portal. I don't know
23 whether you've followed any of that evidence but whether
24 or not you have, could you offer any reflections on how
25 best to manage offers that were coming in, in order to

1 quickly identify those which were most promising, and
2 necessary, given whichever urgent need was presenting
3 itself at a given moment?
4 **A.** Yes. So I think it's very difficult to answer the
5 question, sorry, because there's a "What could we have
6 done differently on March 21, 2020", and there's a "What
7 would we all do now?"
8 They're not the same answer. I can have a go at
9 both, if that's helpful?
10 **Q.** I was asking you the latter.
11 **A.** Okay.
12 **Q.** Let's just complete the story. This urgent need gave
13 rise eventually to the VIP or High Priority Lane, did it
14 not?
15 **A.** I think there were multiple things happening at the same
16 time. I'm not sure it's a straight line. I'm happy to
17 explain what I mean by that.
18 **Q.** I suppose the question is this: did the urgent need to
19 prioritise that you identify in your statement result
20 directly or indirectly in the creation of the High
21 Priority Lane?
22 **A.** So there were two things that we desperately needed to
23 do. The first was to triage offers and find the ones
24 that were actually real, technically qualified and
25 deliverable. The second was to get back to people and

1 to run a professional operation, because that was
2 essential to confidence of ministers, but more
3 importantly, confidence of the public and confidence of
4 staff to show up at work every day. So we needed to do
5 both of those things.
6 What I asked Hannah to do on the 21st was to do the
7 first one.
8 **Q.** Hannah Bolton?
9 **A.** Hannah Bolton, yes.
10 **Q.** So this is triage procurement focused, rather than
11 expectation management focused?
12 **A.** Yes.
13 **Q.** Yes.
14 **A.** Yeah. What -- and there is another exhibit in my EP
15 that I imagine you might come to, which indicates that
16 because both of those needs were true, and Hannah was
17 an individual person and so rather than going to
18 a mailbox you could email Hannah, that very quickly got
19 overwhelmed with people also wanting responses. What
20 I -- and I saw some of that because I'm copied on that
21 email from Matt Hancock's private office. What
22 I didn't -- I wasn't aware of, didn't see, was that
23 eventually I think those two things, the "We have to get
24 back to people because it is fundamentally
25 unprofessional not to and we have to get some of these

1 deals done in a safe financially and technically robust
2 way", I think in retrospect became elided in what
3 eventually became the HPL.
4 I don't know whether we could have predicted that on
5 21 March.
6 **Q.** Do you know whose idea the HPL was, its genesis?
7 **A.** I don't. I'm not sure it even would have ever been one
8 person's idea. We had no playbook. We'd -- nobody had
9 ever done this before, nobody had expected this to
10 happen, and so we needed to build something that worked,
11 and then fix it in flight, which we started to do.
12 I commissioned a review of our processes and governance
13 already by 13 April -- about 15 April.
14 So the Cabinet Office team took massive
15 responsibility immediately for sorting out the
16 additional buying, and in fact within a week they also
17 took over the PPE elements from SCCL, because it had got
18 too much for SCCL to continue to run separately. And
19 that was the right decision.
20 And so I think it was a bunch of pragmatic -- again,
21 this is retrospect, because I didn't see it happening,
22 I was doing about 8 million other things every day
23 and I -- the Cabinet Office team was brilliantly owning
24 this, as far as I was concerned. I can see in
25 retrospect that these things got put together in the

1 group that Max Cairnduff is asked to lead sometime
2 around the beginning of April, but I didn't see that
3 happening and I'm not sure anybody else did.
4 **Q.** Let's return to the question I asked a moment ago.
5 I think we've covered enough of the story and your
6 involvement in it.
7 **A.** Sure.
8 **Q.** As you know, as most people will know now, the HPL
9 proved to be controversial.
10 **A.** Yeah.
11 **Q.** In some ways counterproductive in the sense that part of
12 the reason, as you explained, for its creation was to
13 manage expectations and maintain public trust thereby.
14 Yes?
15 **A.** **(No audible answer)**
16 **Q.** In the event, it, to some degree, resulted in a loss of
17 public distrust, as you know. Yes?
18 **A.** Later and for different reasons, but yes.
19 **Q.** Later and for different reasons?
20 **A.** Yes.
21 **Q.** In the initial --
22 **A.** But definitely, yes.
23 **Q.** -- weeks or even months of its operation, it may not
24 even have been known to be operating by the public.
25 **A.** Yeah, yeah.

1 **Q.** So I return to my question, whether by reference to your
2 experience in data management, modelling or otherwise,
3 can you assist the Inquiry with any reflections on how
4 a system might have been set up or could in the future
5 be set up that might prove more effective at maintaining
6 public trust --
7 **A.** So that we didn't need to -- yeah.
8 **Q.** -- and effective in the efficient procurement of
9 essential medical equipment.
10 **A.** Yeah. I have to say, I'm not an expert on customer
11 relationship management, or CRM, systems. I think
12 that's what we needed but I'm happy to give you my view.
13 When you asked if I had expertise in data and modelling,
14 I thought more of the numbers, but we can come back to
15 that.
16 What we needed was a proper CRM system that allowed
17 you to put a deal in quickly, which could have been
18 dropped in from a webform, that had contact information,
19 and that then anybody of the, you know, hundred people
20 that might have needed to look at it could drop in at
21 any time, see the last time that was contacted, what was
22 happening with it, where in the production process it
23 was, if it needed support from technical assurance, and
24 we didn't have that.
25 What team 2 -- I think in my description earlier, so

1 the Cabinet Office team that was looking at all of these
2 offers -- did on Saturday, the 21st, was to think about
3 whether an Excel database would be an answer or whether
4 they should go for something more complex. They
5 decided -- and I wasn't in the room when this happened,
6 they told me about it later -- to do a -- to install the
7 Mendix system, which came from Salesforce, and that then
8 didn't end up coming to fruition, and we switched later
9 in the spring to Atamis, which was a government approach
10 that already existed. I don't know why Mendix was the
11 chosen solution. If Mendix had been able to be
12 implemented quickly, that might have been absolutely
13 brilliant, but it wasn't.
14 So for those first critical couple of weeks at the
15 end of March and beginning of April, my understanding is
16 everything was being done in Excel databases, which is
17 not designed for that purpose.
18 So the first answer to your question is I wouldn't
19 start from here, because if the SCCL database had been
20 extendible, flexible, and usable by other people, we
21 wouldn't have needed to build the additional supply cell
22 in the first place, the buying bit. But equally, if we
23 had needed to build it, we'd all have been looking at
24 the same -- well, not me, I wasn't doing it -- but the
25 buy people would have been looking at the same

1 information.
2 If we'd been able to rapidly contract for a system
3 that the people involved were skilled to use, again, we
4 wouldn't have needed another system. And if we'd had
5 five years of further development of artificial
6 intelligence and large language models, you might have
7 been able to quickly write an algorithm that would have
8 been able to do at least some of the screening.
9 Although I also think there are challenges with that
10 technology, we all know it trains quickly and can be
11 biased; so I think we should look at it but I don't know
12 whether it would have been the answer.
13 There are all sorts of things that we could do
14 differently now, and in fact I'm pretty sure SCCL is at
15 least partly set up already to do some of those.
16 **Q.** And these alternatives that you mention now would be
17 ways of removing what you describe at paragraph 72 of
18 your statement, and others have described in similar
19 terms, as "noise". You say:
20 "Because of the seniority of some of the referrers,
21 and because PPE was a 'hot topic' already in the media,
22 I was concerned to make sure we minimised 'noise' as
23 much as possible."
24 **A.** Yes, I mean, I might rephrase it as "concern", which is
25 obviously -- gives more of a sense of the legitimacy of

1 people's quite reasonable concerns about what was
2 happening. It was causing enormous -- I don't know what
3 the right word is, but, you know, it was just
4 unbelievably difficult for staff, and therefore for
5 people who were managing things in hospitals, to feel
6 like they were safe every day. So -- forgive me.
7 My major concern was to make sure that we could give
8 a clear message to staff that they would be protected,
9 and trying to manage the media stories was a part of
10 that, was -- obviously the most important thing was
11 getting the supply chain working, it wasn't what the
12 media were saying.
13 **Q.** Yes.
14 **A.** But it was part of the whole -- yeah, we needed to fix
15 all aspects of the system. For some of those we could
16 do -- we could build out and improve what we were
17 already doing or what SCCL was already doing. In other
18 places we needed to do something new.
19 **Q.** And if a system of the type that you describe, whether
20 Mendix or something beyond Mendix, were operated, it
21 would be desirable, would it not, that those individuals
22 working night and day to procure PPE, say, were
23 insulated from what we described or I suggested -- and
24 I think you agreed -- was the expectation management
25 aspect of this process. And to the degree that those

1 expectations needed to be managed, that'd be syphoned
2 off to other individuals. That would be desirable,
3 would it not?
4 **A.** Yes, and to do that the other individuals need access to
5 the information. So obviously CRM would help but the --
6 there was an element that people were always going to
7 need to pick up the phone and talk to each other, but
8 the extent to which that was taking up huge amounts of
9 time because the information was hard to get -- and of
10 course this system would also have to have been extended
11 to, in particular, the British Embassy in Beijing and in
12 a few other places which were absolutely instrumental in
13 the response, and were obviously working in a different
14 timezone.
15 **Q.** Either that, or a harder line be adopted with those that
16 had fed offers into the system, into Mendix or whatever
17 else it was, about the processing of offers, that, "We
18 are in the -- we are still considering offers, we will
19 come back to you if we need further information from
20 you"?
21 **A.** The system did do that. So the webform did give people
22 an immediate response. So that's not in place the week
23 of the 16th, I'm pretty sure it is in place the week of
24 the 23rd.
25 **Q.** The webform did it?

1 **A.** Yeah.
2 **Q.** The VIP Lane didn't do it, did it? The VIP Lane
3 received requests for updates from referrers and there
4 was an expectation that those referrers, or at least by
5 those referrers, or even by those who were receiving
6 requests for updates, that the update would be given?
7 **A.** Yes, but the update could be quite -- sorry, I should
8 probably check which question I'm answering, but the
9 update didn't need to be terribly extensive. I mean
10 I gave several WhatsApp updates to the Secretary of
11 State who enquired about things, and I would say "This
12 turned out not to be anything" and he would just write
13 back saying, "Okay, fine." So it didn't need to be
14 massively onerous, and a CRM system would have helped
15 with that.
16 I have to say I don't think it's reasonable to
17 expect there needing to be no updates to people,
18 particularly the Secretary of State, who was responsible
19 for all of this. But yes, it would have been helpful to
20 have had a really clear data feed so that that wasn't
21 having to be produced manually.
22 **Q.** And you've given your thoughts on separating the roles
23 of the provision of the updates from those involved with
24 the primary task of efficient procurement.
25 **A.** Yes, to the extent that if all of the information is

1 transparent, then that would have been a helpful --
2 (overspeaking) --
3 Q. All right.
4 Dame Emily, I want to move on to another topic,
5 please. I want to ask you about the decision to take
6 greater risks on due diligence.
7 A. Yes.
8 Q. During your work on the PPE Buy Cell, it's right, isn't
9 it, that you took the decision to embrace or to take on
10 greater risk in buying decisions in order to speed up
11 the process?
12 A. Yes.
13 Q. Yes. Could we have on the screen INQ000106355, please.
14 It's pages 3 and 4. This is an email from Chris Young
15 to the Treasury dated 15 April 2020, so we've moved on
16 a little bit in time now.
17 A. Yes.
18 Q. It says:
19 "I discussed with Emily how we rebalance the risk,
20 ie, take slightly more risk on due diligence to help
21 reduce the risk of losing deals and 'stocking out' on
22 international procurement ..."
23 And:
24 "For clarity, we are not preparing to give
25 clinicians any PPE that aren't going to keep them

1 safe -- at no point will this be done, and we continue
2 to be led by the PHE guidance."
3 Dame Emily, this approach meant that there would be
4 stock sitting in warehouses that needed to be tested for
5 compliance and full due diligence completed prior to
6 release to the NHS, didn't it?
7 A. Yes. That's right.
8 Q. And taking the risk of non-compliant PPE and the
9 government bearing the cost of any waste arising
10 therefrom? That follows on from this, this shift, does
11 it not?
12 A. Yes, although it's worth qualifying in that we're not
13 talking about taking stuff that we can see isn't robust.
14 It's that the detailed checking of, you know, the way
15 a Chinese company will have on a certificate their
16 qualification, the thickness of the material, et cetera,
17 might be present differently to the way OPSS -- sorry,
18 the Office of Product Safety Standards -- would do it in
19 the UK. So it was that calibration across different
20 standards that was taking the time. We were not
21 proposing buying things that we could see didn't have
22 a certificate or anything like that. It was one step
23 down, not a kind of complete removal of the technical
24 standard.
25 Q. Why was it at this particular stage in the pandemic that

1 you thought that this was necessary or justified?
2 A. Because the technical assurance part of the eight-step
3 process that you went through with Mr Marron last week
4 was the one we consistently got feedback was the most
5 cumbersome and I remember talking to a couple of the
6 team members from DES, from the MoD buying team who had
7 come on board to do a lot of the technical assurance and
8 they thought they'd done everything they could to speed
9 it up. It was dramatically faster than they ever would
10 have done previously.
11 But until this discussion, Treasury officially would
12 not sign off a deal which had not been proven to be
13 precisely in the standard, and because of different
14 technical specifications in different parts of the
15 world, that was taking -- I mean, maybe 72 hours but
16 even that was sometimes too long in this heated market.
17 Q. The email refers to offers -- or the risk of missing out
18 on certain offers?
19 A. Yes.
20 Q. How frequent an experience was that and what sort of
21 offers were being missed, as a result of due diligence
22 checks?
23 A. Yeah, I mean, I don't have the data. I can give you
24 what it felt like.
25 Q. Okay.

1 A. But I actually don't think any of us would have the data
2 because we weren't recording: 16 deals vanished today
3 because of that. But it was really common at the 8.30
4 meeting for Andy Wood or whoever was reporting to say,
5 "We had eyes on FFP3 masks yesterday but this morning
6 we've been told they've gone."
7 The challenge in answering the question as
8 accurately as I would like to is that sometimes that
9 meant that deal was fake and it hadn't existed anyway,
10 because it vanished when we started asking for
11 certificates or video evidence of the kit. And
12 sometimes it definitely was that somebody else had
13 bought it. And later on, for example, I found out one
14 of those deals had been because a London hospital had
15 bought the relevant product. So we had a conversation
16 about that.
17 But the -- it was -- for anything that was in short
18 supply, which at this point was particularly gowns, but
19 I was increasingly concerned about Type 2R masks, which
20 we weren't officially short of, because the PIPP stock
21 had loads, had, I think, 156 million, but we were using
22 them so fast so I could see we were about to have
23 a problem with them. And those -- what we were wanting
24 to buy was what the race of the world also wanted to
25 buy.

1 **Q.** Did this approach to buying contribute to large stocks
2 of excess PPE?
3 **A.** No, I don't believe so. There was a limited amount of
4 waste. I don't think it can be tracked back to this
5 policy. What we really wanted to do was to put boots on
6 the ground, as Phil said at the time, to inspect in
7 China. And we did do -- the British Embassy did do some
8 of that but they didn't have the capacity to do it for
9 every manufacturer we were dealing with.
10 So we thought the right answer was to buy and bring
11 it into the country. Because remember, at this point,
12 we had no feeling that we were ever going to have an
13 excess of PPE. We were desperately short of pretty much
14 everything. And so we were buying what we needed in
15 order to make sure staff would remain safe, not just, of
16 course, for this Covid wave but for the wave we knew
17 would come in the autumn.
18 **Q.** Dame Emily, when you say there was a limited amount of
19 waste, are you talking broadly the amount of excess PPE
20 that was procured?
21 **A.** I'm talking about specifically goods that were not fit
22 for purpose. So there were three categories of things
23 that would have been regard as waste.
24 So one was goods that were what they said they were,
25 but we couldn't use them, so the FFP2 ear loop masks are

1 a good example of that, where they were bought to the
2 spec but it turned out they didn't meet the needs of
3 clinicians in the UK.
4 The second were goods that weren't what they said,
5 that -- we had bought the right thing, but what arrived
6 was not that, where you could -- we could claim back on
7 the contracts and say, "You didn't supply us with the
8 right thing."
9 Sometimes that was a mistake. Sometimes that was
10 because the factory hadn't produced the right quality.
11 And the third category of waste is stuff we bought
12 and didn't need. So there are different criteria for
13 that.
14 **Q.** Yes, and my question was, of course, directed at the
15 third of those, because I asked you about large stocks
16 of excess PPE, not defective PPE.
17 **A.** Okay.
18 **Q.** You're not suggesting that, ultimately, the amounts of
19 excess PPE were limited in scale, are you?
20 **A.** No, you -- apologies, you were talking specifically
21 about this policy which allows us to buy things which
22 didn't exactly meet the specs and needed an inspection,
23 so that's why -- I apologise -- I assumed you were
24 talking about things on a different spec.
25 **Q.** Okay, not a problem, but it's in relation to excess PPE

1 that I now want to move on to modelling and demand
2 measures.
3 My Lady, I don't know if that's a convenient moment
4 to break?
5 **LADY HALLETT:** Certainly, I shall return at 11.30.
6 **(11.12 am)**
7 **(A short break)**
8 **(11.30 am)**
9 **LADY HALLETT:** Mr Wald.
10 **MR WALD:** My Lady.
11 Dame Emily, we were just moving on to modelling and
12 demand measurement.
13 **A.** Yes.
14 **Q.** We can do that now, please. Throughout the pandemic
15 there were real issues in understanding the stock and
16 usage position for PPE across the country, weren't
17 there?
18 **A.** Yes.
19 **Q.** Yes. And we know from your statement, paragraph 59(c),
20 that as you say, given NHS England was not the buyer or
21 supplier of PPE, it held no information about usage or
22 stocks of PPE held in trusts at the start of the
23 pandemic?
24 **A.** Yes.
25 **Q.** And that was, so to speak, a systemic problem. That was

1 a problem that plagued the efficient process of
2 procurement throughout the pandemic, didn't it?
3 **A.** Yes, it got better but it stayed challenging.
4 **Q.** It's the sort of data that ought to be at NHS England's
5 fingertips for the future.
6 **A.** There's a -- that's going to have a slightly more
7 complicated answer than you might have been intending,
8 if that's okay. I'll take a minute. But the answer is,
9 look, I love data, I do everything by trying to get, you
10 know, a really clear view of what's going on. And
11 I think it's really important to note that trusts are
12 independent entities, they don't report formally to
13 NHS England, their staff are employed by the trusts not
14 by NHS England, and particularly in the case of
15 foundation trusts, they have their own boards that are
16 responsible for overseeing their financial performance.
17 So while it would be enormously helpful, I don't
18 actually think it's appropriate for NHS England to be
19 holding inventory data at all times. What I think we
20 need is the ability to turn that on when necessary, for
21 example during a pandemic.
22 So at the start of the pandemic most trusts had some
23 kind of what's called an inventory management system,
24 but not all, and some of them were fairly basic and what
25 they couldn't do was talk to SCCL or to NHS England.

1 So what we did was, thanks to a colleague called
2 Joanna Peller from Palantir, is we built an inventory
3 tool, which was in place by the end of May, we piloted
4 it at the beginning of May. So we built, frankly,
5 a manual solution to the problem you're identifying.
6 The situation we're in now, we collectively, because
7 SCCL is working extensively on this, is that -- I won't
8 get these numbers precisely right but all trusts have
9 improved inventory management systems, about 130 have
10 a system that can effectively talk to SCCL if needed,
11 and the plan is to continue to roll that out. So partly
12 thanks to what we did during the pandemic, that has move
13 on dramatically.
14 **Q.** So summarising that answer, if I can try to: yes, it
15 would be helpful if not essential for NHS to have such
16 data when it needs it but it shouldn't hold it on an
17 ongoing basis?
18 **A.** No, it's a lot of data that is not up to us. We do use
19 something called the Spend Comparison System to make
20 sure trusts are getting good prices which is related but
21 not the same thing.
22 **Q.** You mentioned Palantir but let's take it in stages.
23 **A.** Yes.
24 **Q.** In order to address the lack of data you engaged first
25 McKinsey, did you not, to carry out modelling work?

1 **A.** Yes.
2 **Q.** And that was in an attempt to work out the demand
3 levels.
4 **A.** Yes.
5 **Q.** McKinsey generated demand models but those models also
6 suffered from a lack of data, didn't they?
7 **A.** So they --
8 **Q.** In particular the data relating to existing stock levels
9 in hospitals?
10 **A.** Yes. So McKinsey explicitly wrote a model called the
11 Requirement Model, and so the inputs to that model were,
12 first, the infection prevention and control guidance,
13 which obviously changed, but they could update that, and
14 secondly, was actual interviews with staff to say, "This
15 is the guidance, what are you actually using?" And
16 making sure it included a range of staff, not just
17 clinicians but also, you know, cleaners and people
18 bringing food and that kind of thing, to try to get to
19 as close as we could to actual usage rates.
20 And that uncovered things like, for example, gown
21 usage, was higher in the Nightingales because the loos
22 were far away and so people had to change gowns more
23 often than they did in a hospital, for example. So we
24 did quite a lot of digging to try to get the usage model
25 but as you've said, what that didn't say was how much

1 inventory you had in the trust to start off with. So it
2 was -- (overspeaking) --
3 **Q.** Which is quite an important starting point in this
4 exercise?
5 **A.** I mean, the thing I definitely will carry with me for
6 the rest of my life is that if you can't see all the
7 parts of a supply chain, you're in a very challenging
8 position, trying to predict total numbers.
9 **Q.** And that challenge was no easier, was it, when Palantir
10 took over from McKinsey?
11 **A.** In terms of seeing the whole length of the supply chain,
12 no, because we continued to have a challenge on the far
13 left-hand side, thinking of Professor Manners-Bell's
14 model, which is we couldn't see what was coming into the
15 country. We had no data on what would arrive when.
16 That problem wasn't fixed until July.
17 **Q.** Why did Palantir take over from McKinsey?
18 **A.** So Palantir were providing support in a range of other
19 areas so Joanna Peller had already built the ventilator
20 allocation tool, which was allowing us to connect case
21 data, hospital information, and ventilator stocks
22 information to make sure we were sending oxygen
23 equipment to the right place.
24 And McKinsey had done the modelling -- by the way,
25 they didn't just do it for trusts, they did that first,

1 they then extended it to social care, primary care,
2 et cetera, so it became quite comprehensive but that
3 model used as a critical input the reasonable worst-case
4 scenarios that came via NHS England's modellers, the
5 Imperial model and the Oxford model, and what Palantir
6 is particularly brilliant at is connecting lots of
7 different models and making them work together in an
8 effective way. That's the particular strength of what
9 they do. So it was appropriate to use that connection
10 to try to add all these data sources together to get to
11 a clearer picture.
12 **Q.** They used the reasonable worst-case scenario figures on
13 infection rates and the IPC guidance?
14 **A.** Yes, the IPC guidance was -- may I just do three
15 categories, because I think it would help? There are
16 three main components of our modelling. The first is
17 the requirements model and I can come back to the
18 different components of that. We've talked about some
19 of them. The second is the reasonable worst-case
20 scenario, which also had a whole range of inputs which
21 changed over time. And the third was the risk level of
22 deals not happening -- sorry, goods not happening at
23 all, arriving late or arriving wrong.
24 And in April and May, as I said, we had no sight.
25 So we were trying to track this based on an army -- what

1 we call the Tiger Team, literally calling around
2 suppliers to try to figure out the likelihood that
3 something was going to arrive. By June, we were using
4 the data of what actually had arrived to get to more
5 accurate estimates of that.
6 So there were three components of the modelling. In
7 all of them there was an element of pessimism and I'm
8 happy to expand on that.
9 **Q.** I think not, probably, in the interests of time.
10 **A.** Okay.
11 **Q.** I would like just to move to this: when did you,
12 Dame Emily, first become aware that the UK was on course
13 to have in stock significantly more PPE than it would
14 need for the pandemic response?
15 **A.** So there are, again, more than one component to it but
16 I'll give you --
17 **Q.** Let's start with the date.
18 **A.** Well, there are different dates, but what happened in
19 June was we started to have a higher success rate of
20 things actually arriving. And the Uniserve system that
21 would give us the end-to-end view of the whole supply
22 chain, so the stuff in shipping, was put in for the most
23 critical categories quickly. It wasn't fully
24 operational until the end of July. And so the third
25 component, so the risk level, suddenly dropped, because

1 we could actually see what was coming.
2 So, starting on 16 June, over the next 12 days we
3 stopped all new buy on all of the PPE items, because we
4 could see that we had what we had committed to the
5 Prime Minister, which was enough for current burn rates,
6 and for create a four-month stockpile. Because what was
7 clear from the reasonable worst-case scenario, and
8 actually got worse from June, was that the autumn wave
9 was potentially worse. So we didn't only anticipate
10 a growth in cases, but also further supply chain
11 disruption as we went into the winter.
12 **Q.** As a matter of fact, most of the PPE that was procured
13 that already been bought by July of 2020?
14 **A.** Well, June, when we stopped buying new, yes.
15 **Q.** Yes. And the UK ended up with just shy of 7 billion
16 items of excess stock of PPE, didn't it?
17 **A.** Yes.
18 **Q.** So that was a considerable excess, eventually?
19 **A.** Yes.
20 **Q.** Partly due to a series of unknowns that modellers had to
21 cope with?
22 **A.** Yes.
23 **Q.** They range from infection rates, existing stocks already
24 held locally within NHS trusts, the quantity of PPE
25 NHS trusts were buying for themselves separately?

1 **A.** Mm-hm.
2 **Q.** When and whether, as you referred to just now, wave 2
3 and 3 of the virus might hit?
4 **A.** Mm-hm.
5 **Q.** Whether contracts would actually deliver PPE?
6 **A.** Yeah.
7 **Q.** Probably, for the transcript, if you say "yes" rather
8 than --
9 **A.** Sorry, apologies.
10 **Q.** That would be helpful.
11 Whether the contracts would in fact deliver? There
12 was, of course, a risk that suppliers themselves would
13 simply not be able to provide the PPE that had been
14 promised?
15 **A.** Yes.
16 **Q.** Whether lockdowns or vaccines would slow or stop the
17 spread of the disease?
18 **A.** Yes.
19 **Q.** Whether IPC guidance would change and require different
20 levels of PPE in different settings?
21 **A.** Yes.
22 **Q.** And whether procurement need might increase to embrace
23 the care sector as well as the NHS?
24 **A.** Yes.
25 **Q.** Anything missing from that list --

1 **A.** Yes.
2 **Q.** -- of unknowns?
3 **A.** Yes, a couple of things.
4 **Q.** Yes, thanks.
5 **A.** So, one, it feeds into the buying bit, but we had really
6 very -- until probably -- certainly in June, we had
7 little understanding of how good UK Make would turn out
8 to be. So although the first order comes through at the
9 beginning of May, which is aprons, we knew that aprons
10 were very straightforward to change manufacturing to buy
11 and it's only in August that we get, for example, the
12 Honeywell FFP3 deal. So that's additional benefit of
13 UK Make.
14 The second thing, that I don't think was on your
15 list, were -- was item complexity. So to start off
16 with, the model only looked, for example, at all FFP3s
17 as a class. What we came to understand particularly in
18 May, was that, actually, there was a whole range of FFP3
19 models that we needed to supply in order to meet the
20 needs of staff, and we did a piece of work I won't dive
21 into to look at that.
22 Equally, there were preferences. So it turned out
23 ambulance crews liked goggles and not visors and
24 hospital staff liked visors and not goggles, and that
25 wasn't built into the requirement model to start off

1 with.
2 So we couldn't just look at each item as a category,
3 both because of the two things I've mentioned, but also
4 because the global manufacturing capacity for those
5 items is very different. So FFP3s are only bought by
6 the UK out of all major economies. We go one level
7 higher than almost every other country. Gloves, for
8 example, are just used so much in the NHS every day that
9 we never really had excess stock of gloves.
10 So there was the complexity within each category
11 which needed to be brought out in the modelling which
12 was done during May, which was why, in June, we can
13 actually have much more accurate data and therefore feel
14 confident in stopping.
15 To be clear, this was a conversation early on.
16 I have an email that I sent Jonathan Marron on 8 April
17 to say, "It looks like FFP3s have stabilised, do you
18 think we should tell the team to dial down buying?"
19 And he quite reasonably said, "We're not even close
20 to having replaced the PIPP stock. I think we need to
21 keep going."
22 And indeed we nearly stocked out of FFP3s at the
23 beginning of -- well, in June.
24 So it was an evolving process. It was very much on
25 our minds to buy -- to use taxpayer money effectively,

1 and I absolutely wish that, for whatever reason, we
2 could have got a few weeks earlier in May, and realised
3 the certainty of what was coming, but we didn't. And
4 I can't at the moment see a point at which I could have
5 done anything sooner to get to that.
6 **LADY HALLETT:** When you say "stocked out", you mean ran out
7 of stock?
8 **A.** Very close to running out of stock, yeah. We never had
9 nothing, but we were very close to not being able to
10 send trusts what they needed. So, for example, there's
11 one day in June -- I'm going to forget the exact date
12 although I did know it yesterday -- where three -- we
13 looked at what trusts received and three out of
14 73 trusts did not get their ideal pick. So we sent them
15 what they officially needed but not necessarily what
16 they wanted.
17 **LADY HALLETT:** "Officially needed"? What does that mean?
18 **A.** So there are -- at the time we were shipping seven
19 different kinds of FFP3 masks, and until the beginning
20 of May it's really not clear to us, in the centre, the
21 extent to which trusts have preferences for different
22 types of FFP3 masks, based on what they've previously
23 used and what works for their staff.
24 And because we had -- were about to run out of some
25 of the PIPP stock masks, the 3M masks, which were the

1 most commonly used in the NHS, we had started to send
2 different masks, and trusts were getting back to us
3 saying that, "But we don't -- we have to now re-fit test
4 all our staff, that's really inconvenient."
5 What then came up was also, actually, some masks
6 didn't suit certain face types, and we did a different
7 piece of work on that.
8 So they got a safe number of FFP3s but, for example,
9 they would have had to have re-fit tested some of their
10 staff with a new mask rather than just put it on and go.
11 Was that okay?
12 **LADY HALLETT:** I think so. I'm still questioning in my head
13 what you mean by "officially needed" as opposed to what
14 the trust said they needed?
15 **A.** So the trust would have told us "We need 1,000 FFP3
16 masks" --
17 **LADY HALLETT:** And the system decided they could actually
18 have --
19 **A.** No, the system sent them a thousand, and
20 Major Ed Bowman, who was doing the work, then analysed
21 that to say, "That trust usually prefers 3M 9332s and
22 they've actually got 700 9332s but also 300 Evusheld
23 masks, so it's not ideal."
24 What we then did was a piece of work to create an
25 ideal pick list for every trust, and -- working with

1 them, obviously -- and testing their staff to link that
2 to our stock, and then we created the pick list which we
3 then used subsequently.
4 **MR WALD:** Thank you, my Lady.
5 Dame Emily, just to finish off, quite a long list,
6 then, of unknowns?
7 **A.** Yes.
8 **Q.** McKinsey passed on their numbers to Efficio whom you
9 mentioned a few moments ago?
10 **A.** I don't think I did but --
11 **Q.** Oh, beg your pardon.
12 **A.** -- yes, they were part of the team, yeah.
13 **Q.** They helped to create buying targets within the buy team
14 in the PPE Cell?
15 **A.** Yes.
16 **Q.** Some of those targets were very high?
17 **A.** Yes.
18 **Q.** And that is a point that is remarked upon by some of
19 those who have given evidence to this Inquiry, including
20 Sir Gareth Rhys Williams. He makes a particular point
21 about the very high buying targets for body bags, which
22 you may have seen?
23 **A.** Yes.
24 **Q.** You have. The high buying targets eventually resulted
25 in a report that the Cabinet Office produced.

1 Could we have displayed INQ000506021.
2 This is a report called Errors in Modelling.
3 **A.** Yes.
4 **Q.** With which you may be familiar?
5 **A.** I was shown it last night. I was not in the PPE Cell at
6 the time this was produced.
7 **Q.** It's not a document that you've produced but could we
8 look at page, first 2, and then 6 and 7.
9 So at page 2 we have, let's take the third item in
10 this flowchart:
11 "Projection guessing at losses from non-performance
12 and late delivery".
13 Much of this was guesswork, wasn't it?
14 **A.** Yes, I think it's not shown on this slide but if you
15 zoom in, it says -- sorry, it's on page 5 --
16 **Q.** Yes.
17 **A.** -- it says figures from 1 June 2020. So yes, at that
18 time we were using the Tiger Team from the military team
19 to call around suppliers and shipping companies to try
20 to understand whether something was en route, and
21 whether it would arrive at its date. We did not have
22 that data.
23 **Q.** Can we go back to the first page so we can be clear of
24 the date. 29 January 2021.
25 **A.** This paper is produced then, but the slide that they're

1 showing, it says on page 5, is figures from the
2 1 June 2020. So --
3 **Q.** Let's go to 5, then.
4 **A.** Yeah. So this is the point at which the team did not
5 have the information.
6 **Q.** Yeah.
7 **A.** A pack produced on 1 January 2021, the Uniserve system
8 would have been in there and they would have known what
9 was coming.
10 **Q.** Let's look at page 6 now. If we can just zoom in on the
11 ... there we are.
12 **A.** Yes.
13 **Q.** Do you see those sort of egg shapes in the penultimate
14 column:
15 "Revised scenario PPE position (after all additional
16 opportunities)."
17 And that indicates the degree of surplus.
18 **A.** That's the requirement, not the surplus. Sorry, the
19 revised scenario circled in red, yes. Apologies.
20 **Q.** We touched on the figure, the overall figure, just shy
21 of 7 billion items, and we see here -- I don't think
22 those add up to 7 billion but that may be because of the
23 date on which this -- the reference date for this
24 document. In any event, there was a very considerable
25 amount of excess PPE procured, wasn't there?

1 **A.** Yes, this chart doesn't show that, though. I agree with
2 your point that excess PPE was procured. This was used
3 to see were we meeting what the Prime Minister had set
4 as the target which was enough for current usage and the
5 four-month stockpile and what it has in the grey bubbles
6 in the middle, so the pale grey, "Planning signal to
7 current COVID", et cetera, were estimates.
8 So it was used to go back to the buying team and
9 say, you know, we still need to buy in this case, for
10 example, gloves, which as I said, were never in surplus,
11 effectively.
12 **Q.** Just while we're on this slide, "The actual Demand
13 signal projected 90 days ahead -- while we were buying
14 150 days ahead."
15 **A.** Yes.
16 **Q.** Any reason for that discrepancy in timelines?
17 **A.** Yes, because you've got two different pressures there.
18 150 days is the, sort of, commercial good sense, you
19 want to buy -- you want to buy manufacturing direct
20 contracts, and in order to get the right deal, you'll
21 give them some surety of future supply. So that's quite
22 a common thing to do. That's -- sorry, 150 days is
23 a bit less than six months, isn't it? So that's
24 a reasonable thing to do in a-- particularly in
25 a challenging market, would have enabled us to get

1 a better price.
2 I think it would be a good question to put to, you
3 know, much -- properly expert modellers, but if we think
4 about the extent to which the Imperial model, the Oxford
5 model were able to even give us accurate numbers 90 days
6 ahead, they would not have wanted to project to 150
7 days. There's so many more variables coming in, you'd
8 have had such a wide range it wouldn't have given us any
9 guidance.
10 So you've got the tension of predictive modelling
11 and you've got then the commercial reality of what you
12 have to do to buy things.
13 **Q.** But that -- I understand your answer in relation to the
14 commercial realities but that 150-day timeline creates
15 a real risk of over-procurement, doesn't it?
16 **A.** I think the real risk of over-procurement is the
17 equation which is laid out on page 2 and which was very
18 similar to the structure that I have in my own thinking,
19 which is you've got the requirements model, which has
20 got a bunch of variables that you're making a really
21 good estimate of but you do not know what is going to
22 happen, for example if the IPC guidance is going to
23 change. That you've got in -- which is the -- your
24 middle column. So the PPE usage. Sorry, yes, PPE
25 usage, the second row.

1 You've got the reasonable worst-case scenario, which
2 is the reasonable worst-case scenario, it's not saying
3 best guess, it's saying reasonable worst case. And then
4 you've got our abundance of caution based on the fact we
5 lost loads of deals and had some stuff that wasn't good
6 enough to use, that said says we can't absolutely assume
7 everything's coming.
8 So those -- you've got three boxes there being
9 multiplied together, all of those have an inbuilt
10 pessimism which we have all accepted is the right
11 answer. Because what we don't want is for staff to be
12 in a position where they don't have enough PPE that
13 winter.
14 So under the ministerial guidance which covers the
15 whole of this page, which was: we absolutely are buying,
16 it may be that we have too much. That is orders of
17 magnitude better than the other scenario, which is that
18 staff are not protected. And so -- but all of those
19 bits of pessimism are effectively multiplied together in
20 this model, as this page shows.
21 **Q.** Let's just finish on page 7 of these slides.
22 And you may have picked up from Professor John
23 Manners-Bell's evidence, the "whiplash" effect:
24 "Uncertainties in estimates multiply up [giving]
25 a much bigger error bar for operational activity:

1 "Duration of confidence of estimate may be much
2 shorter than lead times of activity".
3 We've touched on that just now.
4 **A.** Yes.
5 **Q.** "Limited ability to feedback 'actual' data and correct
6 forecast ..."
7 All of these things were playing against efficient
8 procurement by which I mean procuring the right amount
9 rather than excess procurement.
10 **A.** Yes.
11 **Q.** All right. Let's move, then, finally before I invite
12 any reflections or recommendations, and then move to one
13 last topic.
14 Could we have displayed up INQ000536417, pages 13
15 and 14.
16 It is a statement from Palantir. And it identifies,
17 it's paragraph 11, if we can make our way to that.
18 Sorry, I think I've given an incorrect page number. It
19 would probably be 6 or 7. There we are.
20 And the next paragraph. Well, I'll paraphrase:
21 Palantir have told us in their statement that they
22 observed a number of weaknesses. Fragmented data is
23 one.
24 **A.** Yes.
25 **Q.** You'd agree that that is a weakness?

1 **A.** It was, yes.
2 **Q.** Or was. Low technology penetration?
3 **A.** Yeah.
4 **Q.** Due to years of under-investment in technology meant
5 many critical processes were still analogue or manual.
6 You'd agree with that?
7 **A.** Yes.
8 **Q.** Lack of interoperability between systems, ie, disparate
9 systems belonged to a multitude of different
10 organisations.
11 **A.** (No audible answer).
12 **Q.** And then fragmented or unauditable information
13 governance. You'd agree with all of that?
14 **A.** Just on the last one it would help if I could see it,
15 but I -- I think it was --
16 **Q.** Yeah, there we are.
17 **A.** Sorry.
18 **Q.** So we've got -- it must be page 7, fragmented data is
19 the first.
20 **A.** Got it, yeah. Yes, got it. It's e that you just
21 mentioned.
22 **Q.** It's e.
23 **A.** Yes, thank you. I agree with that analysis.
24 **Q.** So whilst inviting you to reflect on and offer any
25 reflections/recommendations for how these systems of

1 data management might be improved, are there any that
2 you would add to this list?
3 **A.** It doesn't say -- I think there might be an h, but
4 the -- yeah, it relates to -- so look, I agree with all
5 of those. I think, which might be your next question,
6 we are in a much better place on almost all of that and
7 I'm happy to talk a bit about that. I think there's
8 another bit which is about expertise, and I think it's
9 expertise in three places: one is the comfort level of
10 NHS staff in a whole range of roles to actually use the
11 data in data systems so there's not much point putting
12 in a system people are not going to use.
13 And that was indeed one of the things that slightly
14 delayed our inventory tool between 4 May and 27 May,
15 because there was a concern about whether it was too
16 much for trusts, for example. So actually making sure
17 people are comfortable to use the data systems is
18 critical.
19 The second is the expertise that we're never going
20 to have inside the NHS. It doesn't make any sort of
21 technical sense to have it, which is people who can do
22 all this extraordinary engineering like Palantir and
23 others.
24 And then the third is the extraordinary expertise of
25 data analysts and scientists that we had in NHS England

1 and the department, and in trusts, who are absolutely
2 flat out, and so we were using absolutely everybody who
3 did have the expertise across a whole range of pressures
4 and we didn't have the ability to scale that other than
5 by using consultants.
6 **Q.** Why, Dame Emily, do you say we are in a better place?
7 Is it because of changes that have been put in place
8 since --
9 **A.** Yes, so -- sorry, I cut across you.
10 **Q.** No, please.
11 **A.** We learnt a lot in the pandemic in a huge range of ways
12 that I won't start to try to detail, but one of them was
13 this extraordinary power of actually being able to use
14 data to make decisions that we previously hadn't had.
15 So we do now have, or SCCL can talk about this, they are
16 close to having that end-to-end view of the supply chain
17 on an everyday basis not just in an emergency, but the
18 federated data platform programme which grew out of what
19 we learnt working with Palantir in the pandemic, is
20 completely changing the way that we use NHS data,
21 because in my role as Chief Operating Officer, I can sit
22 down in the morning and immediately see both the whole
23 country performance yesterday on ambulance times and
24 I can dive down to look at what's happening at an
25 individual trust. And that is because we've started to

1 join up these fragmented data systems, building
2 capability as we go.
3 We're not there yet, but we are fundamentally in
4 a different position, and it's acknowledging everybody
5 has systems that do things that they like and that
6 they're comfortable with, and what we're not necessarily
7 doing is replacing them; we're giving connection so that
8 one bit of data isn't used in isolation and that's
9 incredibly powerful.
10 **Q.** Finally, Dame Emily, as part of your work with DHSC,
11 were issues regarding the need for PPE that properly
12 fitted an ethnically and religiously diverse workforce
13 brought to your attention?
14 **A.** Yes.
15 **Q.** Did the NHS Confederation contact you in May 2020
16 raising specific concerns about appropriately-sized
17 masks and gowns available to female and BAME staff in
18 particular?
19 **A.** Yes.
20 **Q.** And what was your response?
21 **A.** So we -- that was 26 May, I think you said?
22 **Q.** I just said May 2020. It might be the 26th.
23 **A.** Sorry, I know I looked at it. I might be confusing
24 other dates.
25 So at -- on 12 May, Major Ed Bowman raised at one of

1 our daily meetings that we were now getting really
2 helpful specific feedback from trusts that said, as
3 I was just explaining to my Lady earlier, the
4 combination of masks we were sending to trusts did not
5 meet their needs. It was not flagged that that was
6 about ethnicity or gender, it's just that they didn't
7 fit -- well, first of all, that fit testing was
8 a productivity challenge. If you had to keep fit
9 testing people, it used a lot of time. But secondly,
10 that the right combination of masks wasn't necessarily
11 coming.
12 So Ed and a team, including Liam Hawkin, from the
13 east of England, who is a nurse, Amanda Lyons, from the
14 south east, who was a strategy director, worked with
15 a range of trusts to try to get under the skin of this
16 problem and say: which masks were the problem? Was it
17 that the mask itself was a problem or that we weren't
18 good at fit testing it?
19 And came back, as I mentioned earlier, with a --
20 basically a spec for what did each of the trusts we were
21 supplying need in terms of FFP3s. We then had some
22 challenges to link that to actual supply I won't go
23 into.
24 So by the time NHS Confed is raising with me, which
25 I think is at the end of May, I already knew quite a lot

1 about the problem. The fact that this was also about
2 ethnicity and gender became clear through the work that
3 Ed Bowman led.
4 So what we did, starting on I think it was 2 June,
5 I spoke to Sue Tranka, who was one of the senior nurses,
6 was to commission a piece of work which did a much
7 broader piece of work. So Sue did a piece of work
8 starting in June that went until October and tested
9 5,557 staff across a range of ethnicities, and very
10 explicitly looking at gender, to see what was the link
11 between different types of masks and different types of
12 individuals. And that then led to a change in buying to
13 make sure that we had sufficient range and, in June '22,
14 to the addition in your electronic staff record of what
15 mask fits you, and therefore should be purchased for
16 you.
17 **Q.** When you say "sufficient range", was the availability of
18 relevant data a problem in this context as well?
19 **A.** I mean, I think we've made a brilliant use of data in
20 the work -- it wasn't me -- that was done to add it to
21 ESR. The data, yes, in that we didn't know -- sorry,
22 let me take a step back. Apologies, because I feel like
23 it's frustrating when I do this, but --
24 **Q.** The question is aimed at this: did you and others have
25 sufficient data on the make-up of the frontline

1 workforce, in terms of gender, ethnicity, to be able to
2 make decisions on PPE that fit properly?
3 **A.** No, that was not the issue. So --
4 **Q.** Did it have sufficient data then? Was that available?
5 **A.** No, that's not the issue.
6 **Q.** Okay.
7 **A.** At the start of the pandemic, FFP3s would previously
8 have only been used by a tiny minority of staff. It's
9 very, very few people used them, they're very specialist
10 bits of equipment. You suddenly expand that. So our
11 first problem is loads more -- you just need loads more
12 FFP3s. We bought everything we could buy in end of
13 March and April of FFP3s, along with everything else.
14 So there is -- data would not have made a difference to
15 what we did at the start of the pandemic.
16 And the issue that is reported to us from trusts is
17 not that it's ethnicity and gender that is a problem,
18 it's that fit testing is a pain. And it's only by
19 investigating that that we find that actually there are
20 some masks that fit some different people more or less
21 well. It's much more related to individual face shape
22 than it is to everything else.
23 It isn't just FFP3s by the way, there was also --
24 really well publicised in April by
25 Christina Criado-Perez (sic) -- the fact that women were

1 having to wear gowns that were much too big for them.
2 That was the same issue: we were buying what we could
3 buy. As soon as we had a choice, we started buying much
4 more of a range, and then, as I said, trying to
5 understand what each hospital needed and getting it to
6 them.
7 **Q.** So if data wasn't the issue, how would it be possible to
8 make sure that from the very beginning there was
9 a sufficient range, as you put it, of PPE to fit
10 everyone that needed it?
11 **A.** Going forward, first of all we now know which masks fit
12 any staff member who's been tested. Secondly, we would
13 need to have the right range of PPE in the PIPP stock,
14 which is supposed to, you know, manage those first few
15 weeks of a future pandemic, and each hospital needs to
16 be aware of what the right mix is for their staff. And
17 as you've said, the data, the understanding of the
18 ethnicity and gender of the workforce is built into
19 SCCL's purchasing decisions now.
20 **Q.** Mr Kelly, from whom we'll hear later today, in his
21 statement says that they -- discusses a project that
22 gathered evidence from over 5,000 participants to inform
23 PPE improvements.
24 **A.** Yes.
25 **Q.** How did that project specifically address the needs, if

1 you know, and feedback of ethnic minority healthcare
2 workers, and what impact did this have on subsequent PPE
3 procurement strategies?
4 **A.** Yes, so that is the piece of work I mentioned that
5 Sue Tranka led over the summer of 2020, and it
6 reported -- I got a draft of the report on 1 October,
7 and that was then built into the buying -- the further
8 buying and manufacture of FFP3s going forward, and that
9 resulted in the addition of the information of what you
10 need to your electronic staff record.
11 **MR WALD:** Dame Emily, thank you very much. Those are all
12 the questions that I had for you. I gather that there
13 are additional questions from one of our CPs.
14 **LADY HALLETT:** Mr Thomas.
15 **Questions from PROFESSOR THOMAS KC**
16 **PROFESSOR THOMAS:** Dame Emily, I am representing the
17 Federation of Ethnic Minority Healthcare workers.
18 So where we've just left off with your questioning,
19 I'm going to continue that theme, if I may.
20 Oversight of the procurement and distribution of PPE
21 was crucial during this period. We can agree on that?
22 **A.** Yes.
23 **Q.** And we've heard a lot of evidence about the
24 disproportionate impact of the virus on ethnic minority
25 communities, particularly those who I represent,

1 healthcare workers.
2 Now, you've just said and accepted that you were
3 aware of the problem with, particularly, ethnic minority
4 healthcare workers; that's correct, isn't it?
5 **A.** I was aware of the challenge of FFP3 masks and that
6 there was some relation to ethnicity in the autumn
7 of 2020. In May 2020, I was aware that a whole range of
8 staff were finding some masks difficult to wear. It was
9 not, at that point, linked to ethnicity.
10 **Q.** Can I just ask you for some clarity on this --
11 **A.** Of course.
12 **Q.** -- before I put my question to you.
13 When do you say you became aware that there was
14 a problem with ethnicity and the provision of this
15 particular PPE? When?
16 **A.** We became aware through May that hospitals were saying
17 to us that there were particular challenges with
18 particular ethnic groups. We did not have any data on
19 that that showed that until the autumn, and Sue Tranka's
20 report which looked at a whole range of people.
21 **Q.** So you became aware of a problem in May.
22 **A.** Yes.
23 **Q.** And I'm assuming, you correct me if I've got this wrong,
24 that you'd have said, "What problems?"
25 **A.** Sorry, could you ask me -- could you repeat the

1 question?
2 **Q.** Yes. You said you became aware of the problem in
3 May 2020. Yes?
4 **A.** That there were masks that didn't fit --
5 **Q.** Yes.
6 **A.** -- that staff were finding it challenging to find masks
7 that fit, yes.
8 **Q.** In relation to ethnic minorities, you said just a moment
9 ago, you became aware in May?
10 **A.** That was definitely part of the reporting by late May,
11 yes.
12 **Q.** My question to you is: I'm assuming you would have said,
13 "What problems?"
14 **A.** The problem of fit? I'm sorry, I don't understand the
15 question. We were being told that some staff were
16 finding it had to find a mask that fit. That was the
17 problem.
18 **Q.** That was the problem.
19 **A.** Yes.
20 **Q.** And those staff were of particular ethnic minorities?
21 **A.** No, they were -- partly. It was relayed that it was
22 some ethnic minority staff but it was also women and it
23 was also people with beards and it was also people with
24 particularly small faces.
25 **Q.** Forgive me, I'm confused, and it's probably just me.

1 When you say you became aware of problems with ethnic
2 minorities in May, what were the problems you became
3 aware of? It's particularly relating to ethnic
4 minorities.
5 **A.** Yes, I apologise, I am trying to answer the question.
6 We became aware, first, that certain masks were -- well,
7 that trusts were saying: some masks don't fit some of
8 our staff.
9 **Q.** Yes, but that's just general. Correct?
10 **A.** Yes.
11 **Q.** Right.
12 **A.** And we then did a piece of work to work in detail with
13 trusts to see what's going on, to say what is the
14 problem? So is it the mask --
15 **Q.** When was that?
16 **A.** -- is it the fit testing?
17 **Q.** When was that?
18 **A.** May.
19 **Q.** Right.
20 **A.** So that's the first piece of work which Major Ed Bowman
21 leads, and by the end of May, we now have an
22 understanding for each trust that says the right
23 combination of masks for this trust, which are likely to
24 fit their staff, is the following, and we therefore
25 change our distribution system to make sure trusts are

1 getting as close to that list as possible, and we change
2 our buying to make sure we are continuing to buy a range
3 of FFP3s and not narrowing in on any one particular
4 type.
5 **Q.** Okay. Let me move on to my last question, and it's
6 this: given your significant involvement in the PPE
7 supply and distribution as outlined in several parts of
8 your statement, particularly where you've discussed the
9 initial challenges with PPE orders, help me with this:
10 what feedback mechanisms were in place to capture
11 concerns from ethnic minority healthcare workers
12 regarding PPE, and how were these concerns addressed in
13 real time during the pandemic?
14 **A.** So there were -- I'm going to say three main ways --
15 well, multiple ways for staff to feed back concerns.
16 The primary one would be within the hospital via their
17 line manager, the health and safety officer, people who
18 were supporting them, and that could potentially be
19 addressed locally because the trust has the
20 responsibility of making sure every staff is protected.
21 There were, then, one of three routes, depending on
22 the issue. One is it was fixed, great. One was that
23 the product was a problem, so this product was not
24 working as planned, and that would have been reported,
25 depending on the item, but via a hotline that was run by

1 the technical team at SCCL, which we augmented, to make
2 sure that product complaint was reported and then
3 appropriately investigated.
4 And if there was a -- if the product itself was
5 faulty, we obviously would have taken one set of
6 actions. If it was, you know, a sizing issue or
7 whatever, then we would have worked on distribution.
8 And there would also have been -- I've forgotten the
9 technical term, but there's a Datix reporting if it
10 actually has -- inside the hospital, if that's generated
11 an unsafe situation for staff, and that would have been
12 fed back through multiple routes including the MHRA
13 Yellow Card system.
14 So we would have taken action on those, depending on
15 the nature of the problem that was being reported.
16 **Q.** Given the number of -- the disproportionate number of
17 deaths of particularly Black, Asian and Minority Ethnic
18 healthcare workers and the complaints made about PPE, do
19 you think you moved timely enough?
20 **A.** I think there is -- I think there is no operational
21 process in the world that can't be made better. So I'm
22 never going to say that everything was perfect, because
23 demonstrably, we built at speed, and we then worked to
24 make it better. In this instance, I think we had good
25 processes to collect feedback, particularly if something

1 was unsafe, but also on preference, for example learning
2 that goggles didn't work well in certain hospitals.
3 What we didn't have in March, April and quite a lot
4 of May and June, for some items, particularly FFP3s, was
5 any ability to do anything other than buy what was
6 available in the market and make sure it was safe when
7 it arrived. So we responded by making sure we had the
8 stock, and when we had the stock, we then worked with
9 trusts to make sure they were also getting according to
10 preferences and what would best suit staff.
11 So I think we did respond absolutely as best we
12 could. As I've said, I think it would help -- and I
13 believe there are plans to do so -- to make sure there
14 is the right range based on actual mapped staff need
15 that we now know, in the PIPP stock going forward, and
16 I would also expect that to be built into a very
17 tailored distribution system that would better connect
18 individual staff needs to the overall supply.
19 **LADY HALLETT:** Thank you very much, Mr Thomas.
20 **PROFESSOR THOMAS:** Thank you.
21 **Questions from THE CHAIR**
22 **LADY HALLETT:** Can I take you back to the beginning of your
23 evidence, Dame Emily. I got the impression as you went
24 through it with Mr Wald that it was somewhat chaotic.
25 Would that be fair, or is that unfair?

1 **A.** It was really full on.
2 **LADY HALLETT:** It wasn't just that; it was the structures.
3 **A.** Okay, yeah.
4 **LADY HALLETT:** As you'll appreciate, as you know, I have
5 already examined the preparedness and resilience of the
6 system.
7 **A.** Of course, yeah.
8 **LADY HALLETT:** And I've already made certain comments about
9 the lack of preparedness, in my view.
10 I've also heard about exercises that were
11 conducted --
12 **A.** Yes.
13 **LADY HALLETT:** -- to try to enable the system to respond to
14 a pandemic. But I gained the impression from your
15 evidence in the first few answers that you gave that the
16 system couldn't cope with purchasing and distributing
17 large amounts of PPE required for a pandemic. Now, if
18 all this planning that I've been told about had been
19 going on, why was the system in that state?
20 **A.** That's a really good question. So what I have observed
21 by doing my research both at the time but also obviously
22 preparing for this, is that in February in particular,
23 everybody did what they were supposed to do. So
24 NHS England declares a major incident. Keith Willet,
25 the lead of the response in NHS England, asks for

1 a supply cell meeting. On 3 February that happens.
2 NHS England commissioned a reasonable worst-case
3 scenario modelling -- sorry, I'm repeating --
4 (overspeaking) --
5 **LADY HALLETT:** Can I just interrupt you to get to the point
6 I am trying to get to.
7 **A.** I apologise.
8 **LADY HALLETT:** We ran out of time a long time ago.
9 **A.** -- (overspeaking) --
10 **LADY HALLETT:** If I could just ask the question again just
11 so you can focus on it.
12 Basically you told me, just to give one example, the
13 warehouses couldn't cope with the large-scale
14 distribution that we had.
15 **A.** Yeah.
16 **LADY HALLETT:** Now, why hadn't that come up in any of the
17 exercises? Why was there that kind of structural
18 problem that meant the system could not cope with buying
19 and distributing at large scale for a pandemic?
20 **A.** So I think there was a plan that would have worked for
21 the pandemic that was planned for. What there wasn't
22 was a plan for when that plan demonstrably wasn't
23 working. And I think it is putting those different bits
24 of the plan of what's not working in early March, mid
25 March, is what enabled me to come to the conclusion that

1 said: you can't keep following this plan, it's not going
2 to meet the needs of the pandemic we are actually in.
3 So I think it's back to the modelling. The
4 modelling tells you some of the answer but it doesn't
5 give you an answer. You have to then use it to make
6 decisions, and I don't think there was a plan for if the
7 PIPP stock is not going to keep you going for long
8 enough because it's got the wrong stuff in it, and if
9 hospitals do not have what they actually need because
10 the IPC guidance says they need something different than
11 what was planned for. And so what we need in the future
12 is both a plan that responds to this, and also
13 a mechanism that says what do you do when the plan is
14 not working? How do you scale? How do you make
15 slightly different decisions?
16 **LADY HALLETT:** I'm grateful, it sounds as if you agree with
17 my recommendation in the Module 1 report that you need
18 not just a plan for a flu pandemic but something that's
19 adaptable.
20 **A.** Yes.
21 **LADY HALLETT:** Secondly, you told Mr Wald that there were
22 7 billion items of PPE that you managed to, as it were,
23 over-stock -- I'm not trying to be pejorative.
24 **A.** No, I understand.
25 **LADY HALLETT:** Were those 7 billion items wasted or were

1 they able to go back into the system?
2 A. I think the 7 billion number is after the things that
3 were used back. So there were things that expired
4 before they could be used rather than what was used.
5 I think Jonathan Marron's statement says in the end
6 23-and-something billion out of the 32 were used, and
7 some were used for waste, et cetera. So I think there
8 were heroic efforts both to dial back on contracts and
9 try to buy slightly less to re-use stuff, to donate it
10 to other countries, to sell it in the open market, but
11 regrettably there was a substantial amount of waste at
12 the end.
13 **LADY HALLETT:** Given the circumstances we faced, do you
14 think there's anything that could be put in place, apart
15 from the better data management, but by the sound of it
16 that would be better data systems that spoke to each
17 other, but is there any other way one could avoid that
18 amount of -- I appreciate you were fulfilling
19 instructions from on high that you had to cater for the
20 second wave, as well -- any way we could avoid that
21 level of waste?
22 A. Yes, and it is having -- it's knowing what you stand up
23 at certain levels of stress, right? So it's -- in
24 particular, we were having to buy everything from
25 a substantial distance which then involved the whole

1 issue of: is it coming at all? It's a brand new
2 relationship, is this place trustworthy? How long is
3 the boat going to take? Are there holds in Shanghai on
4 what's being shipped?
5 There was a massive tension there.
6 If we had a plan that very explicitly stands up
7 UK Make on certain items, if the PIPP stock has been
8 adjusted for the kind of things we have just discussed,
9 and if we are not overly reliant on wholesalers to buy
10 stuff -- because wholesalers had the same risks we did,
11 there was a whole layer of risk built into this
12 market -- actually having a direct understanding, if not
13 relationships, with the people who are making the stuff,
14 so you cut out that level of uncertainty, that would
15 have helped.
16 I would also say, again, I would love to have not
17 had that waste. I'm really glad that we had enough PPE
18 in the second wave, and I think it would have -- I think
19 in any future pandemic there will always be a mismatch.
20 I'd rather it was that way round. I would love it not
21 to be the same scale.
22 **LADY HALLETT:** I understand.
23 Thank you very much indeed for your help, and I do
24 understand that maybe it's a difficult week for you.
25 **THE WITNESS:** Thank you.

1 **LADY HALLETT:** So, thank you for coming along and for your
2 written statement and for the evidence you've given
3 today.
4 A. Thank you.
5 **LADY HALLETT:** Ms Shehadeh.
6 **MS SHEHADEH:** My Lady, our next witness is Paul Webster, so
7 can I ask that he be sworn or affirmed now.
8 **MR PAUL WEBSTER (sworn)**
9 **LADY HALLETT:** Sorry to keep you waiting, Mr Webster.
10 **THE WITNESS:** No problem at all.
11 **Questions from COUNSEL TO THE INQUIRY**
12 **MS SHEHADEH:** Can I ask you first of all to state your full
13 name.
14 A. Yeah, Paul Webster.
15 Q. Thank you.
16 Now, you have provided the Inquiry with a number of
17 witness statements. I'm just going to read out the
18 Inquiry document reference numbers and then ask you to
19 confirm that they are indeed your evidence.
20 So you have provided us with a statement dated
21 27 June 2024. It runs to 59 pages. That is
22 INQ000492085.
23 You've provided us with a statement dated 6 January
24 that runs to 4 pages. That is INQ000533280.
25 You have provided a further statement of the same

1 date that runs to 3 pages. That is INQ000533279.
2 And, finally, another statement, January 2025, that
3 runs to 8 pages. INQ000533278.
4 Can I ask you this: are the contents of all of those
5 statements true to the best of your knowledge and
6 belief?
7 A. Yes, they are.
8 Q. Thank you. And we'll be largely dealing with the
9 contents of the 59-page statement, INQ000492085, if that
10 assists you.
11 Can we turn briefly to your own professional
12 background before we start to discuss the events of the
13 pandemic.
14 You are the executive director of governance, and
15 legal and company secretary of SCCL; is that correct?
16 A. Yes, it is, yes.
17 Q. And SCCL is Supply Chain Coordination Limited; is that
18 right?
19 A. Yes.
20 Q. We'll continue to use SCCL, if that's all right?
21 A. Seems sensible, yes.
22 Q. Now you've been directly employed at SCCL since 2022,
23 but actually your involvement with the organisation
24 began some years prior to that, didn't it?
25 A. Yes, in about 2016 I was part of the Department of

1 Health team that was helping develop and then implement
2 the new model, and then -- but at that stage I was
3 seconded to the department from the Cabinet Office. All
4 rather complicated, but actually essentially the same
5 job in the same organisation.
6 **Q.** Yes. And by the period in the pandemic that we are
7 discussing, so roughly from January 2020 onwards, you
8 were working at SCCL --
9 **A.** Yes.
10 **Q.** -- under some form of arrangement?
11 **A.** Yeah, and had been since the company was set up in 2018.
12 **Q.** Now, SCCL is a company limited by shares and it was
13 created on 25 July 2017 by the Department of Health and
14 Social Care.
15 We'll come on to the structure. Can you give us
16 a very brief overview of the purpose of SCCL?
17 **A.** Yes. So the new model that was implemented in 2018 had
18 constituent parts of the NHS Supply Chain in terms of
19 procurement, delivery and IT, and the intention was that
20 there would be a body that sat across the top of that,
21 the management function, which would manage the
22 individual contracts within that model. So it is
23 referred to as the management function of the NHS Supply
24 Chain, but its role at that stage was effectively as
25 kind of contract management direction setting.

1 **Q.** Is it right that SCCL was initially wholly owned by the
2 Secretary of State for Health and Social Care?
3 **A.** Yes.
4 **Q.** And that ownership was transferred to NHS England on
5 1 October 2021; is that correct?
6 **A.** It is, yes.
7 **Q.** Right. And so in fact, ownership was transferred while
8 the pandemic was ongoing?
9 **A.** Yes, the original intention had been for that transfer
10 to happen earlier, but it was delayed because of the
11 first wave of the pandemic and people having other
12 things to focus on.
13 **Q.** You've told us a few moments ago that the idea behind
14 SCCL was that it would perform contract management
15 services, effectively. It was organised using something
16 called the Future Operating Model, and it oversaw
17 something that's widely referred to and is in fact the
18 NHS Supply Chain.
19 The NHS Supply Chain, regardless of what it says on
20 the tin, is not the entire supply chain for the NHS in
21 England, is it?
22 **A.** No, that's right. And I think there is some confusion
23 at times that it is a part of the supply chain into the
24 NHS. It's the bit that has a kind of trading name of
25 NHS Supply Chain, but there are other ways in which the

1 NHS will receive products of the same sort that we
2 provide.
3 **Q.** So NHS trusts or NHS customers, from your perspective,
4 are able to place orders with the NHS Supply Chain, or
5 SCCL, but they're also free to purchase items they need
6 from the open market -- (overspeaking) --
7 **A.** Yes, and they do that, yeah, on a regular basis.
8 I think our market share is somewhere in the region of
9 about 65%, slightly higher, probably, than that. So
10 that, yeah, there is -- there is a significant
11 proportion of those products are purchased through other
12 routes.
13 **Q.** I've used the phrase the "Future Operating Model" a few
14 times. We perhaps ought to explain it. Can you give
15 a very brief overview of the idea behind the Future
16 Operating Model?
17 **A.** Yes. So from 2006 through to 2018 there was a contract
18 that was held by the NHS Business Services Authority
19 with DHL which provided the NHS Supply Chain service at
20 that point. So one contract for procurement, storage,
21 distribution of products, plus all of the sort of the
22 back office and IT functions.
23 That had a market share of penetration of about 35%,
24 and the view from the Lord Carter review was that by
25 placing a greater focus on leveraging the NHS spend, you

1 could drive up that market share and thereby reduce the
2 costs of products, and you would remove some of the
3 duplication from the system with competing organisations
4 by essentially buying the same product and selling into
5 the NHS.
6 So the idea was that we would break down that model
7 into its constituent parts, which essentially are three:
8 the buying element, the logistics element, and then the
9 IT element, with -- and as I've said, with SCCL over the
10 top as a sort of overarching contract management.
11 **Q.** And you've told us in your witness statement
12 INQ00492085, at paragraph 3.2, that the idea was to
13 increase the market share of the NHS Supply Chain, and
14 it was at about 36% under DHL and was the target to
15 increase it to 80%?
16 **A.** Yes. That was the target, yeah.
17 **Q.** And you tell us in your statement that it's now risen to
18 60%; is that still roughly accurate?
19 **A.** I think it's probably higher than that now but it's
20 somewhere between 60 and 70%. And it varies by product
21 line. So we sell more of high-end capital equipment
22 than we do some other products, for example.
23 **Q.** And are you able to tell us roughly the market share of
24 clinical consumables that SCCL was supplying at the time
25 of the pandemic or not?

1 **A.** I'm not sure I could. I can probably -- well, it's --
2 the difficulty is that our customer base is fluid. So
3 some trusts will buy products from us one day but then
4 not the next. So we don't have a consistent flow of
5 products or consistent requirement for products.
6 So we would have -- and at the start of the pandemic
7 we had customers who didn't buy product X from us asking
8 for that. So it's difficult to give you an accurate
9 figure. It's also quite difficult to know what the
10 overall market is that we are taking a percentage of, if
11 that makes sense.
12 **Q.** It does. The NHS Supply Chain is not designed to make
13 a profit, is it?
14 **A.** That's correct. It's not.
15 **Q.** And I think you use in your statement the phrase "buy
16 price equals sell price", so does that mean that SCCL
17 allows NHS trusts to buy items at the same price that it
18 purchased them itself?
19 **A.** Yes, so the previous model, if we bought a pen for £1,
20 we would sell it to the NHS at £1.05, and that
21 five pence went towards the overall cost of managing the
22 model. The new model was predicated on the basis that,
23 exactly as you say, if we bought it for a pound, we
24 would sell it to the trust for a pound, and we were
25 funded by NHS England for those costs that would

1 otherwise have come out of what was the margin of the
2 previous model.
3 **Q.** Can we have on the screen, please, INQ000347820.
4 This will be very familiar to you, I'm sure. This
5 is a representation of the tower system.
6 **A.** Yes.
7 **Q.** Or the -- that makes up the NHS Supply Chain.
8 Is each of these towers run by a separate contractor
9 put in place by SCCL?
10 **A.** Yes. That's essentially it. All of the products that
11 we sell were split into one of the 11 categories that
12 you see at the top of -- the 11 boxes there. So only
13 one organisation would buy one particular product. So
14 there were 11 what we called "towers" but effectively
15 were category managers. We went out for -- well, the
16 department rather than SCCL went out for a procurement
17 for each of those towers. Now, some of the providers
18 have more than one or had more than one tower, so we
19 don't have 11 separate providers, but they operated as
20 separate buying entities.
21 **Q.** They were buying entities. So were these contractors in
22 turn letting contracts for the supply of individual
23 items?
24 **A.** Yes. But --
25 **Q.** Or -- (overspeaking) --

1 **A.** -- but as agent for SCCL. So as far as the customers
2 were -- and indeed the suppliers -- they thought or they
3 believed that they are contracting, as they are, with
4 SCCL.
5 **Q.** All right. In terms of PPE, am I right in saying PPE
6 did not neatly fit into just one of these towers?
7 **A.** Yes. So it was bought by, I think, towers 2, 8 and 11,
8 I think. But PPE prior to the pandemic was a tiny
9 fraction of the products that we purchased. I think our
10 spend -- and I'll get the figures wrong, but was roughly
11 in the region of £100 million spent on PPE out of
12 a spend of about 3.5 billion. So there wasn't
13 a category of PPE; there were items, such as gloves,
14 that were purchased routinely, but there wasn't
15 a category of PPE. So it doesn't sit neatly into one of
16 those 11 towers.
17 **Q.** Thank you. We can take that down. Thank you very much.
18 In terms of the contract management function of
19 SCCL, just very briefly, how did that work in practice?
20 For example, if one of the CTSPs, one of the contractors
21 running a tower, the company with whom they had
22 contracted in turn failed to deliver something and it
23 caused problems in supplying an NHS trust, what would
24 happen, what would SCCL's role be?
25 **A.** Well, as it relates to the customer, they would take

1 that up with us as the provider of the service. We
2 would then contract manage that tower to make sure that
3 we understood where the responsibility lay. But in
4 terms of how the system, the NHS system, would see that,
5 they would see it as a failure of the NHS Supply Chain
6 and therefore of SCCL. We had, then, contract
7 management steps in place to be able to manage our
8 relationship with the individual towers to pick up any
9 issues that were arising.
10 **Q.** All right. I'm going to move on to ask you about the
11 contractual arrangements around the PIPP stockpile, the
12 pandemic stockpile.
13 **A.** Sure.
14 **Q.** That was set up in 2009. So it predated the creation of
15 SCCL.
16 **A.** Correct.
17 **Q.** And is it right that SCCL effectively inherited
18 responsibility for managing the stockpile?
19 **A.** Yes. So we managed it under a contract with PHE as they
20 then were. So we are very much a transactional
21 organisation rather than a -- rather than the body that
22 makes the decisions in respect of the stockpile.
23 **Q.** So is it right that Public Health England owned the
24 physical stock in the stockpile?
25 **A.** Yes.

1 **Q.** But SCCL ultimately was responsible for managing the
2 contract, for the contractor who was --
3 **A.** Movianto.
4 **Q.** -- monitoring the stockpile, administering the
5 stockpile?
6 **A.** Yes, and we were responsible for some of the -- for the
7 purchasing of the products that went into the stockpile,
8 albeit that we weren't responsible for deciding what
9 those products should be.
10 **Q.** You have, in your witness statement, described a process
11 of stock rotation, one of swapping out, one of product
12 cycling, as well. You've explained that the procurement
13 cycle for items in the stockpile was 12 months. What
14 does that mean? Why did it take 12 months to run
15 a procurement cycle?
16 **A.** I think that reflects just the time it takes to run
17 an EU, as it then was, compliant procurement, most of
18 which was done through frameworks, us putting in place
19 frameworks. That takes time. And then once you've
20 placed orders, ensuring that you actually have those --
21 those orders have arrived, there's a significant lead
22 time on the majority of those products, so 12 months is
23 a relatively safe assumption as to the time, if you
24 start from scratch, you can have products in
25 a warehouse.

1 **Q.** You've told us in your statement that most products have
2 a 60-month shelf life from the point of manufacture?
3 **A.** Yes.
4 **Q.** It is also possible to extend the shelf life of products
5 for up to 10 years; is that right?
6 **A.** Yes. Although I'm straying into territory, and I have
7 to rely on my colleagues rather than my own knowledge.
8 **Q.** That 60-month shelf life, was that something that was
9 taken into account when considering whether to start
10 a fresh procurement cycle, that 12 months that you've
11 just described?
12 **A.** Yes, and as were some of the other ideas that -- you
13 just mentioned in terms of, sort of, cycling through.
14 And so, for example, gloves, which is something used all
15 day every day, we would take, as they reached the end of
16 their shelf life, we would take them out to the
17 stockpile and put them into the general NHS Supply Chain
18 and then replace. So the idea being that where you
19 could increase the life of products in the stockpile,
20 you would.
21 **LADY HALLETT:** To what extent is taking stuff out of the
22 stockpile, when otherwise it would become useless, used
23 generally?
24 **A.** It depends on the volumes of products that you're using.
25 So gloves is the most obvious example, because that is

1 one that you know you're always going to use. Some of
2 the other products that are in the stockpile just
3 weren't used regularly. I was listening to Dame
4 Emily Lawson's evidence earlier on about the number of
5 FFP3 masks, for example, that was being used. You
6 wouldn't cycle that through because the volume of demand
7 was so much less. So I think gloves was the one that
8 was the main product that was cycled through, just
9 because there was that demand.
10 **LADY HALLETT:** I would have thought a lot of items of PPE
11 were likely to be in use most of the time in NHS trusts?
12 **A.** I think the reality -- and again, I'm straying into
13 territory that I'm not an expert on -- is, as I said,
14 that we only spent about £100 million on PPE out of the
15 overall spend of 3.5 billion. It's a very small amount
16 of the everyday products that an NHS hospital uses in
17 order to be able to function.
18 **LADY HALLETT:** So who should we ask about how you make sure
19 the stockpile doesn't end up wasting product?
20 **A.** In terms of what is in the stockpile, and decisions as
21 to when products should be cycled through, those were
22 decisions made by PHE, UKHSA as they now are.
23 **LADY HALLETT:** Sorry to interrupt.
24 **MS SHEHADEH:** I think you mentioned the name of the
25 contractor, Movianto --

1 **A.** Yes.
2 **Q.** -- that was tasked with administering the stockpile,
3 warehousing it, and so on. Were they responsible for
4 that product cycling and notifying SCCL if they needed
5 to be in --
6 **A.** They were aware of the products that were there, and
7 then -- and obviously the shelf life of those products.
8 So they would report on a regular basis into SCCL, and
9 we would then, in turn, discuss with PHE what the right
10 way of either replacing or renewing or recycling the
11 products would be, depending on the product.
12 **Q.** So to be clear, Movianto would report to SCCL, SCCL
13 would then liaise with Public Health England for
14 instructions; is that right?
15 **A.** Yes.
16 **Q.** And so would you say that in January 2020, SCCL had good
17 visibility of the status of the items in the stockpile?
18 **A.** In the PIPP stockpile, yes.
19 **Q.** In the PIPP stockpile. Do you make a distinction there
20 with other stockpiles?
21 **A.** No, just trying to be -- well, there was also the EU
22 exit stockpile, but the PIPP stockpile was one that
23 obviously we managed so we had the greatest
24 visibility of.
25 **Q.** Yes.

1 My Lady, I am conscious of the time. There are
2 other topics I wish to cover, so I am in your hands as
3 to --
4 **LADY HALLETT:** Certainly, we could break -- I think you were
5 warned -- well, I don't know if you would have been
6 warned because I think we went on rather longer with
7 Dame Emily than we intended, but we'll break now and
8 come back at 1.45.
9 **(12.45 pm)**
10 **(The Short Adjournment)**
11 **(1.45 pm)**
12 **LADY HALLETT:** Ms Shehadeh.
13 **MS SHEHADEH:** Before the break I was asking you about the
14 PIPP stockpile and the contractual arrangements around
15 the management of that. So we'll carry on from there.
16 Did SCCL have visibility of the state of the
17 stockpile in England, the PIPP stockpile in England?
18 **A.** Yes, yeah, we had no responsibility for any of the other
19 devolved nations.
20 **Q.** No.
21 Can we have up on screen, please, INQ000330795.
22 This document shows us the status of the PIPP
23 stockpile in England, we see there England figures only,
24 at row 5, and it's updated on 27 January 2020.
25 There's information in this table around stock

1 levels but also the expiry dates and the status of
2 certain items in the PIPP stockpile.
3 In respect of surgical facemasks, there's a note
4 that says:
5 "No significant volume expires until 2021."
6 But we also see that of the 156 million, 84 million
7 of these have no labelled expiry date and are currently
8 undergoing QA testing -- is that quality assurance
9 testing?
10 **A.** Yes, sorry.
11 **Q.** Yes -- to demonstrate the product remains fit for use.
12 So the reality is, in relation to surgical
13 facemasks, there is a significant proportion in respect
14 of which the expiry date wasn't known in January 2020;
15 is that right?
16 **A.** I don't know enough to be able to tell you confidently,
17 I'm afraid. I've seen this last week but I'm not sure
18 where -- from where it comes.
19 **Q.** Right. So this level of detail contained is this table,
20 when we talk about visibility of the stockpile, would
21 SCCL have been aware of this level of detail about the
22 status of the items in the stockpile?
23 **A.** My honest answer is I don't know. My assumption is yes.
24 But I'm afraid I couldn't tell you with any certainty,
25 I'm afraid.

1 **Q.** It's all right, it was a long time ago. The table also
2 tells us in relation to FFP3 valved respirators, that
3 stocks were stressed and it was expected that by
4 1 April 2020 there would be around 1.3 million in date.
5 I'm sorry, by 1 April 2020, we expect circa 1.3 million
6 to be in date and 120K by August 2020. But there was
7 also work going on in respect of shelf life extension
8 there, and the activation of JIT, is that
9 just-in-time --
10 **A.** Yes.
11 **Q.** -- arrangements, the delivery in between five to 11
12 weeks.
13 Looking at that, there were a number of key items
14 that were required for the pandemic response within the
15 stockpile in respect of which work was ongoing simply to
16 ascertain whether they were still safe for use. Does
17 this reflect, in your view, a properly managed PIPP
18 stockpile?
19 **A.** Well, I think you have to remember that it's for
20 a stockpile for a different pandemic to the one that
21 then transpires. But it seems to me that the system of
22 understanding when products will expire and which of
23 those are capable of being given additional shelf life
24 by further testing is sensible and being on top of how
25 many of those there are would appear to be a sensible

1 approach.
2 **Q.** Certainly having the information at your fingertips is
3 important. In relation to having the stockpile ready to
4 deploy, when faced with a pandemic, this is not the
5 optimum status of a stockpile that's ready for use,
6 is it?
7 **A.** I'm not sure why not.
8 **Q.** If there's a stockpile in respect of which there are
9 significant numbers of key items that have to undergo
10 testing in order to determine whether they are safe to
11 be deployed, would you agree that --
12 **A.** But that's about extending their shelf life beyond the
13 current shelf life, which is largely done by the
14 manufacturers to provide their own confirmation that
15 that product remains fit for purpose for an additional
16 period. So what it does is it avoids a need to take
17 stuff out of the stockpile and then buy new in. So it's
18 a case of active stock management as opposed to, you
19 know, at any point in time products that have come in
20 will be nearing the end of a shelf life.
21 **Q.** All right, well, just staying with the example of the
22 FFP3 valved respirators that we have in the table, the
23 first line there is respirator volumes are currently
24 stressed. So there were pressures around the stocks of
25 those items; do we agree?

1 **A.** That's my assumption based on that, yes.
2 **Q.** All right, then the next sentence is:
3 "By 1 April 2020 we expect circa 1.3 million to be
4 in date."
5 So as at January 2020, which is the date at which
6 this table was put together, there was uncertainty,
7 there was an expectation that 1.3 million would be in
8 date but that wasn't a given, was it, and that they
9 would be in date at a future date, so not until
10 April 2020.
11 **A.** But then the next line does say that, however, there's
12 going to be 4.6 million that we think will be shelf life
13 extended. So I guess it is a snapshot in time, and
14 I can't give you very much more information than that,
15 I'm afraid.
16 **Q.** All right. One final question on this table, then we
17 can take it down. Would you agree that more of the
18 stockpile should have been ready to go without the need
19 to extend its shelf life or carry out QA testing when it
20 is needed to be deployed? A greater proportion should
21 be ready to go at any given moment?
22 **A.** I've never been responsible for managing a stockpile so
23 I'm talking from a position of ignorance, but what I see
24 here is that there is what would have been considered
25 a sufficient number of products available in the

1 stockpile, and there would then have been a -- this
2 table, I imagine, would have been discussed between SCCL
3 and PHE and decisions made as to whether additional
4 products are required to be purchased, whether products
5 should go back in for retesting or additional shelf
6 life. So the decisions would be being made on a regular
7 basis based on the information that is included here, to
8 ensure that at all times the stockpile had what was
9 expected to be needed.
10 **Q.** Thank you. We can take the table off the screen now.
11 Thank you.
12 Professor Sanchez-Graells, who provided evidence to
13 this Inquiry, has said that the control and management
14 of the PIPP stockpile had been under a complex chain of
15 contracts, and that this contractual complexity, as he
16 put it, created operational difficulties, and that it
17 also affected the procurement of goods to replenish the
18 stockpile, for example in the case of items running out
19 of date. Would you agree with that characterisation?
20 **A.** Well, I think he makes that statement more widely about
21 the whole model, and I'm not sure I would agree.
22 I don't think it has the level of complexity that he is
23 suggesting it does. As we talked about before lunch,
24 each of the 11 towers were responsible for a number of
25 items, and therefore they were solely responsible for

1 buying those items, so there wasn't that level of
2 complexity about who would be buying the items. And as
3 I said before, we were the sort of overarching customer
4 point, or customer-facing element.
5 So I know he talks a lot about complexity, I think
6 it is probably not as complex as he suggests it is.
7 **LADY HALLETT:** Dame Emily Lawson said the tower structure
8 was complicated.
9 **A.** She did. I -- yeah, I don't think, in practice, it was
10 as complicated as it might -- I appreciate that looking
11 at it onscreen it looks complicated, but the idea that
12 each of the products was in only one category meant that
13 you are effectively asking people to have speciality and
14 knowledge of only a smaller proportion of products as
15 opposed to the whole. We have 600,000 products in the
16 catalogue at the moment, so, rather than having to have
17 knowledge of all 600,000, you're looking at the
18 however many thousand that will make up your particular
19 areas of expertise. I think, in practice, it's probably
20 more simple than it looks, but I do understand that to
21 the outside world it looks incredibly complicated.
22 **MS SHEHADEH:** Just to wrap up questions around the PIPP
23 stockpile, then, as far as you can recall, was SCCL
24 satisfied with how it was being administered by its
25 contractor?

1 **A.** Yes. There were no contractual issues.
2 **Q.** Moving on then to the events early in the pandemic, so
3 from early 2020. You've described in your statement
4 that trusts started significantly increasing their
5 orders, and we know from other witnesses that of course
6 at the same time, supply chains around the world were
7 disrupted. And obviously that affected the work of SCCL
8 as well. Lockdowns brought a halt to the production of
9 some items; is that right?
10 **A.** Yes. I mean, I don't think there's any secret that
11 there was problems, you know, for worldwide supply
12 chains.
13 **Q.** And there were also shipping delays and export bans?
14 **A.** Yes.
15 **Q.** All right. In terms of how that impacted the work of
16 SCCL, some witnesses have referred to SCCL's contractual
17 arrangements collapsing when faced with this global
18 market disruption. How would you characterise the
19 effect of global market disruption on, let's speak first
20 about the business-as-usual contracts that were in
21 place.
22 **A.** So, as I said earlier on, business as usual included
23 very, very small elements of PPE, 100 million out of
24 3.5 billion, and those other products are those that
25 allow a hospital to operate on a daily basis. It's all

1 of the products that are used in everyday procedures, in
2 operations and including food, as well. So without
3 those products, a hospital doesn't function, and if our
4 supply chain breaks then hospitals are very quickly
5 unable to operate as they are intended to do.
6 That element of the business was what we focused on,
7 on keeping going, and we continued to deliver right the
8 way through the pandemic and beyond with very high
9 levels of delivery. There were obviously some products
10 that were harder to source and also subject, as you
11 said, to delays in shipping and the like, but by and
12 large the 'business-as-usual' element, which is the
13 vast, vast majority of the business, kept going, kept
14 delivering, and a significant number of people involved
15 in the supply chain were working ferociously hard to
16 ensure that was the case.
17 The problem comes when you then add PPE on top of --
18 or the demand for PPE on top of what is already a finite
19 resourced supply chain, and ask it to deliver products
20 that have grown exponentially in terms of demand. We
21 have a finite number of warehouses and a finite number
22 of warehouse lorries to do deliveries and we were only
23 ever set up to deliver products to 240 NHS trusts.
24 Being asked then to deliver PPE in volumes that were so
25 significant, and then ultimately to 58,000 locations,

1 means that, you know, that's just not sustainable.
2 **Q.** The 58,000 locations you mentioned, that's a reference
3 to when -- does that include care
4 settings -- (overspeaking) --
5 **A.** Yes, so that was where the PPE was then ultimately being
6 delivered to. So when we -- we talked before about our
7 market share. So we were a business set up to manage
8 roughly 50, 60% of the hospitals -- or NHS trusts'
9 hospitals' daily requirements, and did that, and our
10 capacity allows us to meet those levels. It just
11 wouldn't have existed or survived had we been able to or
12 been required to add the levels of PPE, such that, you
13 know, even the 800 people you heard about last week in
14 terms of doing the buying to Parallel Supply Chains
15 through Clipper.
16 **Q.** The long and short of it is, however, that had the
17 Parallel Supply Chain not been set up, had the
18 procurement of PPE not been effectively taken out of the
19 hands of SCCL, SCCL would have been unable to provide
20 what the NHS needed, is --
21 **A.** Absolutely, but we would have had to make a choice: do
22 you either by PPE and then not provide any of the
23 products that NHS actually needs to be able to deliver
24 or do you split it up? The decision -- it seems like
25 the decision was eminently sensible.

1 **Q.** You've described in your statement the amount by which
2 demand for all items, not only PPE, but of course
3 including PPE, surged, and NHS trusts were placing much
4 larger orders than they had been historically, and NHS
5 trusts that hadn't placed orders with SCCL began to
6 do so --
7 **A.** Yes.
8 **Q.** -- is that right? Now, one of the ways that SCCL
9 responded to that, and we know that SCCL was liaising
10 with DHSC, and we've heard from Dame Emily Lawson about
11 her involvement, one of the ways SCCL responded to that
12 was through instituting demand management. In simple
13 terms, does that mean cancelling down orders placed by
14 NHS trusts?
15 **A.** In some cases but most -- certainly initially, in
16 looking at those anomalies in demand -- sorry, in
17 ordering patterns, I think, Dame Emily referred to 150%
18 as -- so if somebody had normally ordered 100 and was
19 suddenly asking for 150, someone would question whether
20 that was needed because it was just simply a question of
21 trying to make sure that as many customers got as many
22 products as we could give them with, as you said, an
23 increasing customer base, customers who'd never bought
24 certain items from us coming to us because their
25 existing routes no longer existed.

1 **Q.** And is it right that there was no centralised
2 information on inventories, so for example SCCL couldn't
3 know how much stock was held, whether as a buffer for
4 immediate use, by any given NHS trust?
5 **A.** That's absolutely correct and that's one of the biggest
6 problems we faced, is knowing if somebody was ordering
7 1,000, did they already have 1,000 in stock, or was it
8 because they had absolutely none? So knowing where
9 stock was and how much stock existed was impossible, and
10 to a large extent, still remains the case now.
11 **Q.** You've said in your statement at paragraph 7.32, your
12 statement INQ000492085, that:
13 "Demand control (rationing) was not routinely
14 communicated widely at the start of the pandemic as this
15 often serves to encourage customers to place multiple
16 orders to get around any rationing which defeats the
17 objective of ensuring that all orders are fulfilled at
18 least in part, ie a fair share goes to all customers."
19 You've given a reason there for not routinely
20 communicating widely rational control. Firstly, what do
21 you mean by not communicating widely? How was rationing
22 communicated to NHS customers?
23 **A.** My understanding or recollection is that trusts were
24 informed, both by the department and others, not to
25 stockpile, and I think in one of the earlier paragraphs

1 at the top of that page, there is the information that
2 we sent out to trusts explaining that we were trying to
3 meet as many people's demand as possible.
4 But what we didn't do is say, "We are now only going
5 to allow X number of products or X per cent of your
6 orders to be fulfilled", because that did breed the sort
7 of stockpiling behaviour in some cases that not
8 dissimilar to -- we saw in supermarkets and whatever,
9 people buying as much as they could, not necessarily as
10 much as they needed.
11 **LADY HALLETT:** Can I just take you back -- I'm sorry to
12 interrupt, Ms Shehadeh. Can I just take you back to one
13 of your answers a minute ago. You said that one of the
14 problems, as was put to you, was that the difficulties
15 of knowing how much stock trusts held, and you said that
16 that's still the case.
17 Dame Emily said that there is now in place a system
18 whereby in an emergency, SCCL could find out, and the
19 systems -- (overspeaking) --
20 **A.** Well, I think -- and again, my recollection may not be
21 quite right -- I think she talked about a number of
22 trusts that have inventory management systems in place,
23 and that certainly isn't all -- my understanding is
24 there are about 60 or 70 trusts that have an inventory
25 management system that is capable of talking to us or

1 providing reports. But it's certainly not the full
2 extent of the NHS, and we are working on a project with
3 NHS England to introduce inventory management systems
4 into 20 new trusts to give us realtime data that will
5 say -- so it wouldn't just -- so I know Dame Emily was
6 talking about it being used in an emergency, but for
7 actually a supply chain business like ours, we want to
8 have that information all day, every day. We want to
9 know how many bandages you've got, how many sutures
10 you've got, so that we can help manage that. And some
11 of the -- particularly some of those products that are
12 used in operating theatres, for example, as they're
13 being used, we know that that's one less unit, and
14 that's a point we'll place a reorder without the trust
15 having to do anything.
16 So it's that kind of data that we just didn't have
17 going into the pandemic, and largely we don't have as
18 a system even now.
19 **LADY HALLETT:** So it's 60 already got this new management
20 system.
21 **A.** That's my understanding.
22 **LADY HALLETT:** 20 you're rolling it out to?
23 **A.** Yes.
24 **LADY HALLETT:** Remind me how many trusts there are.
25 **A.** About 240.

1 **LADY HALLETT:** So you've got a long way to go?
2 **A.** Yes. And it's not cheap and that's the trouble.
3 There's a benefit to it, but I think our number one
4 recommendation, certainly from our perspective, is that
5 if the money can be found, inventory management systems
6 throughout the NHS would be a benefit.
7 **LADY HALLETT:** Thank you.
8 Sorry to interrupt.
9 **MS SHEHADEH:** Finally on this point, did SCCL consider that
10 NHS trusts might have been concerned that they weren't
11 able to source PPE from SCCL, and this in itself might
12 have caused panic buying if they weren't being
13 communicated with?
14 **A.** I think it's less about the communication but more about
15 the concern. I think the concern that you outline is
16 very real. You need -- you suddenly need a quantity of
17 products that you've never bought in that volume before,
18 the place that you may have typically bought from
19 doesn't have access to it, and then what you think is
20 the, sort of, NHS's own supply chain also doesn't have
21 it, certainly in the volume. So that kind of concern
22 and fear element, I think, is only -- it's only natural.
23 **Q.** Is it right to say that SCCL did not have plans in place
24 that anticipated a pandemic?
25 **A.** SCCL as a -- well, we had -- we managed the PIPP

1 stockpile, so that was our understanding of what the
2 pandemic plan would have been. So we would have, and
3 the contract that we had with PAG and Mo -- with
4 Movianto made clear all the steps that would happen and
5 how that stockpile would be deployed. So to that
6 extent, there was a plan.
7 **Q.** In terms of supply chain disruption in terms of what
8 would happen once the stockpile had been used up, SCCL
9 didn't have a plan as to what came next, did it?
10 **A.** No, but I'm not sure that in that circumstance we would
11 have been expected to because, again, we take
12 instructions from PHE about the volume and the nature of
13 the products to be put in the stockpile and the -- so --
14 and, again, my understanding is the expectation was that
15 PIPP stockpile would have been sufficient -- I can't
16 remember, I've got the number in my statement -- the
17 first X weeks of a flu-type pandemic. So there would
18 have been an expectation then that that would have been
19 replenished. So I think there was a plan, but in terms
20 of did we have a separate plan, no, we didn't, but I'm
21 not sure that there was an expectation that we should
22 have done, because we would have been operating under
23 the instruction of PHE, who would be making all the
24 calls about whether there was a pandemic, when to deploy
25 that stockpile, and in what form.

1 **Q.** You now have in place something you refer to as
2 a pandemic "playbook". Does that address --
3 **A.** Well --
4 **Q.** -- that --
5 **A.** -- some of that is an internal facing in terms of -- so
6 one of the -- in terms of how we deploy our own
7 resources, we had lots of people working incredibly
8 hard, but then we've still got, on PPE, ignoring the
9 difficulty of maintaining the BAU ways of working. So
10 we have a greater level of planning as to how we would
11 manage, because again, like the rest of the country, we
12 were dealing with people not being able to get into the
13 office. Skipton House, where Dame Emily Lawson was
14 based, was where we were largely based; that became --
15 that was shut down. And it's all that kind of "How do
16 you work in a pandemic?" So that's in our plan.
17 We have the ability to scale up, should we need to
18 reopen, effectively, the Parallel Supply Chain, that
19 kind of thing. So all of that is in there.
20 But again, a large amount of that we will be acting
21 under the instruction of whether it's UKHSA, the
22 Department of Health or NHS England, depending on who is
23 calling the shots at that point.
24 **Q.** All right, thank you. Thank you. And you go into more
25 detail about that in your written evidence for which

1 we're grateful.
2 I'm just going to move very swiftly on to the
3 physical warehouses. We've heard a bit about that this
4 morning.
5 **A.** Yes.
6 **Q.** There's a distinction between a distribution warehouse
7 and a storage warehouse, if I can put it in those terms.
8 You say in your statement that the Haydock warehouse was
9 accessible 24 hours a day, seven days a week. Am
10 I right in saying that in respect of distribution of the
11 stockpile, your analysis is that the issue wasn't with
12 logistical or physical issues but rather it was around
13 measuring and monitoring demand signals?
14 **A.** Yes, that's -- yeah, that's right.
15 **Q.** Can I put up on screen, please, INQ000569777.
16 This is an extract from an account by Matt Hancock
17 in his book entitled Pandemic Diaries. If we go to
18 pages 6 and 7 of that document -- that's printed
19 pages 95 and 96. Thank you very much.
20 I just want to ask you about the way he describes
21 the difficulties with the warehouse:
22 "Continuing to work through the practicalities,
23 Steve Oldfield updated me on the huge stocks of PPE in
24 a warehouse in the north-west: a billion items. Just
25 one problem -- we can't get it out. It turns out that

1 when they laid down the PIPP stockpile in the 2000s,
2 no one thought about the circumstances under which we
3 might need it, ie, an emergency, in which time is of the
4 essence. It's a huge storage unit which only has one
5 door."
6 Just pausing there, on a factual level, is it
7 accurate that the Haydock site only had one door?
8 **A.** I don't believe that is the case.
9 **Q.** All right, and in terms of difficulties, with moving
10 something out of deep storage into a distribution
11 warehouse, would you accept that that process in and of
12 itself takes up valuable time that isn't available in an
13 emergency?
14 **A.** No, because we can demonstrate that at one point they
15 moved 1,000 pallets in a 24-hour period. I don't know
16 where the information came that goes into this extract,
17 but I wanted to check before I came here, and one of my
18 colleagues has shown me that if you put the Haydock site
19 into Google Maps you'll see that there are a dozen
20 lorries all loading up at the same time. So I think
21 there is some misinformation in terms of how this story
22 has been relayed.
23 Undeniably, it is quicker to move product from
24 a distribution warehouse because that's what it --
25 because the stuff is coming in and going out on a daily

1 basis. Deep storage is there for a particular period,
2 but it's a modern facility with modern technology, and
3 as I said, capable of moving 1,000 pallets in 24 hours.
4 So it -- the stock can be moved.
5 Now, Dame Emily Lawson gave an incredibly articulate
6 explanation of what happens next in terms of then being
7 transported to and being broken down into the right size
8 of packaging or parcels, depending on the nature of the
9 organisation then receiving the products, because
10 obviously it's different if you're going to an NHS Trust
11 than if you're going to a care setting. But I'm not
12 aware that the problems that this suggests, in terms of
13 ability to access stock, and then move it around the
14 country, are anything like as they are portrayed here.
15 **Q.** All right, and then finally, you tell us in your
16 statement that SCCL has now brought the procurement of
17 PPE in-house.
18 **A.** Yes.
19 **Q.** What does that mean, and how will that affect
20 preparedness in a future pandemic?
21 **A.** So that chart that you showed at the start of the
22 session has now been largely rubbed out. The
23 procurement of medical products, so eight of those 11
24 towers, has come in-house, in part as a recognition that
25 if there was an emergency situation, being able to

1 deploy those procurement people to buy particular
2 products rather than the range. So, previously, they
3 only bought whatever capital equipment. Now we can say,
4 actually, you are now buying PPE or you're now buying
5 whatever it is. So there's an element of building some
6 greater level of control over our staff and our
7 procurement patterns.
8 It will help us a bit with resilience, as well, and
9 it means that the decisions that we will -- we will be
10 able to respond quicker to direction from NHS England or
11 the department without having to go to a third party,
12 which is what the case was with the towers.
13 **MS SHEHADEH:** Thank you.
14 My Lady, I am conscious there are questions from
15 others. Those are all -- (overspeaking) --
16 **LADY HALLETT:** Thank you very much.
17 Mr Weatherby.
18 **MR WEATHERBY:** Yes, my Lady I'm asked to shorten our --
19 **LADY HALLETT:** Well, I'm sorry, it's because we've run over,
20 but if you can't without affecting the substance then --
21 **MR WEATHERBY:** Well, I was about to say, you covered parts
22 of them anyway.
23 **LADY HALLETT:** All right.
24 **MR WEATHERBY:** Can I just have a quick go.
25 **LADY HALLETT:** Yes, of course.

1 **Questions from MR WEATHERBY KC**
2 **MR WEATHERBY:** Mr Webster, I ask questions on behalf of
3 members of the Covid Bereaved Families for Justice UK,
4 and my Lady was asking you questions about the inventory
5 system or the lack of inventory systems in trusts. And
6 you gave us your answer about that.
7 In your witness statement you described it as
8 a major difficulty with the system that SCCL had an idea
9 of what was being ordered by trusts but it had no way of
10 tracking what individual trusts actually already had,
11 and that gave rise to serious issues, your words, during
12 the pandemic because it was impossible to know how much
13 stock of a particular product a specific trust or the
14 wider system held. Okay?
15 **A.** Yes.
16 **Q.** So you've been involved since 2016, I think you said?
17 **A.** Yes.
18 **Q.** Did you or any of your colleagues not consider this
19 ahead of the pandemic: that SCCL might have the need to
20 monitor the inventory of PPE across the system, PPE and
21 other critical supplies, as well as usage? Was that
22 never considered?
23 **A.** Well, yes, in the sense that would it be helpful to know
24 what is stocked and where? Being able to do something
25 about that is the issue, and as I explained a moment

1 ago, putting in inventory management systems is an
2 incredibly expensive undertaking --
3 **Q.** Yes.
4 **A.** -- and not one that we would be able to do. So it
5 relies on each NHS trust making that information
6 available centrally.
7 **Q.** Yes.
8 **A.** So would it be a good idea? Incredibly so. Was it
9 something that we were able to influence? Unfortunately
10 no.
11 **Q.** Right. My question was, was it given thought ahead of
12 time --
13 **A.** Not in the sense of a pandemic, but in the sense of
14 actually running an efficient supply chain knowing what
15 stock exists throughout that end-to-end supply chain,
16 both downstream and upstream into our customers.
17 **Q.** Yes.
18 **A.** Yes, we would regularly feel that the lack of that
19 information was a -- (overspeaking) --
20 **Q.** Yes, and did you escalate that? Did you feed it up the
21 line to government?
22 **A.** It would have been part of the ongoing discussions.
23 **Q.** Yes, okay. And finally this, then: the real problem
24 now, five years on from the onset of the pandemic, the
25 real problem now, is that the progress that's been made

1 is not sufficient, and that's because of limited
2 funding. Is that a fair way of putting it?
3 **A.** I think so, yes.
4 **MR WEATHERBY:** Yes, thank you very much.
5 **LADY HALLETT:** Very grateful, Mr Weatherby. Thank you.
6 Mr Stanton, right the way over there.
7 **Questions from MR STANTON**
8 **MR STANTON:** Thank you, my Lady. My Lady, I'll do my best
9 to shorten my questions also.
10 Good afternoon, Mr Webster.
11 **A.** Good afternoon.
12 **Q.** I ask questions on behalf of the British Medical
13 Association. My first question relates to the question
14 of communication with healthcare workers. I'd like to
15 ask you the question: given that healthcare workers were
16 risking their lives to care for patients, do you believe
17 that there should have been more honesty and candour
18 with frontline healthcare workers about the reality of
19 PPE shortages? For example, healthcare workers were
20 assured that PPE was stockpiled and available to flow
21 into the system while in fact rationing and demand
22 management was taking place in a number of different
23 forms.
24 **A.** Well, that communication largely, in terms of
25 reassurance, came from elsewhere within the system.

1 Should we be as honest as possible with healthcare
2 workers in an ideal situation? Absolutely, we should.
3 I think in part, it came from -- as I said, PPE was such
4 small fraction of what the NHS uses on any daily basis
5 that there wasn't an expectation that that type of PPE
6 would be needed in the volumes that turned out to be.
7 The PIPP stockpile is there for a flu-type pandemic, not
8 the kind of virus that Covid is.
9 But to your question, should there be as much
10 candour as possible, yes, yes, absolutely.
11 **Q.** Did you think, then, that that occurred? That there was
12 in fact candour and honesty? We heard earlier from
13 Dame Emily Lawson that they were desperate -- well, she
14 described the situation as being desperately short of
15 pretty much everything. Do you think healthcare workers
16 on the front line who were taking on very serious risks
17 were aware that the situation was quite as bad as it
18 was?
19 **A.** I can't speak to what they would have known. We
20 wouldn't routinely have a discussion with clinical --
21 between us and clinicians. Our discussion would be with
22 procurement managers within a trust and it's there that
23 we are having the discussions about volumes. We
24 wouldn't expect to then push out further information
25 into healthcare providers.

1 **Q.** Thank you, Mr Webster. I'll move on to another question
2 area. This area relates to the extent to which you
3 received input, clinical input, into procurement
4 decisions. I'd like to refer you, please, to
5 a document.
6 INQ000339268. It's page 40 of that document.
7 If you could let me know when you have it, please.
8 **A.** I do, yeah.
9 **Q.** Thank you. If you see the second paragraph of that
10 document, it begins:
11 "DW ..."
12 And that's the person David Wathey, who is elsewhere
13 named in full in this document.
14 "... advised an area that had arisen ... is the
15 supply of FFP3 masks, seeing a three times surge in
16 demand over the last few weeks in orders coming through
17 NHS SC, the reason for this will be trusts preparing,
18 such as fit testing activity which will have increased
19 demand. DW advised if we model that level of demand
20 we've identified for certain product lines in the FFP3
21 we will be in a position where we would not be able to
22 support BAU [business-as-usual] demand, as a result of
23 this, we have taken a decision today that we are going
24 to place a restriction on orders that are placed on the
25 NHS SC system to limit these to BAU demand levels, this

1 will be based on the customers last 12 months BAU
2 demand. The system will place a ration on this, daily
3 ordering will be monitored to ensure there is no
4 abnormal ordering."
5 My question is, would you accept that this is
6 a blunt and bureaucratic response that lacked insight
7 into the clinical and ethical importance of the
8 equipment being restricted?
9 **A.** Well, it's a decision made by the department and not by
10 NHS Supply Chain.
11 **Q.** Yes.
12 **A.** So I -- it would be wrong for me to put, kind of -- put
13 into words what they were trying to do here. But in
14 terms of trying to ensure that people have access to as
15 much product as possible, there has to be some limit.
16 If you only have a finite capacity at any given time,
17 you can only give out that many. But as to whether --
18 how they came to that decision, that would be something
19 the department or David Wathey would have to --
20 **LADY HALLETT:** It's rather a strange criterion, isn't it?
21 Business as usual doesn't usually involve too much use
22 of FFP3 --
23 **A.** Yes, as we heard this morning, yes.
24 **LADY HALLETT:** Whereas when you're fighting a virus of this
25 nature then it's more likely to be. So business as

1 usual wouldn't help anybody, would it?
2 **A.** As I say, it's probably something --
3 **LADY HALLETT:** Wasn't your decision?
4 **A.** Yeah. Yes.
5 **LADY HALLETT:** Right.
6 Sorry for interrupting, Mr Stanton.
7 **MR STANTON:** No problem at all, my Lady.
8 Mr Webster, I'll move on to one further document, if
9 I may.
10 If I could have up on screen, please, INQ000553817.
11 Again, if you could indicate when you can see that
12 document, that would be helpful.
13 **A.** Yes.
14 **Q.** Thank you. This a witness statement from Rosemary
15 Gallagher on behalf of the Royal College of Nursing, and
16 at paragraph 23a you should have feedback provided by
17 RCN members on procurement stock that had been procured.
18 And we have one example, at 23a, which reads:
19 "So far we have had 4 different types [of mask] from
20 two different manufacturers, none have been clinically
21 acceptable, they simply do not fit. I am aware that
22 contracts have already been signed to purchase. When
23 I have fed back to cabinet office that they don't fit,
24 I was told any mask was better than nothing."
25 Then over the page, page 8, 23b. You'll see some

1 further feedback:
2 "The clinical engagement is being done AFTER the
3 purchasing decisions have already been made. It is
4 paying lip service to it and it is too late once
5 decisions have already been made based on tech specs,
6 NOT clinical specification and evaluation."
7 So my question, Mr Webster, is: in your experience,
8 was this type of end user experience missing from the
9 procurement process during the pandemic, and would you
10 have benefited from this type of input?
11 **A.** Well, I think this extract refers to a period when the
12 Cabinet Office was buying the products. So it was
13 FFP3 masks, as Dame Emily mentioned this morning, were
14 used in a far smaller number, and at that stage my
15 understanding is that the testing didn't -- and the
16 specification didn't involve the sizing element that was
17 clearly, with hindsight, something that would have been
18 beneficial. But at the time, it wasn't.
19 And I think it's -- this -- I imagine -- and again,
20 I don't have the expertise to speak to this, but
21 I imagine this is one of those things that you learn as
22 time goes on. It would have been helpful to know that
23 in advance, absolutely it would. But I think at the
24 time, there wasn't that recognition that the size was
25 going to be the issue that it clearly became later on.

1 **Q.** Just thinking in more general terms and looking to the
2 future, do you think the process that was in place at
3 the start of the pandemic was missing this end-user
4 feedback, and is this something that you'd recommend for
5 the future?
6 **A.** I think end-user input into specification of any product
7 makes sense. Absolutely, yes.
8 **Q.** Thank you.
9 Mr Webster, my final question, which I'll shorten,
10 is a question that was put to Dame Emily Lawson earlier,
11 and I think you indicated you heard her evidence. The
12 question was, why did it take a pandemic for the issues
13 around FFP3 types -- that would fit a variety of
14 different face types -- take -- to be recognised during
15 the pandemic, why wasn't it recognised earlier?
16 You obviously heard, I think, Dame Emily Lawson's
17 answer. Do you agree with the answer she gave?
18 **A.** I'm not sure I necessarily recall what -- what her
19 answer was.
20 **Q.** Her answer was along the lines: FFP3 was quite
21 a specialised piece of equipment, it needed to be used
22 during the pandemic across a much wider range of
23 healthcare worker, and they simply didn't know at that
24 time the number of different types that would be needed.
25 As somebody who has worked in this area for quite

1 some time, would that be your assessment?
2 **A.** That's certainly my understanding, yes.
3 **Q.** And would that be the case even though a particular
4 group that had issues with fit testing were women, and
5 women make up 77% of the healthcare workforce?
6 **A.** If you're asking now would that still happen, or at the
7 time? So at the time there wasn't that expectation or
8 recognition that size and shape was going to be so
9 important, which is why the specification for FFP3s in
10 the PIPP stockpile were as they were. If you're saying,
11 as we look forward, would we expect the specification
12 for products going into any new stockpile to reflect the
13 experiences of clinicians of whatever gender or whatever
14 race, then absolutely you would expect that to be
15 a lesson taken away and incorporated into the
16 specifications for the future.
17 **MR STANTON:** Thank you, Mr Webster.
18 Thank you, my Lady.
19 **LADY HALLETT:** Thank you, Mr Stanton.
20 Those are all the questions we have for you,
21 Mr Webster. Thank you for the help you've given to the
22 Inquiry and for coming along to give evidence today.
23 **THE WITNESS:** Thank you.
24 **MS SHEHADEH:** My Lady, our next witness is Julian Kelly.
25 **LADY HALLETT:** Thank you, Ms Shehadeh.

1 **MR JULIAN KELLY (sworn)**
2 **LADY HALLETT:** Sorry to keep you waiting, Mr Kelly.
3 **THE WITNESS:** That's okay.
4 **Questions from COUNSEL TO THE INQUIRY**
5 **MS SHEHADEH:** Can you state your full name for the record,
6 please.
7 **A.** Julian Kelly.
8 **Q.** Thank you very much. You have provided a witness
9 statement to this Inquiry. It is INQ000528585, and it
10 runs to 143 pages and is dated 23 December 2024. Can I
11 just ask you, are the contents of that statement true to
12 the best of your knowledge and belief?
13 **A.** Yes.
14 **Q.** Thank you. You have been the Chief Commercial Officer
15 for NHS England and you've held that post from
16 April 2019 and you've also acted as its deputy Chief
17 Executive; is that correct?
18 **A.** No, I've been the Chief Financial Officer not the Chief
19 Commercial Officer, I think is what you said, since
20 2019. But I have been the deputy Chief Executive since
21 July 2021.
22 **Q.** Thank you. I'm so sorry. Chief Financial Officer?
23 **A.** Yes.
24 **Q.** You, in terms of the rest of your professional
25 experience, you tell us at paragraph 9 of your statement

1 that prior to joining NHS England you were the Director
2 General Nuclear, and you were also the Director General
3 of Public Spending and Finance at HM Treasury; is that
4 correct?
5 A. That is correct.
6 Q. And you've held a number of other senior roles including
7 with the UK Border Agency and also in the private
8 sector; is that correct?
9 A. Yes.
10 Q. And what were your responsibilities within NHS England
11 during the pandemic?
12 A. So largely I was responsible for agreeing the aggregate
13 funding arrangements with government which were used for
14 funding the NHS, for agreeing and setting some of the
15 rules for commissioners and providers by which they
16 spend that money. And then, as needs required, there
17 were specific programmes and projects that I got
18 involved in.
19 Q. Thank you.
20 In terms of a brief overview of what NHS England did
21 at the time and its responsibilities in relation to
22 procurement generally, NHS England is an executive,
23 non-departmental public body sponsored by DHSC. What
24 does that mean in simple terms?
25 A. We are an arm's-length body, ie a separate organisation

1 with a separate legal identity, where the objectives we
2 are required to meet are set by the department, the
3 funding provided by the department, and we are
4 accountable to the department for seeking to meet those
5 objectives with the money that they give us.
6 Q. And is it right that NHS England doesn't itself provide
7 services to patients, but it makes sure that they are
8 provided by commissioning services?
9 A. Yes.
10 Q. And this module, as you know, is focused not on services
11 but on key medical equipment and supplies.
12 In normal times NHS England has a very limited role
13 in relation to physical items that are used in the NHS;
14 is that right?
15 A. Yes, we were not and are not responsible for directly
16 buying the goods and services that, for example,
17 hospital trusts use every day.
18 Q. That said, during the pandemic, NHS England did carry
19 out some very limited procurement of medical devices and
20 some cover-alls and gowns; is that correct?
21 A. Yes, and we bought some pulse oximeters which were
22 distributed to GPs, for example, but, as you say, in
23 pretty limited circumstances.
24 Q. In respect of procurement of PPE and other key equipment
25 and supplies, NHS England did of course have a role,

1 principally assisting DHSC, in setting up and running
2 the Parallel Supply Chain and in liaising with the NHS.
3 Is that a fair summary?
4 A. Well, I would summarise it as we provided people and
5 resource to support the department in setting up the
6 PPE Cell, and then of liaising with them to communicate
7 to the NHS what was going on and what was expected of
8 the NHS.
9 Q. In terms of communications with the NHS, I'd like to ask
10 you now about how NHS England sought to engage with the
11 NHS in preparation for the pandemic in January and
12 February 2020, if I may.
13 Can we have up on screen, please, INQ000409919.
14 So this is a presentation from NHS England and NHS
15 Improvement dated 1 February 2020. It summarises what
16 actions NHS England was taking in January and
17 February 2020.
18 Could we go to page 1, please, or page 2. This is
19 effectively a snapshot in time of what was known at this
20 stage. So:
21 "On 9 January, Public Health England [a different
22 organisation] declared an Enhanced national incident due
23 to an outbreak of novel coronavirus in ... China."
24 In terms of your organisation's actions, NHS England
25 and NHS Improvement opened an incident coordination

1 centre on 22 January, and on 30 January NHS England and
2 NHS Improvement declared a level 4 national incident.
3 Briefly, what is the significance of declaring a level 4
4 national incident?
5 A. In simple terms, it means NHS England takes the
6 authority to give stronger direction to NHS providers as
7 to what they should do during that incident. Normally,
8 for example, hospitals are autonomous organisations
9 making their own decisions, but in a level 4 incident,
10 we will take responsibility for giving stronger
11 direction on certain issues.
12 Q. So does it limit the discretion of NHS trusts in their
13 decision making, effectively?
14 A. Yes, for certain things. I mean, clearly, on
15 a day-to-day basis you're running an emergency
16 department, you're still responsible for running an
17 emergency department. We're not going to tell you
18 exactly how to do that. But where, for example, we
19 think new capacity needs to be put in place, or, you
20 know, there's a particular response -- you know, things
21 we want to do to enhance staffing, we will give
22 a stronger instruction.
23 Q. Can we go to page 6 of this document, please. And also
24 page 5. Thank you. So those two slides are about the
25 assurance work that was being done. Effectively,

1 NHS England was liaising with NHS trusts to ensure that
2 they were ready in the event that they had to deal with
3 the pandemic.
4 We can see there that CCGs were asked to complete
5 assurance assessments of general practices, and over the
6 page, we see that there was assurance work being done by
7 multiple NHS organisations to ensure that they were
8 ready.
9 Were the sorts of questions that were being asked by
10 NHS England at this point, did they extend to stock
11 levels of PPE and the ability to comply with any
12 emergency IPC guidance that might be issued?
13 **A.** So as you see from the third bullet, we were asking
14 people what the supplies of their PPE were at that point
15 in time, and we were clearly -- I think I'm right, if
16 you're able to show one of the other slides, asking
17 people "Have you exercised your staff ready for" -- what
18 at the time we were preparing for was a high consequence
19 infectious disease, which has certain protocols that
20 have to be followed. So it was, you know, are people
21 prepared? Have you exercised? Have you briefed your
22 staff? And, as I said, we were at least asking people
23 "Do you have adequate supplies?" at that point in time.
24 **Q.** And the answer was generally adequate supplies of PPE
25 reported, and that was the answer coming from NHS

1 organisations, was it?
2 **A.** Yes. I mean, clearly if you were to look at the slides
3 that go further on, there are varied responses between
4 hospitals and, for example, what we thought was going on
5 in GPs.
6 **Q.** Yes.
7 And thank you, we can take that document down.
8 In relation to messaging, going to NHS trusts
9 regarding the PPE supply from others, can we have up,
10 please, INQ000049357.
11 This clearly carries the Department of Health and
12 Social Care header. It's not an NHS England letter.
13 But this letter is addressed to suppliers to the NHS.
14 And this letter asks suppliers to conduct a full risk
15 assessment of the impact of the pandemic on their supply
16 chains and to consider demand management plans in the
17 event of excessive or unusual ordering patterns.
18 Did NHS England have input into this communication?
19 **A.** I don't know, is the simple answer to the question. You
20 would have to ask the department. I mean, I suspect,
21 who would have seen it, aware that it was going out, but
22 I don't know what specific input we had.
23 **Q.** All right. Was NHS England aware that this letter was
24 going out to suppliers to the NHS?
25 **A.** As I said, I think we did -- we would have seen it.

1 There was a supply chain cell which had been set up
2 between ourselves, the department, PHE, and various
3 others at the beginning of January, February. It would
4 not surprise me if this letter was shared before it was
5 sent out.
6 **Q.** Thank you. We can take that letter down.
7 So in January and February 2020, NHS England was
8 asking NHS trusts, very sensibly of course, to carry out
9 assurance, checking to ensure that they had adequate
10 supplies of PPE. In February, the DHSC was encouraging
11 suppliers to monitor ordering patterns, to consider
12 demand management. And we've heard from Mr Webster,
13 speaking on behalf of SCCL, that SCCL was experiencing
14 a surge in orders.
15 All of those threads taken together, did that put
16 NHS trusts in a position, do you think, where they were
17 being asked to demonstrate that they were prepared but
18 were struggling to access PPE from the normal sources?
19 **A.** I think right at the start, in February and March, you
20 clearly see, as you have just described, trusts
21 concerned about what might be coming down the road, and
22 starting to try to increase the level of their local
23 stocks.
24 I mean, at this point, the number of patients
25 actually in hospital -- I mean, I forget -- I don't know

1 the precise numbers, but they were very, very small. So
2 you can see them preparing.
3 The steps that the department, PHE and SCCL agreed
4 to take in the middle of February, which is to begin to
5 put some limits on what orders are fulfilled, is clearly
6 people thinking: how do we just sensibly manage the
7 stock? And the communication that because from
8 NHS England on 2 March is saying to people: yes, okay,
9 make sure you have enough stock. And certainly for what
10 you can forecast is going to happen over the short term,
11 so I would say two to three weeks, given -- because it
12 also says "anticipate that normal supplies can
13 continue", and there was a sort of two to three-week
14 timetable for those flows, ie, don't start to create
15 very large stocks.
16 So I think that is the communication that is going
17 on, even while the department and PHE are at this point,
18 I think I'm right in saying, agreeing to start to put
19 the PIPP stockpile at the disposal of the NHS.
20 **Q.** I think the letter you're referring to is 2 March 2020.
21 We do have that.
22 So could we have on screen, please, INQ00087445.
23 Is this the letter you had in mind?
24 **A.** That's the letter I had in mind.
25 **Q.** Can we go to page 3 of that document, please. These are

1 the bullet points that are giving direction or guidance
2 to NHS and trusts that you've just taken us to; is that
3 right?
4 **A.** That's right.
5 **Q.** So:
6 "Ensure local stock levels are maintained at levels
7 proportionate to anticipated short term demand,
8 underpinned by regular replenishment from normal supply
9 routes and NHS Supply Chain."
10 So this letter is effectively asking trusts not to
11 create local stockpiles. Did that need saying because
12 you observed that local stockpiles were being created?
13 **A.** Well, I -- I am -- and I wasn't party to this letter at
14 the time, but from having spoken to Keith Willett, who
15 is our national clinical incident director, this is
16 them, in coordination with seeing what was going on with
17 the department and PHE, just trying to control the
18 immediate demand so they could manage the flow of stock
19 equitably and maintain sufficient reserves as they
20 looked ahead.
21 **Q.** Thank you. We can take that document down.
22 We know that eight days later, NHS England's CEO
23 asked the CCO to investigate issues arising from trusts
24 being unable to secure the PPE that they needed. So
25 it's a fast-moving picture.

1 We've heard Dame Emily Lawson's evidence of what
2 happened next after NHS England gained a fuller picture
3 of how NHS trusts were struggling to access PPE. So
4 I won't ask you about that.
5 Prior to that, NHS England was also engaging with
6 the status of the stock in the PIPP stockpile; is that
7 right? I'm jumping around in timeline a little.
8 **A.** Yeah --
9 **Q.** There were concerns -- NHS England had concerns about
10 the stockpile as early as January 2020; is that right?
11 **A.** Well, I think at the end of January it wasn't
12 necessarily that we were concerned, ie, that we were --
13 that we were -- and indeed, Professor Willett was
14 immediately concerned there wasn't enough in the
15 stockpile. His question was: can I reassure myself that
16 these -- you know, that this stockpile is in reasonable
17 shape?
18 So at that point, and I think it's in one of the
19 documents you had in my EP, you know, we asked for
20 information about what was in the state of the
21 stockpile -- sorry, what was in the stockpile at that
22 point in time.
23 He was also asking the question of the department,
24 whether they were going to reverse a decision that had
25 been made to start to decommission the EU stockpile or

1 the stockpile that had been prepared for the potential
2 Brexit disruption, because he was clearly thinking:
3 entirely uncertain what is going to come, at this point
4 in time we should preserve, you know, as many of the
5 stocks and supplies that there are.
6 **Q.** All right.
7 It's at paragraph 199 of your witness statement that
8 you say that:
9 "On 27 January 2020, in expectation of a pandemic
10 requiring PPE measures, NHS England's National Director
11 for Emergency Planning and Incident Response approached
12 DHSC to discuss concerns regarding the PPE stockpile."
13 Are you saying now that "concerns" possibly isn't
14 the right word at this stage? NHS England wasn't
15 "concerned" or "worried" about the stockpile as such?
16 **A.** Well, I mean, whether -- having spoken to Keith, I don't
17 think he was immediately thinking there definitely isn't
18 enough. He is concerned to make sure that he does
19 understand what there is there, and that appropriate
20 steps are being taken.
21 **Q.** All right. Thank you.
22 I'd like to move on to a different topic now, still
23 focusing on work that NHS England did with NHS trusts
24 but this time I'd like to turn to the Trust Supplier
25 Sourcing team, the TSS, as you refer to it in your

1 statement. Can you tell us briefly what the TSS was.
2 **A.** Yes. And could you just remind me where the paragraph
3 in my statement is where I raised that?
4 **Q.** You might want to turn to paragraph 222, page 48 of your
5 witness statement.
6 **A.** So at the time, there were a lot of leads, offers as to
7 where PPE supplies could be bought. A lot were coming
8 into individual hospital trusts because they were also
9 seeking leads. This was also a point in time where the
10 department was trying to give much stronger coordination
11 of buying, as they tried to make sure that people were
12 not -- you know, that NHS trusts and the department were
13 not competing with each other, and the department and
14 NHS England wanted to make sure individual hospital
15 trusts were properly engaged in that process.
16 So what the decision was to identify a trust and
17 a commercial lead who would take responsibility for
18 coordinating the leads that were coming into trusts
19 across the country for individual commodities, and then
20 to pass those leads on to the national buying team, who
21 at the time -- well, throughout the period, I was trying
22 to work out which might actually lead to actual stock
23 that can really be bought at scale.
24 **Q.** And for the TSS or the lead trust, were they then
25 effectively triaging and investigating offers of PPE

1 supply?
2 A. I think they were largely coordinating all the offers
3 and passing them on to the departmental team. I will
4 admit I don't know how much triage they were actually
5 doing. If you'd like to know, I'm sure we can follow
6 that up.
7 Q. I'm sure we can deal with that level of detail with
8 others. And when you say the departmental team, you
9 mean the DHSC, the parallel supply team?
10 A. Yes, the PPE Cell.
11 Q. And we read in your statement also that trusts were
12 collaborating, were sharing excess stocks of their own
13 PPE with others, for example.
14 You've also described at paragraph 258 of your
15 statement that some trusts had hired their own
16 warehouses for PPE, and put together local distribution
17 systems, and some used storage systems made available by
18 Local Resilience Forums.
19 Were NHS trusts, outside of the work of the TSS,
20 which involves passing on promising leads, were NHS
21 trusts basically creating their own versions of Parallel
22 Supply Chain, mini Parallel Supply Chains?
23 A. I wouldn't describe it like that. I would say that in
24 this case trusts were deciding whether they needed
25 better local storage arrangements from which they could

1 then work out how they distributed the goods that they
2 were then receiving out to their individual sites.
3 So, for example, I know that Manchester trust, which
4 is a very big trust with lots of sites, did procure
5 a warehouse facility and I am assuming that was because
6 they thought it was better that they had a bigger,
7 single central location from which they could manage,
8 I want to say the last leg of the distribution to their
9 local sites.
10 Q. Thank you. I'm going to turn briefly to ventilators.
11 Now, I'm conscious NHS England was not responsible
12 for sourcing or procuring ventilators, but it is right
13 that NHS England was responsible for the allocation of
14 ventilators -- within England, that is?
15 A. Yes.
16 Q. And NHS England also assisted with the modelling for
17 ventilator need; is that right?
18 A. Yes.
19 Q. You've set out in your statement that the allocation
20 process was based on three principles so that they
21 should be held centrally by NHS England, that they would
22 be distributed as required between hospitals and between
23 regions; is that right?
24 A. Yes, I mean, so it's hospitals within regions, yeah.
25 Q. All right. They were also allocated to devolved nations

1 based on an objective number of ventilators per million
2 population; is that right?
3 A. Yes, that would have been decided by the department who
4 was responsible for the coordination across the four
5 nations. That would not have been the job of
6 NHS England.
7 Q. And the prioritisation of where ventilators would be
8 sent at any time, that was based on actual data and
9 patient numbers; is that correct?
10 A. Yes.
11 Q. And the way it worked in practice was that on arrival
12 into the country, if they were new ventilators, that is,
13 that had been bought, they'd be transported to
14 a warehouse in the Midlands and then the military would
15 assist with transport onwards; is that your
16 understanding?
17 A. That is my understanding.
18 Q. Was all of this work called the National Ventilation
19 Allocation Programme?
20 A. That's my understanding.
21 Q. NHS England also carried out work in relation to the
22 supply of oxygen. Summarising it, in your witness
23 statement, you don't pretend there were no issues around
24 oxygen but the analysis in your witness statement is
25 that issues around oxygen supply did not relate to the

1 procurement or physical distribution around the country
2 of oxygen; they were to do with the state of the NHS
3 estate and its buildings; is that right?
4 A. Yes.
5 MS SHEHADEH: I have one other topic that I'd like to ask
6 Mr Kelly about, but is this is an appropriate time for
7 a break?
8 LADY HALLETT: If you'd rather just complete your questions,
9 that's fine. It's up to you.
10 MS SHEHADEH: Perhaps if we can turn to changes and lessons
11 learned then, at this point. I'll try not to keep you
12 too long, Mr Kelly.
13 One of the suggestions within the witness statement
14 that you provide is that there should be the ability to
15 centrally procure when a level 4 emergency is declared.
16 We've talked about the significance of declaring
17 a level 4 emergency, that some discretion is taken away
18 from NHS trusts and NHS England has the ability to
19 provide more direction.
20 Is it envisaged that NHS England would carry out
21 that procurement centrally, or that some other body
22 would do that?
23 A. Well, what I think we learnt from the pandemic we have
24 just been through was you needed the capability to surge
25 capacity. I think in an ideal world, we would plan for

1 that capacity to be within one place, building on an
2 existing infrastructure and system. I think the best
3 place for that actually is SCCL, if properly constituted
4 and set up and with a clear requirement upon them to
5 plan for that eventuality, because it is best if you can
6 surge capacity of an existing system and you're not
7 having to create something from scratch which was, of
8 course, our experience in the last pandemic, was that we
9 did need to create parallel capacity from scratch.
10 **Q.** Part of creating that parallel capacity in the Parallel
11 Supply Chain of course was the seconding of staff from
12 various government departments and other bodies to
13 create that new team. In terms of lessons learned, has
14 NHS England made any changes as relate to the surging of
15 staffing, different skill sets around distribution,
16 logistics, modelling? Has NHS England done any work in
17 relation to how NHS England, the NHS, SCCL, might be
18 better prepared to deal with emergency procurement if
19 the needs arose again?
20 **A.** So the responsibility both for the stockpile and for
21 thinking about how you prepare for the pandemic actually
22 still remains with the department. SCCL, I think, have
23 done actually quite a lot of work to think about how
24 they could prepare for the future. I think Paul Webster
25 just spoke about some of it, but it includes, and

1 actually the decision by the department to hold on to
2 the extra capacity warehouse and logistical capacity
3 that was created through the Parallel Supply Chain, now
4 properly integrated as part of SCCL, the work SCCL have
5 done, which again Paul described just now, which is
6 effectively to, I'm going to say in-source the buying
7 capability that used to be in the towers, and is now
8 provided by, for certainly medical consumables, a single
9 team within SCCL who have standard operating procedures,
10 clear training programmes.
11 So I think if you were to ask Andrew New, the chief
12 executive, he is more confident that that actually
13 creates the platform from which, if you needed to surge
14 buying capacity, again, you could. Even if you are
15 taking staff and resources from other bits of government
16 or from elsewhere, they have thought about how the IT
17 system is set up so you could actually put new customers
18 on it faster than was possible.
19 We, you know, they have held on to some of the IT
20 systems you would need to put in place if you actually
21 want to track what is coming out of the factory door in
22 China all the way to the port in the UK, have a new
23 logistics supplier contract which aims to embed that
24 more fundamentally in the way they work. And I think as
25 Paul also was describing, we, with them, have been

1 investing in some of the inventory management systems
2 you would want in individual hospital trusts. And now
3 we're doing that because actually we think there's an
4 economic case to do it today, but it would have the
5 added advantage that you would then have kind of more
6 realtime visibility of what is going on in individual
7 hospitals, and we, in NHS England, have invested in
8 a data platform which, again, I think it was -- Emily
9 was describing this morning, makes it much easier to
10 connect a wide variety of systems across the NHS so you
11 can pull all of that information very easily and rapidly
12 together in one place.
13 **Q.** And is there anything beyond what you have just outlined
14 that, reflecting on your experience in NHS England
15 during the pandemic, you would recommend so that
16 NHS England and SCCL are better prepared for a future
17 pandemic?
18 **A.** I mean, actually, the decision has already been made to
19 have a bigger stockpile, and the work I think that is
20 underway to think about what are the different things
21 you might need with different sorts of pandemics.
22 I mean, I am not the expert in that field, but just to
23 test the thinking of, you know, what are the sorts of
24 things one might need? And where might it be
25 appropriate to hold things in stock versus you need to

1 have a plan to surge the ability to access other goods?
2 You know, that clearly is a bit of work that needs to
3 continue to be done.
4 I would say we should make SCCL or whoever -- if
5 they are going to be our -- I'm going to call it the
6 provider of last resort, like the platform upon which
7 you would surge capacity, I think there that be a formal
8 part of pandemic exercises in the future, because you
9 really want to exercise your actual physical ability to
10 change, you know, your practice from business as usual
11 into emergency or crisis situations.
12 **MS SHEHADEH:** Thank you, those are all my questions.
13 **LADY HALLETT:** We've got about 10 to 15 minutes more
14 questions, Mr Kelly, and we usually take a break for
15 everyone's benefit, but particularly the stenographer.
16 Are you okay if we take the break now or would you
17 rather get the questions done so you can get on?
18 **THE WITNESS:** I really don't mind. Whichever is easiest
19 for --
20 **LADY HALLETT:** Are you sure?
21 **THE WITNESS:** Yes.
22 **LADY HALLETT:** In which case I think we'll take the break
23 now and I shall return at 3.20.
24 **(3.06 pm)**
25 **(A short break)**

1 (3.20 pm)
2 LADY HALLETT: Mr Weatherby.
3 Questions from MR WEATHERBY KC
4 MR WEATHERBY: Mr Kelly, I ask questions on behalf of the
5 Covid Bereaved Families for Justice UK group. Can
6 I start with the adequacy of PPE stocks. So you've
7 already been taken to the report of 1 February which
8 included the assessment of generally adequate supplies
9 of PPE, and you've told us that was based on asking
10 trusts to undertake an assurance process and that --
11 rather than any kind of detailed look at actual supplies
12 or forecasted demand. Yes?
13 A. I don't believe it was based on a forecasted demand for,
14 let's say, the kind of reasonable worst-case scenarios
15 that subsequently emerged.
16 Q. Yes. So you refer certainly in your statement to just
17 undertaking an assurance process.
18 On the next day, 2 February, in your witness
19 statement at paragraph 201 you refer to an email that
20 was received and dealt with by Mr Willett,
21 Keith Willett, that you've referred to, and I wonder if
22 we could have that up. It's INQ000409918.
23 This from a clinical director in Alder Hey,
24 Simon Kenny, to Mr Keith Willett that you've referred
25 to, and I am just going to start at the bottom and work

1 up. It's:
2 "Hi Keith, I know you are really busy -- but
3 [redacted] is [an] intensivist in [the north west] and
4 it sounds as though stock levels of PPE are very low and
5 resistance to buying more on grounds of costs.
6 "Not sure if there has been messaging to trusts from
7 NHSE on this ..."
8 And so it goes on.
9 And Mr Willett replies above that:
10 "Simon, stock levels are not low in the NHS supply
11 chain -- I literally have millions of sets -- I have the
12 EU Exit stockpile too!"
13 And then it refers to costs.
14 And Mr Kenny replies "Very helpful".
15 So you refer to that in your witness statement and
16 you say in your witness statement that in fact, despite
17 that reassurance that's given it was then escalated up
18 to DHSC.
19 Given that NHS England didn't have detailed
20 knowledge of the stockpiles, and it had raised these
21 concerns with DHSC, and they didn't have any model for
22 the demand to come, or inventory data, and was aware of
23 these reports, okay, anecdotal reports, but reports
24 nevertheless, which it took seriously, do you think
25 that, would it be right that there wasn't really

1 a robust evidential basis for the reassurance that was
2 given by Mr Willett in that email, or indeed in the
3 1 February report?
4 A. So at this point in time I don't think Keith's
5 reassurance to Simon is wrong. Simon's email, I think
6 it's dealing with actually, when you look at it, a very
7 specific issue which is really straightforwardly a trust
8 coming to the end of the financial year trying to make
9 sure it's balancing its books.
10 Q. Yes.
11 A. And at this point in time -- so, you know, before
12 I think people have necessarily really appreciated
13 everything that will come, it sounds like there's a bit
14 of an instruction to kind of control the budget on very
15 local grounds. But Keith, I think, has at least an
16 awareness. I can't quite remember when he is shown the
17 sort of update on the PIPP stockpile and the stocks,
18 which is also in my bundles.
19 Q. Yes, sure.
20 A. So he knows there are, as he says, literally millions of
21 sets --
22 Q. Yes, okay --
23 A. So at this point I think it is not a supply issue;
24 I think it is a specific local issue.
25 Q. Okay, point taken about the email, but I'll put it in

1 the context of the 1 February general reassurance. Do
2 you not think that NHS England should have been more
3 transparent about the position it was in at that point,
4 particularly now with the benefit of hindsight what we
5 know happened, that --
6 A. I think --
7 Q. Just let me finish the question.
8 A. My apologies.
9 Q. It simply didn't have sufficient data to determine
10 whether there was adequate supplies for the purpose that
11 on 1 February it was reporting, ie, where we were in
12 terms of the onset of the pandemic.
13 A. So if I can separate two things, which is the exercise
14 that Keith had instigated to ask NHS providers and
15 commissioners whether they were prepared and preparing
16 for an incident, which includes a whole series of
17 questions, one of which is, can you check that your
18 stocks of PPE are adequate at that point in time? And
19 then two, the question is looking ahead, what might be
20 about to happen, and his question to the Department who
21 are responsible for the PIPP stockpile, which is "Can
22 you provide me with some" -- you know, Keith asking
23 them, "Can you just provide reassurance about the state
24 of the PIPP stockpile?"
25 So I think it is fair that Keith and his team get

1 back a set of reassurances they do from the, if I call
2 it the awareness raising and preparing, sort of
3 operation exercise they instigated, but that is
4 different from Keith looking ahead and asking, "Okay,
5 can you tell me what the state of the PIPP stockpile
6 is?" And the work that's commissioned at the same time,
7 which NHSE with PHE agreed to do, which is start to kind
8 of do some reasonable worst-case scenario modelling, and
9 the actions that are being taken by the Department in
10 parallel, which include, around the end of that first
11 week in February, asking SCCL to increase their buying.
12 **Q.** Yes, okay. Sorry, I'm not trying to talk across you or
13 cut you short, but time is very short.
14 It may well be that at 1 February, for the
15 1 February's purposes, there were generally adequate
16 supplies. But going forward, and the purpose of the
17 1 February report, it should have had made clear that
18 whereas we may have adequate supplies as of 1 February,
19 we're certainly not going to have adequate supplies on
20 1 March or 1 April. That's the message that should have
21 been given, isn't it?
22 **A.** No, because I just want to again separate the two
23 exercises. There was an exercise which is reporting
24 what have we just had fed back from NHS providers and
25 commissioners at the end of January? And there's a

1 separate exercise which is looking ahead, and as I said,
2 includes NHSE and PHE agreeing to do some sort of
3 reasonable worst-case scenario modelling to say, "Okay,
4 but if we look ahead over a course of three, four, five
5 months, what might the demand be and what do we think is
6 the state of the stockpile relative to that demand?"
7 And I would just say the slides which say "general
8 reassurance" are just reporting back a specific
9 exercise, and that is separate from the work that gets
10 commissioned out of the supply chain cell to say, "Okay,
11 what do the stocks look like and what do we think about
12 the future?"
13 **Q.** Okay, well, I'm going to move on from that but finally
14 on the same point, that when NHS England did create
15 national and regional projections of demand in February
16 and March, and I'm referring to your paragraph 219,
17 those projections only considered direct Covid care in
18 the acute care sector, and they then failed to capture
19 the level of demand across primary care, ambulances and
20 other healthcare settings. Why was that?
21 **A.** So at that point in time, we are probably focused on the
22 demand that is going to be experienced in hospitals. We
23 were still preparing, I think at that point in time, for
24 dealing with a high consequential infectious disease,
25 that has quite a specific protocol within GP settings.

1 Again, I'm not the expert, but you would have seen
2 probably much lower levels of kind of PPE demand. So
3 the focus is on where we are expecting to see the vast
4 bulk of the demand within the NHS.
5 **Q.** Let me move on. Oxygen. You've told us, and told us
6 through your statement, that NHS England weren't aware
7 of any procurement issues that arose in relation to the
8 supply of oxygen, as opposed to the infrastructure,
9 which I'll come on to in a moment.
10 In Module 3 the Inquiry heard from Dr Crisp from
11 NICE who gave evidence about NHS England guidance on
12 9 April, referring to the reduction of required levels
13 of oxygen saturation. So the most acutely ill patients,
14 94-98% saturation, and the new guidance, said that it
15 was reasonable to go down to 90-94%, because of supply
16 problems with oxygen.
17 Were you aware of that?
18 **A.** So as I explain in my witness statement, the issue was
19 not per se the supply of liquid oxygen to hospitals; it
20 was the confidence and ability to flow that in
21 sufficient volume to enough beds if we saw, or when
22 indeed we saw, very high levels of demand for oxygen
23 therapy.
24 **Q.** Right. So infrastructure?
25 **A.** And that was to do with the state of the infrastructure,

1 the pipes, the -- and I apologise, I'm about to use
2 words that I even barely understand, but the evaporators
3 and various others of the mechanisms.
4 **Q.** Okay. The actual legend by the guidance from Dr Crisp
5 as put into evidence suggests the guidance was lowering
6 O2 saturation in response to limited supply, not
7 infrastructure, but limited supply.
8 **A.** But it's the supply to the bed. So it isn't that there
9 isn't, like, a tank, a sufficient tank with enough
10 liquid oxygen on the hospital site, it's the ability to
11 flow it to the number of beds. So it's literally the --
12 taking it from the tank through the pipes to the bed and
13 it's the ability to flow enough of it to enough
14 patients. So it's the supply issue to the bed rather
15 than the kind of aggregate volume of liquid oxygen that
16 is available to the hospital.
17 **Q.** Yes. In terms -- final point. In terms of
18 infrastructure, you have described in your statement
19 what you've just touched upon at paragraphs 321 to 325,
20 and you state that NHS England has mandatory guidance in
21 place to ensure the infrastructure is adequate. But
22 that is monitored by, although it's mandatory, it's
23 monitored by self-reporting.
24 Do you agree that the pandemic revealed that the
25 self-certification process or requirement was inadequate

1 as many hospitals didn't meet the mandatory guidance?
2 A. Well, it certainly revealed that where trusts had
3 maintained good governance and maintained some of the
4 expertise, they were the trusts that tended not to have
5 problems. And those who had not maintained some of that
6 governance is where we saw some of the problems emerge.
7 It is always a question as to how many things you are
8 trying to sort of monitor nationally, and what is the
9 responsibility of individual boards within hospitals who
10 are responsible for the safe operation of those
11 hospitals.
12 Q. Okay. Can I take it that that's a "Yes"?
13 A. Well, there were certainly issues.
14 Q. And do you agree that plans for preparedness in the
15 future must ensure that that self-certification process
16 is changed so that it doesn't lead to the same problem
17 in the future?
18 A. I would say it is a question the boards need to ask
19 themselves, which is: are they maintaining the, sort of,
20 right standards within the estate, and I also flagged,
21 as part of the lessons learnt in my report, one of the
22 issues is going to be are we able to invest enough into
23 the critical infrastructure risk within the estate to
24 maintain the quality --
25 Q. Okay, so can we take that as a yes, as well?

1 A. Certainly yes on we need to maintain the quality of the
2 estate.
3 MR WEATHERBY: Okay.
4 LADY HALLETT: Thank you, Mr Weatherby.
5 Mr Thomas is over there.
6 **Questions from PROFESSOR THOMAS KC**
7 PROFESSOR THOMAS: Mr Kelly, I'm representing FEMHO, the
8 Federation of Ethnic Minority Healthcare Organisations.
9 Mr Kelly, at paragraph 242 of your witness statement
10 you note concerns with the FFP3 masks not fitting black,
11 Asian or minority ethnic staff adequately, due to --
12 often due to facial hair or for religions reasons.
13 My question is this: what steps were taken to
14 address these fit issues, and was there consideration or
15 procurement of alternative types of respiratory
16 protective equipment to better meet the needs of these
17 particular groups?
18 A. I don't have a lot to add to what Dame Emily Lawson said
19 this morning, which was actually at the beginning of the
20 pandemic, as I understand it -- I was not involved, it
21 was not NHS England's decision, there was a decision by
22 PHE to procure, I think, a few thousand powered hoods to
23 provide some alternative to the use of FFP3 masks, and
24 as these issues began to be raised in May, there was
25 clearly consideration to, did a broader range -- you

1 know, was there a broader range of masks that were
2 available on the market? I think that did become part
3 of, as things became available, part of the approach of
4 the PPE Cell, as well as the work that was done by the
5 Deputy Chief Nursing Officer to understand what was
6 really driving this, how could we improve the training
7 and resources available to individual trusts in how to
8 do fit testing to make sure those things were being done
9 properly, as well as a reminder to boards and the
10 leadership of NHS trusts of their responsibilities to
11 make sure that staff had been appropriately fit tested.
12 Q. Sorry, Mr Kelly, can I just cut through this. The
13 reality is this was not thought of as an issue, despite
14 it being absolutely clear that one size would not fit
15 all? That's the reality, isn't it?
16 A. I don't think that's the case. I think, in advance of
17 the pandemic and when the requirement was set for the
18 PIPP stockpile, people had thought that you would need
19 a variety. I think issues emerged in May and the teams
20 responsible took action to try to address the issues
21 that emerged in May, as you were discussing with
22 Dame Emily this morning.
23 Q. Sorry, I don't understand, and perhaps it's just me.
24 If this was an issue that you and your team were
25 aware of beforehand, why is it that such

1 a disproportionate number, particularly of the groups
2 that I represent, had problems with fitting of this
3 equipment? Because it's not making sense to me.
4 Perhaps you can help.
5 A. So it was not my team that was responsible for what was
6 in the stockpile before the pandemic, though
7 I understand consideration was given to what was the
8 kind of variety of masks that you would need for
9 different groups of people.
10 It is why there was such an effort, as described
11 this morning, and by others, to seek to, you know, buy
12 stock through the pandemic. And issues emerged in
13 May -- or where there were problems, it is why the teams
14 took action to respond to what was going on, on the
15 ground. And clearly it's why, you know, lessons being
16 learnt now, which is a-- the work to enable the
17 employment -- the electronic staff records to record
18 what the preference is for individual members of staff,
19 to look at how you can keep a rolling programme of
20 testing staff, as well as the research that is going on
21 or planned to look at, like, what alternatives there
22 are.
23 Q. Let's look to the future. It's crucial that NHS England
24 learns from the experiences of the pandemic to improve
25 its procurement processes. I'm sure you'll agree with

1 that. Yes?
2 A. Well, it's -- I mean, yes, NHS England, yes, what we
3 have learned that I discussed earlier with the supply
4 chain, and yes for the responsibilities that the
5 department and others still hold.
6 Q. Right. So the development and implementation of a fit
7 testing algorithm indicates a move towards addressing
8 some of the challenges faced during the pandemic.
9 However, ensuring that these improvements are sustained,
10 and that inclusivity remains a core consideration in the
11 procurement strategies, you would agree that that's
12 essential for future preparedness.
13 So, at paragraphs 248 and 249 of your witness
14 statement, the publication of a fit testing algorithm
15 and processes by NHS England, looking forward, help us
16 with this: what long-term reforms are planned to ensure
17 that inclusivity is fundamentally integrated into the
18 procurement processes, particularly concerned concerning
19 the needs of ethnic minority healthcare workers?
20 A. So the things I just said, which is the lessons from the
21 pandemic to make sure that the stockpile that we now
22 have or is planned for the future has as broad a range
23 of relevant masks as are necessary, the work that's
24 already been done to automate the electronic staff
25 records so it is possible to actually log individual

1 staff preferences, the work I just spoke about, which is
2 how do you have a sort of rolling programme of
3 fit testing and training the trainers. And the
4 research, that I cannot remember if it is planned or
5 already under way, to look at what alternatives are
6 there for individuals where an FFP3 mask might never
7 work, for example the use of powered hoods and other
8 bits of equipment.
9 **PROFESSOR THOMAS:** Thank you, Mr Kelly.
10 **LADY HALLETT:** Thank you, Mr Thomas.
11 Those are all the questions that we have for you,
12 Mr Kelly.
13 As I said to Dame Emily, I do understand that this
14 is a difficult week for you, so thank you very much for
15 taking the time to come to help us and for your written
16 statement.
17 **THE WITNESS:** I appreciate it, thank you.
18 **LADY HALLETT:** Thank you.
19 Could you pause, please. Sorry.
20 **MR ALAN BRACE (sworn)**
21 **LADY HALLETT:** Sorry you've been kept waiting for so long,
22 Mr Brace.
23 **THE WITNESS:** Not a problem.
24 **LADY HALLETT:** You're the last witness but certainly not the
25 least, today.

1 Questions from COUNSEL TO THE INQUIRY
2 **MS SHEHADEH:** Could you state your full name, please.
3 A. Yeah, Alan Brace.
4 Q. Thank you, you have provided the Inquiry with a witness
5 statement dated 9 December 2024. And it is
6 INQ000527571.
7 Can I ask you, are the contents of that witness
8 statement true to the best of your knowledge and belief?
9 A. Yes, they are.
10 Q. Thank you.
11 You were the Director of Finance of the Health and
12 Social Services Group in Welsh Government during the
13 pandemic; is that right?
14 A. Yes, that's correct.
15 Q. And prior to that, you have held a number of senior
16 leadership roles within the NHS in Wales --
17 A. Yes.
18 Q. -- and also within Welsh Government. So I'd like to
19 really focus on the work that you did during the
20 pandemic, and you were in fact asked to chair the
21 PPE Sourcing and Distribution Group between June and
22 September 2020, were you not?
23 A. Yeah, I was approached around about 23 March by
24 Dr Andrew Goodall, who was director general. Basically
25 there were growing concerns around PPE at the Welsh

1 Government NHS social care ministerial level. So Andrew
2 asked me to take a leadership role on behalf of the --
3 on behalf of himself, really, and to focus on the
4 sourcing of PPE, any storage issues, but also
5 distribution at that time.
6 There were two main challenges: buying replacement
7 product and distributing the product that we had.
8 Q. And were you doing this as well as shouldering your
9 responsibilities for finance for the NHS in Wales?
10 A. Yeah, I kept on with all of my responsibilities as
11 Director of Finance and got involved in things like the
12 field hospitals taking over private hospitals. So there
13 was a fairly significant component to the other part of
14 my job.
15 Q. And you reported to the Director General of the Health
16 and Social Services Group, or chief executive of NHS in
17 Wales, so that would have been Dr Andrew Goodall at the
18 time; is that right?
19 A. That's correct.
20 Q. You've described your role during in the pandemic as
21 providing a bridge between Welsh Government and the NHS
22 in Wales to ensure coordination and communication across
23 Welsh Government. On a day-to-day basis, what did that
24 look like?
25 A. There was probably two phases for me for the time I was

1 involved in the -- in PPE particularly. The first phase
2 was probably March, April and May, which was really all
3 about stabilising the position we found ourselves in
4 both on the distribution front to health and social
5 care, but also on the replenishment front around how we
6 would replenish the stock that was quickly depleting,
7 and I didn't really have any time, or inclination
8 really, to set up any new groups then. I was outside
9 the planning and response structure. There was
10 a countermeasures group who was involved in the release
11 of the PIPP stockpile.
12 So my focus in that period was just to stabilise
13 both the distribution and the replenishment. As that
14 became more stable, I then established two main groups:
15 the sourcing and distribution group, which was to not
16 just keep things stable, to start to build resilience
17 and to think about planning ahead, particularly for the
18 winter.
19 I also set up a policy and modelling group, to start
20 to have a look ahead around any changes to guidance and
21 what that could look like in relation to volumes.
22 I was also running, for a lot of that period,
23 a weekly meeting with the PPE leads from every health
24 board in Wales, and sitting alongside that I also had
25 a weekly meeting with the directors of finance for the

1 NHS in Wales, who in Wales are also directors of
2 procurement. So there was a crossover on some issues,
3 I think, where I needed perhaps more sort of involvement
4 with a procurement hat on. I use that sort of structure
5 as well.
6 Q. Thank you.
7 I'd like to turn to the relationship between the NHS
8 in Wales, the Health and Social Services Group, and
9 NWSSP. NWSSP is the NHS Wales Shared Services
10 Partnership; is that right?
11 A. That's correct.
12 Q. And it is the organisation that procures goods and
13 services for use across the NHS in Wales?
14 A. Yeah, and it also is responsible for storage and
15 distribution of goods, as well. So it's the sourcing,
16 storage and distribution organisation for the NHS in
17 Wales.
18 Q. And is it correct that the NWSSP provided almost all of
19 the medical consumables needed within the NHS in Wales
20 on a day-to-day basis?
21 A. Yes, that was the basis of the shared service.
22 Q. Health boards and trusts occasionally bought from other
23 sources. They were free to do so. Is that right?
24 A. It was probably very limited. Each of the local health
25 boards would also have a small procurement team that was

1 also employed by the shared service. So they were
2 literally outposted in LHBs and trusts, and if they felt
3 that there was probably more of a need for a local
4 procurement they would handle that on behalf of Shared
5 Services but within the NHS bodies.
6 Q. And broadly speaking, prior to the pandemic, NWSSP's
7 remit did not include provision to social care or to
8 GPs, dentists, pharmacies, community healthcare
9 providers; is that correct?
10 A. That's correct.
11 Q. Yes. And how would you describe the relationship
12 between NWSSP and the Health and Social Services Group
13 or Welsh Government, organisationally?
14 A. Organisationally, very close. There were certainly
15 elements that Welsh Government also had a relationship
16 with Shared Services on, particularly expert advice on
17 capital, building programmes and development, and also
18 there was an SLA in place for the PIPP stock that Welsh
19 Government was responsible for.
20 Q. Sorry, to stop you there. SLA, service level agreement;
21 is that right?
22 A. Yes, service level agreement. Sorry.
23 Q. Sorry, do carry on.
24 A. Generally most of the relationship was between Shared
25 Service and the local health boards and the NHS trusts.

1 There was a committee. Welsh Government were
2 represented on that committee. My deputy sat on that
3 committee, which really just picked up any issues that
4 were relevant for the Health and Social Services Group,
5 and a coordination, and information exchange function.
6 Q. Thank you. I'm going to turn to the Welsh share of the
7 PIPP stockpile, if I may. You tell us in your statement
8 that the Wales share of the UK health countermeasures
9 stockpile was 4.78% based on the Barnett formula, and
10 the administration of the stockpile was delegated to
11 NWSSP, as you've just told us, through an SLA. Was
12 NWSSP ultimately responsible for the storage and then
13 onwards distribution of the stock in the PIPP stockpile?
14 A. Yes, I think the plans that were in place, there was
15 a countermeasures group put in place to oversee the
16 release of the PIPP stockpile to the NHS.
17 Q. And did the Health and Social Services Group, or Welsh
18 Government more broadly, monitor the stockpile prior to
19 the arrival of the pandemic to ensure that it was fit
20 for purpose?
21 A. That would have been the responsibility of NWSSP unless
22 there were any issues that they needed a different
23 decision made by Welsh Government, basically.
24 Q. Can we please display INQ000298983.
25 This is the ministerial advice provided to

1 Vaughan Gething who was in post as Minister for Health
2 and Social Services at this point. And this ministerial
3 advice asks him to agree to the release of the Welsh
4 share of the PIPP stockpile.
5 Could we turn to page 3 of that document, please.
6 There's a summary of what actions are taken by other
7 nations and then we come to Wales in the middle of the
8 page:
9 "... has a COVID-19 Health Countermeasures Group in
10 place, chaired by the Health Emergency Planning
11 Adviser", as you've just outlined to us, and "includes
12 key officials from Shared Services Procurement ..."
13 Is that NWSSP? Shared Services Procurement?
14 A. Yes.
15 Q. Effectively, through this structure, NWSSP is in the
16 process of making up distribution boxes of PPE for GP
17 sites across Wales.
18 And we have there a breakdown of what is going to be
19 distributed to GP surgeries in Wales.
20 So this is principally at this point in March,
21 6 March 2020, a request that NWSSP be permitted to push
22 out supplies of PPE to GP surgeries; is that right?
23 A. Yes, that's correct.
24 Q. Thank you. We can take that down.
25 Vaughan Gething has been frank with the Inquiry in

1 his witness statement regarding the stockpile itself.
2 Can we have up INQ000536418, thank you.
3 Paragraph 104 of his witness statement. He tells us
4 he encountered issues regarding distribution from the
5 stockpile:
6 "The pandemic influenza stockpile of PPE was crucial
7 during the first four months of the Covid-19 response
8 but the key issues for us were how quickly the PPE
9 pandemic stockpile would be used up, how rapidly supply
10 chains would fail and frankly that a small amount of our
11 stockpile was not fit for purpose. However, having the
12 stockpile in place did buy time for the NHS Wales Shared
13 Services Partnership to successfully secure ongoing PPE
14 supplies from other sources."
15 Thank you.
16 Were you aware that there was, as he puts it,
17 a small amount of the stockpile that was not fit for
18 purpose?
19 A. Not at the time I got involved in PPE, but in one of the
20 meetings, I believe it was probably one of the trade
21 union discussions, an issue was raised around respirator
22 masks, what they call the FFP3, where a question was
23 raised about out-of-date stock, and Mr Mark Roscoe from
24 Shared Services responded to say that there was
25 out-of-date stock that had been re-tested, some of it

1 re-dated, but given the pressure on the stockpile, some
2 of it was sent out having been tested but with -- the
3 dates were out of date. And that was the only real
4 issue that I personally got, you know, picked up around
5 the issues with the stock.
6 The bigger issues for me was the speed that they
7 went out, and the basis that they were going out with.
8 As I described earlier, Shared Services not only
9 procured for the NHS but they stored and distributed,
10 and that was very much a pull system where the NHS would
11 ask for stock and it would go to the delivery point, who
12 had requested the stock. The countermeasures was very
13 much about a push system, and that created quite a bit
14 of confusion, I think, initially in the NHS and
15 obviously subsequently in social care.
16 Q. All right, we'll come to that shortly, but just
17 returning to the issue of the FFP3 respirators, were you
18 aware that in fact the Welsh share of FFP3 masks within
19 the stockpile had expired? Of that product, FFP3.
20 A. What I understood at the time was that stock had
21 expired, had been re-tested for suitability, redated,
22 but not all of the stock had been redated, and that was
23 the only sort of dealings that I had with -- about that
24 issue with the PIPP stockpile.
25 Q. All right. The NWSSP's remit was widened. It was

1 expanded to encompass the social care sector, and that
2 decision was made on 19 March 2020. Is that right?
3 A. That's correct, yeah.
4 Q. So that dramatically increased the NWSSP customer base,
5 effectively, and distribution targets, didn't it?
6 A. Yeah, it sort of bought two challenges, really. One was
7 greater pressure to replenish the stock, and the second
8 challenge was not an established distribution network,
9 that had to be sort of agreed quite quickly with the
10 local authorities in Wales.
11 Q. By 7 May 2020, around two-thirds of the social care
12 sector's needs were being met by NWSSP. Is that right?
13 A. That's correct, yes.
14 Q. In other words, the care sector was still making its own
15 arrangements to secure one-third of the PPE that it was
16 using day to day?
17 A. Yes, I understand that even after that date, there were
18 still ongoing procurement buy-in by parts of the social
19 care system in Wales.
20 Q. And so local authorities, largely, were having to carry
21 out procurement of PPE in relation to that PPE, to that
22 one-third that was not supplied by NWSSP; is that right?
23 A. Yes.
24 Q. And during that period, would you accept there was an
25 element of competition over the same types of items?

1 NWSSP was trying to source PPE, local authorities and
2 the care sector were trying to source PPE; they were
3 both after the same things, essentially?
4 A. Probably not to any great extent. I don't think the
5 local authorities -- as I understand it, it was some of
6 the elements of the social care system that was within
7 the private sector had made their own arrangements, but
8 I don't believe it was -- the local authorities didn't
9 collectively purchase PPE. They had spread their
10 procurement expertise quite thinly amongst the 22 local
11 authorities, so there was no central capacity or
12 capability to do very much in relation to PPE. So
13 that's why the shared service actually took over social
14 care.
15 Q. And it wasn't until October 2020 that NWSSP formally
16 confirmed it was going to be able to supply most of the
17 PPE needs of the social care sector; is that right?
18 A. It was a lot sooner than that, I think. The formal SLA
19 was probably signed later in the year, but I think from
20 19 March, when social care came under the shared
21 service, the objective was to supply all of social care
22 needs from the one source.
23 I think there was a slight delay around the formal
24 service level agreement but that was just more of an
25 administrative issue rather than anything to do with any

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1 delay in shared service trying to cover all of social
2 care.
3 Q. So the service level agreement was in place by
4 October 2020. When do you say in fact NWSSP was
5 supplying most of the needs, the PPE needs, of their
6 social care sector?
7 A. From memory I think we felt a lot more confident and
8 assured around the NHS by the end of April/beginning of
9 May. I think we probably felt a little bit more
10 confident and assured for social care through sort of
11 June and July. I think it was probably during that
12 period we started to feel that, with the volumes that we
13 were sourcing, with building resilience into our stock,
14 that we felt that we -- felt a little bit more confident
15 and assured.
16 There were individual items which remained
17 a constant challenge but I think generally through that
18 summer we felt more confident and we started to turn our
19 attention to the winter plan then to make sure we had
20 enough stock to get us through what felt like it was
21 going to be a difficult winter.
22 Q. All right. When you say you felt more confident and
23 assured, at what stage would you say the social care
24 sector was having the majority of its PPE in fact
25 supplied by NWSSP?

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1 A. I certainly believed by -- through the summer, we had
2 put that on a -- for those who needed it supplied by
3 Shared Services, I think we were then supplying.
4 I believe. From my understanding.
5 Q. And why was there such a delay between the announcement
6 on 19 March and the signing of the SLA in October?
7 A. I think at the time I was pretty much sort of working on
8 my own at a Welsh Government level with colleagues
9 around me. Shared Services was a smallish team,
10 actually, focused on, you know, sourcing material,
11 distributing material. There was no issue between local
12 authorities and Shared Services or Welsh Government on
13 the need to put it on a formal footing.
14 The thing that really sort of probably held it up
15 was more in the modelling and the data. I think local
16 authorities took quite a while to have an agreed
17 methodology across 22 local authorities that could feed
18 into a service level agreement that would form a more
19 formal basis of the type of volumes that were both
20 needed and also required to be sourced. So it was more
21 in the modelling and the data side rather than in any
22 intent or any disagreement on Shared Services continuing
23 in the role. I think the decision was made in 19 March.
24 All of us just really focused on dealing with health and
25 social care as one and the same thing.

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1 Q. You talked about modelling and data, perhaps we'll turn
2 to that now. You've addressed the social care sector.
3 Is it right that there were also real difficulties in
4 getting a clear picture of existing stocks within the
5 NHS state in Wales, stocks held by individual health
6 boards or indeed hospitals, and indeed their usage
7 rates? That was a challenge that you faced at the
8 outset of the pandemic; is that right?
9 A. I think that certainly was the situation in the last
10 part of March and up until the beginning of April when
11 we had asked the military to go in and assess what the
12 issues were, and they produced a report on 2 April which
13 was exceptionally helpful in highlighting the things we
14 needed to quickly put right.
15 So I think from the NHS side of things we certainly
16 had sort of got into a better position early April, and
17 because Shared Services had traditionally distributed
18 and stored items, you know, the systems weren't ideal
19 but we had a lot more data and a lot more intelligence
20 and insight into the NHS. We, I guess collectively, had
21 to sort of try and create that as quickly as we could
22 within social care.
23 Q. I think we have the report you're referring to dated
24 2 April 2020.
25 Can we have up on screen, please, INQ000299126.

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1 I'm very grateful indeed.
2 This is a report produced by the military, having
3 conducted review into the distribution and logistics
4 arrangements in place for PPE. Was this done at your
5 request?
6 A. Yes. When I took up the role in PPE, as I said, there
7 were sort of two main challenges. Could the
8 UK Government replenish stock? But the other one was
9 what I probably would say is a disconnect between Shared
10 Services believing that they had pushed out enough stock
11 to the NHS and before, I guess, I got involved, a lot of
12 issues being raised by the NHS, particularly with
13 Dr Andrew Goodall, I guess, saying that there was real
14 concerns around the availability.
15 So there was a slight disagreement, I guess, or
16 a disconnect between what Shared Service believed was
17 out in the NHS and what the NHS believed they had, and
18 we didn't really have any significant capacity or
19 capability to spend a lot of time on this. So the
20 military seemed to be an obvious choice to quickly try
21 and understand what the issues were.
22 And I guess they confirmed that there was enough
23 stock out there. They didn't encounter any of the
24 hospitals without stock, but because, I guess, they were
25 pushing the product out, there clearly was coordination

1 issues at the hospital end about what stock was held
2 where, and how to sort of distribute that as quickly as
3 possible across the various sites and hospitals within
4 the hospital.
5 Q. Can we go to pages 3 and 4 of that document, please. Go
6 to page 3 first. At paragraph 11:
7 "The assessment is that the NHS Wales PPE
8 distribution system has sufficient capacity to meet
9 current demand."
10 So there was capacity, as you say, and resilience to
11 meet the likely increased demand, but there are certain
12 pinch points.
13 Examples are given.
14 "However, at current usage rates, NHS Wales SSP only
15 have four weeks of supply of PPE in storage, with no
16 clear idea of where and how the supply will be
17 replenished."
18 So there may have been PPE within actual hospital
19 buildings or care settings but the reality is, at this
20 point, there was the prospect of only having four weeks'
21 supply in storage; is that right?
22 A. Yeah, that was when I got involved, my -- I was
23 concerned about distribution but by far my biggest
24 concern was getting clarity and assurance from the
25 UK Government that they could fulfil their obligations

1 under the emergency plan, and that proved exceptionally
2 difficult. So I think at the 2 April, I was really
3 spending quite a lot of time there trying to get clarity
4 and assurance from Department of Health in England
5 around can they meet the needs because the stock was
6 diminishing more rapidly than we had anticipated, and we
7 really wanted to know, were they able to fulfil their
8 obligations or not?
9 So yeah, that statement was true, I think. There
10 was no assurance that stock, there was no guaranteed
11 dates or no guaranteed volumes about when we could
12 expect stock to arrive, and procurement was the
13 response, the plan for the PIPP stock was the
14 responsibility of the UK Government.
15 Q. We can take that down, thank you.
16 Can we just turn quickly, then, to your -- you had
17 a role in liaising with UK Government regarding PPE; is
18 that right?
19 A. Sorry, I think I missed that last bit.
20 Q. I'll speak up. You did personally carry out some work
21 liaising with UK Government regarding PPE.
22 Wales also took part in mutual aid arrangements
23 between the four nations of the UK, is that right?
24 A. Yes, that's right.
25 Q. Can you describe in brief terms what you think are the

1 most important lessons learned from that work that you
2 did liaising with UK central government regarding PPE,
3 both the stockpile and then PPE that was procured, and
4 mutual aid arrangements and the sharing of PPE between
5 nations.
6 A. Yeah, on the first point it was fairly obvious, you
7 know, and we probably were a very small coordinated type
8 team with a very centralised approach in Wales. I think
9 Scotland and Northern Ireland were probably the same.
10 England was quite fragmented and disjointed. You had
11 trusts procuring supply chain, you had NHS England, you
12 had the Department of Health. So it was really
13 difficult to be able to sort of talk to anybody and get
14 that sort of confidence, clarity and assurance about
15 what was going to get procured and when could we expect
16 it.
17 And that never really -- in that first phase, we
18 never got to a stage where we could get any confidence
19 or assurance so we quickly made the decision that we
20 would have to start sourcing ourselves. There was no
21 other option, the stock was going too quickly, and we
22 needed to sort of make sure the front line was protected
23 in health and social care.
24 Q. Is that why NWSSP was then tasked to take that on?
25 A. Yes, absolutely. The mutual aid question, I guess, is

1 slightly different.
2 There was very good, I guess, understanding,
3 cooperation around the need for mutual aid. The First
4 Minister and the Minister for Health, Vaughan Gething,
5 was hugely supportive of helping any other country that
6 we could. And we did put formal arrangements to start
7 sharing data, intelligence and where we could help, and
8 we probably had stronger relationships through
9 procurement networks with Northern Ireland and Scotland,
10 but the approach to mutual aid, once we got it on
11 a better footing, was actually very positive and
12 helpful. And we had some help from other countries and
13 we were -- we were -- actually were a net helper. We
14 managed to particularly give England quite substantial
15 amounts as a result of our sort of sourcing activities.
16 Q. You say you were a net helper. Wales provided more
17 items of PPE by way of mutual aid than it received from
18 others, didn't it?
19 A. Yes.
20 Q. Reflecting on your experiences during the pandemic, what
21 would your lessons learned be, if you were to give
22 advice as to how Wales could be better prepared, not
23 only for the procurement of PPE but you've alluded to
24 real issues around distribution, how Wales could be
25 better prepared for both of those challenges in the

1 future?
2 A. Yeah. I think the Wales Audit Office report I'd fully
3 agree with their insight and their recommendations,
4 their very helpful recommendations for the future, so
5 I won't sort of repeat those. And there are
6 certainly -- certainly improvements need to be made in
7 planning. But I've always believed that plans are great
8 but it's people that makes plans work, and we were
9 really fortunate in Wales to have some very experienced
10 procurement professionals sitting within an organisation
11 that had central responsibility for buying, storing,
12 distributing, and fairly sort of joined-up established
13 relationships, and I think they were critical,
14 particularly in that early phase of the pandemic.
15 The other thing which I think is really important,
16 and particularly for Wales, is something that I call
17 small country governance. One of the things that really
18 helped was, rather than adding to groups that were
19 probably too many and often conflicting, the ability to
20 get key people together really quickly, get a really
21 good handle on a problem, and then put in place actions
22 really quickly, and for that to sort of go quickly
23 through structures even up to the Minister to get
24 approval for something was actually quite fundamental
25 and important, I think, in our ability. And it's hard

1 to capture that, I think, in the usual formal approach
2 to emergency planning, because most people would say,
3 "Well, what does that look like as a plan?"
4 And I think probably for Wales, we could probably
5 put a lot more attention on sort of trying to capture
6 that in a slightly different way.
7 Then my last point, which I think remained a worry
8 or me, is the collapse of global -- we had understood
9 the just-in-time global supply chains probably for cost
10 reasons was the way to do things, and when they
11 collapsed, we had no resilience in our supply chain.
12 And I still worry for future pandemics how we build
13 resilience, because resilience comes at a cost, and
14 ideally, the most resilient approach is UK manufacturing
15 that we could probably rely on, but we're probably not
16 big enough to manufacture all our PPE needs, and there
17 would, I guess, need to be an understanding that at
18 times, public money would have to be used to write stock
19 off and to replenish stock that was out of date, and
20 that's always a challenge, I think, when there's
21 competing demands for public money.
22 The more you spend on pandemic responses, the more
23 resilient you probably are, particularly the supply
24 chain, and how you deal with sort of sourcing. But it's
25 a difficult juggling act.

1 So I think a debate around what does resilience
2 really look like, then, given the lessons that we
3 learned from this and given the lessons of PPE, I think
4 would be critical.
5 Q. There was an attempt in Wales to stimulate domestic
6 manufacture of PPE. I wonder whether you're able to
7 tell us how much of that capacity has been retained
8 post-pandemic?
9 A. I wouldn't know. I mean, I retired in June 2021 so
10 I wasn't around for how much was sort of kept on.
11 I mean, I know for certain, you know, the Royal Mint
12 made visors. I think that stopped. That was just
13 something to support the pandemic. And whereas that was
14 critical, it was never a huge part of meeting the
15 demands and the needs that was generated by the thing.
16 But I think -- I understand some aspects of it
17 continued, but I think some was definitely more of
18 a call to arms for companies to help produce, but with
19 a clear idea that they would stop at the end.
20 Q. And then in terms of recommendations going forward,
21 would you agree that the care sector in Wales should be
22 part of distribution plans for PPE from the outset?
23 A. Oh, yes, absolutely, I think one of the issues with
24 local authorities, is that there are 22 local
25 authorities in Wales which means procurement expertise

1 is often spread very thin. I think when the pandemic
2 hit, they started to create groups outside the main
3 planning thing, which I don't think helped, and their
4 more natural route was through to the Welsh Government
5 procurement team which weren't really doing anything on
6 procurement at all.
7 But equally, they had no central storage or
8 distribution capability, and I just think it would make
9 entire sense that for business as usual, social care is
10 dealt with by the Shared Service. I think for emergency
11 planning and pandemic response, that just -- it's
12 a scaling up of business as usual, rather than trying to
13 create things from new, which I think the lessons from
14 the pandemic are never do that, trying to create
15 organisational-type models, groups, can often add to the
16 problem -- not help.
17 **MS SHEHADEH:** Thank you, my Lady. Those are all my
18 questions.
19 **LADY HALLETT:** Thank you very much indeed.
20 Mr Weatherby has a couple of questions for you.
21 **Questions from MR WEATHERBY KC**
22 **MR WEATHERBY:** Very briefly indeed, Mr Brace.
23 I ask questions on behalf of Covid Bereaved Families
24 for Justice UK. Firstly, you note at paragraph 47 of
25 your statement that:

1 "The first meeting of the Covid-19 Planning and
2 Resource Group was held on 20 February 2020."
3 Given that it was a strategic group, and looking at
4 the state of preparedness, are you able to help us as to
5 why it wasn't in fact stood up before 20 February?
6 **A.** The planning and response structure that was put in
7 place in February was much more of a government service
8 joined-up structure. So there was -- the NHS were
9 represented on --
10 **Q.** Yes.
11 **A.** -- there was a subgroup of Welsh Local Government
12 Association, directors of Social Services, and Welsh
13 Government officials, so it was very much to quickly
14 connect up what was happening at a government level with
15 what was happening operationally. So I think it was
16 much more than a strategic --
17 **Q.** Yes.
18 **A.** -- it was more of a practical "what are the problems,
19 how do we deal with them" structure.
20 **Q.** Yes.
21 **A.** And I'm not sure -- I wasn't -- I never sat in that
22 structure, actually, in my roles --
23 **Q.** Right, would you agree that it might have been
24 preferable had it been set up earlier, given its role?
25 **A.** Certainly for all aspects of the pandemic, speed was

1 important.
2 **Q.** Sure. Now, my other point, I was going to pick up the
3 point you'd made already, that the NHS Wales Shared
4 Services Partnership was expanded to procure and supply
5 PPE for social care settings only on 19 March, and I was
6 going to ask you whether you agree that it should have
7 been set up earlier but I think you've probably answered
8 that by saying that you think it should do so as
9 business as usual?
10 **A.** Yeah, I think the only additional point would make
11 is that when you look at the countermeasures group and
12 the social care subgroup, PPE was getting flagged
13 earlier than that. And I think around 9 March the
14 countermeasures group actually advised the minister
15 that, where possible, the local health boards should
16 help out social care because they seemed to be having
17 emerging difficulties.
18 **Q.** Right. But going forward, your recommendation is it
19 should simply be dealt with as, throughout, business as
20 usual, never mind in an emergency?
21 **A.** Yes, and you've got a much stronger foundation then to
22 deal with both health and social care collectively.
23 **MR WEATHERBY:** Thank you very much.
24 **LADY HALLETT:** Thank you very much, Mr Weatherby.
25 Ms Parsons, who is over that way.

1 **MS PARSONS:** [microphone not on]
2 **THE WITNESS:** That's a little bit quiet but that may be
3 probably because I'm probably slightly deaf.
4 **LADY HALLETT:** No, it's quiet for me too. Try again.
5 **MS PARSONS:** Is that better?
6 **THE WITNESS:** Yes, that's much better.
7 **Questions from MS PARSONS**
8 **MS PARSONS:** Good afternoon, Mr Brace. I ask questions on
9 behalf of Covid-19 Bereaved Families for Justice Cymru.
10 Just one, possibly two, topics. Firstly, please,
11 modelling and distribution of PPE.
12 You say in your statement that with the help of
13 modelling, by late April 2020, you achieved, and
14 I quote, "a clear burn rate picture across all key
15 categories of PPE".
16 That's paragraph 75, Mr Brace.
17 Then you explain, just a few paragraphs later, that
18 burn rate means days remaining of PPE. Do you recall
19 that part of your statement?
20 **A.** Yes, I think the burn rate probably means two things.
21 It was the rate that stock was getting used up, as well
22 as sort of what stock we had left, you know. One of the
23 two key pieces of data, that certainly I was interested
24 in, was how quickly we were using the thing,
25 particularly as guidance was changing, but what that

1 meant in terms of stock held and then how quickly we had
2 to replenish and how much more we had to do to
3 replenish.
4 **Q.** I understand that. And as far as you were aware,
5 Mr Brace, did Wales ever run out of PPE at a national
6 level?
7 **A.** Not at any time from my involvement was I aware that we
8 had run out. The military on 2 April said that we
9 hadn't, but there were issues on distribution, and the
10 only other time, actually, probably late April, a call
11 came through to the ministerial team that one of the
12 care homes in one of the local authorities in Wales had
13 run out of PPE, and there was none available.
14 I contacted Mark Roscoe in Shared Services who said
15 that's very unusual because the joint equipment store
16 has been replenished.
17 He sent a van there and actually the joint equipment
18 store was complete with stock, but there were clearly
19 communication or distribution issues just between that
20 care home, the local authority, and the joint equipment
21 store.
22 So that was the only other occasion that, in my
23 dealings, it was raised with me that we were out of
24 stock.
25 **Q.** Thank you. And so to summarise that, what you're saying

1 is the only instance that you're aware of was in fact
2 a false alarm, because there was stock, it's just that
3 it hadn't been communicated?
4 **A.** Yes, absolutely.
5 **Q.** Right. Members of the group who I represent, Mr Brace,
6 witnessed real shortages of PPE and inadequate PPE.
7 They I did so, Mr Brace, in every healthcare setting,
8 hospitals, hospices, care homes, and for them, I'm
9 afraid, they would have felt neither confident nor
10 assured that those who were caring for their loved ones
11 had what they needed.
12 Now, my question is this: from your position as
13 chair of the PPE Sourcing and Distribution Group, can
14 you explain, please, or help us understand why, if Wales
15 never ran out of PPE at a national level, problems were
16 so evident at a local level?
17 **A.** Yeah. And look, could I, not for any sort of effect at
18 all, but my dad died in a care home in April 2020 in
19 Wales so this one, I've grappled with ever since I was
20 involved with PPE. And I think there were sort of two
21 issues. I think guidance and the change in guidance,
22 I think, caused a lot of tension at the direct service
23 end around what PPE was required and did we have the
24 right mix of PPE. So that was definitely an issue.
25 And I certainly understood, before taking up PPE,

1 that there were concerns raised with Dr Andrew Goodall
2 and others around there not being PPE.
3 The only assurance that I could take was the
4 military had said, "Look, we've checked this, and it
5 is", but there are all of those tensions that I just
6 described.
7 I think social care, given sort of the need to
8 really sort of knit together something a lot more
9 central, and to build some central insight and
10 intelligence, I would not sort of really want to comment
11 about sort of every instance of where that was felt in
12 social care.
13 **Q.** Just this, before I end, Mr Brace: I think you referred
14 to coordination issues at the hospital end about what
15 stock was held and where across sites and within
16 hospitals. So moving away from the care sector to the
17 hospital sector.
18 Mr Brace, this conjures up images of stocks of
19 aprons, FFP3 masks, gloves being stashed in a cupboard
20 somewhere and overlooked by hospital staff. Is that
21 what you intended to convey, or was it something else
22 when you talked about that disconnect?
23 **A.** No, absolutely not, and very early on I met with all of
24 the PPE leads weekly, but we were in conversation daily,
25 and they always were able to assure me that there was

1 enough stock in all of their locations, apart, as
2 I said, from -- I took over about 23 March, so
3 I certainly understood that there were concerns before
4 I took over.
5 After I took over, those concerns never came to sort
6 of any of the groups that I was on or to my personal
7 attention, that there were still issues where -- it
8 certainly wasn't stock stuffed in cupboards. I think
9 every hospital has got a central receipt and
10 distribution point that then distributes stuff to wards.
11 So there would have been stock in receipt and
12 distribution points and I guess the challenge was how
13 was that -- how quickly. And a feeling, I think, among
14 staff, as the guidance was changing, was it the right
15 PPE? So they may have felt they were out of PPE but
16 they were out of a certain type of PPE.
17 **Q.** Lastly this, if I may, just to end, the Inquiry heard
18 yesterday, Mr Brace, evidence from a supply chain expert
19 called Professor Manners-Bell, and he said this:
20 "... not getting [goods or] PPE to the right place
21 means a critical supply chain failure. You [might as
22 well not] have bothered to have had those goods in the
23 first place if you're not able to get them to where
24 they're needed at the right time, to the right people."
25 And in respect of that, Mr Brace, do you agree, and

1 was it a failure in supply chain that members of the
2 group witnessed during the pandemic in Wales?
3 **A.** The big issue that I guess confronted me straight away
4 was the emergency planning was based on a push system,
5 so you just pushed out standard packs to the NHS as an
6 example, and therefore, the NHS had to adapt between
7 where that stock was and then distribute, which wasn't
8 how they would normally operate with the Shared Service.
9 So I think that was absolutely one of the early
10 problems, and one of the lessons for the future is, you
11 know, going against a normal way of working was far from
12 helpful.
13 **LADY HALLETT:** Thank you very much.
14 **MS PARSONS:** Mr Brace, thank you.
15 **LADY HALLETT:** Thank you very much indeed, Mr Brace. It
16 must have been really difficult for you to lose your
17 father when you were trying to cope with so many
18 different tasks. I lost count of how many hats you were
19 wearing, but I'm really sorry to hear that he died in
20 a care home.
21 So thank you very much indeed for all that you tried
22 to do during the pandemic and for all the help you have
23 given to the Inquiry. And a safe journey back to Wales.
24 **THE WITNESS:** Thank you, my Lady.
25 **LADY HALLETT:** Very well, I shall return at 10.00 tomorrow.

1 **(4.33 pm)**
2 **(The hearing adjourned until 10.00 am the following day)**
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