Witness Name: Lord James Bethell
Statement No.: 2
Exhibits: [LB2/1 – LB2/159]
Dated: 20 December 2024

UK COVID-19 INQUIRY

SECOND WITNESS STATEMENT OF LORD JAMES BETHELL

I, LORD JAMES BETHELL, will say as follows: -

Introduction

1. I make this statement in response to a request from the UK COVID-19 Inquiry (the Inquiry) dated 7 May 2024 under Rule 9 of the Inquiry Rules 2006, asking for a draft witness statement for Module 5 of the Inquiry (ref: M5/Bethell/01) (the Rule 9 Request).

2. I will necessarily focus on events that occurred during my time as Minister for Technology, Innovation and Life Sciences as these fall more squarely within the scope of this module. I have included events from 1 January 2020 to 28 June 2022 where relevant, but this statement will centre on the period of my appointment, so between 9 March 2020 and 17 September 2021.

3. I confirm that this statement is from my own recollection of events, but I should note that I have had the benefit of reading the draft corporate statements for this module from the Department of Health and Social Care (DHSC). I have drawn from and expanded on their content, where relevant. For Section One, I have also drawn from relevant content from my statement to the Inquiry for Module Four, submitted in draft on 14 June 2024.

Opening Remarks

4. I think it important to set out my overarching sentiments from the time as it is easy to forget the pressures that we were under. I will never forget, after the World Health Organisation had declared COVID-19 a global pandemic, speaking to the Leader of

the House and resolving that we would keep Parliament open. These were extraordinary times. I was standing up in Parliament every day listening to parliamentarians calling for action, referring to stories they had heard of desperate frontline workers. Everyone was demanding that something, anything be done to procure new PPE.

5. With regard to PPE, I was frustrated that there was a global breakdown in the supply chains and production capacity for PPE, and I was hugely frustrated that our normal procurement system did not seem capable of securing the vast volumes that we needed so quickly. Matters were made worse by the slow development in understanding that COVID-19 could be transmitted by a person showing no symptoms at all (asymptomatic) or with very limited symptoms (pauci-symptomatic). This made worse the unexpected nature of the demand for PPE. And we should also remember that at the beginning of the pandemic our knowledge of how this new virus transmitted was very poor. It would be a mistake to under-estimate the pressures on the system to find vast quantities of PPE, at an urgent rate and in competition with the major economies of the world.

6. Having had time to reflect on the question of the system of procurement in our healthcare system, it is clear to me that it had become increasingly optimised for cost and waste-minimisation but not built for flexibility and for resilience. I believe that was a serious mistake. Britain was not the only country to make this mistake. Given the way that the procurement system let us down, I believe we did as well as could be expected to procure the stock that we so desperately needed.

7. On diagnostics, I hugely regret that we had not invested in the sort adequate population diagnostics capability for the pandemic that hit us. It is all very well being good at forensic pathology and public health investigations, but modern public health requires population-wide platforms for engagement such as mass tracing systems. This is true in the management of modern population health – we should have had better diagnostics, screening and tracing capability for supporting day-to-day public health. But this is particularly true when dealing with an airborne pandemic. This one of the lessons we should have learned from SARS. This was a long-term strategic mistake. It cost us heavily. We were not the only country that made such a mistake, and in the circumstances, given the poor start, the UK did as well as could have been expected. This is one of the most important lessons from the pandemic.

SECTION ONE: OVERVEW OF MY ROLE AND CORPORATE STRUCTURES

Overview of my role as Parliamentary Under Secretary of State for Technology, Innovation and Life Sciences

8. I had entered Government as a whip in the House of Lords in mid-2019 and responsibilities included the Home Office and DHSC. It was working as a whip with responsibility for DHSC that gave me my first insight into what became the Pandemic. I can recall the Chief Medical Officer (CMO), Sir Chris Whitty, commenting that there is "this thing that we're all keeping a close eye on". By mid-January 2020 those of us in DHSC could see the growing threat and had started to react.

9. On 9 March 2020, I was appointed as Parliamentary Under Secretary of State for Technology, Innovation and Life Sciences (PS(I)). Further to my legislative business in the Upper House, my portfolio, which evolved to incorporate further COVID-19 related business (LB2/1 - INQ000486281) (LB2/2 - **INQ000327961**), included the following:
    a) COVID-19
        i. Supply (medicines and testing)
        i. Treatments and vaccines
        ii. Long term health impacts
        iii. Test and trace: testing, trace, technology
    b) Research and life sciences
        i. Science and Research & Development
        ii. Genomics, genetics, regenerative medicine
        iii. Accelerated Access Collaborative
        iv. NHS Test Beds
        v. National Institute for Health and Care Research (NIHR) Overseas Development Assistance Budget
    c) Anti-Microbial Resistance (AMR)/Global health security
        i. AMR
        ii. Global Health Security
    d) International Diplomacy and Relations
        i. Multilateral events (G7, G20 and WHO)
        ii. Foreign and Commonwealth Office-led international funds
    e) Data and Technology
        i. NHS IT
        ii. Data to support innovation

f) Medicines
    i. Regulation
    ii. Pharmaceutical Price Regulation Scheme
    iii. Uptake of new drugs and med tech, including Adaptive Licensing and Early Access
    iv. Cancer Drugs Fund
    v. Complementary and Alternative Medicine
    vi. Prescription charging
    vii. Specialised commissioning policy
g) Rare diseases
h) NHS Security Management incl. cyber security
i) Blood and transplants, organ donation
    i. Health ethics
    ii. Fertility and embryology

10. In delivering effective relationships between DHSC and its Arm's Length Bodies (ALBs), I had sponsorship of a number of bodies, including: NHS Blood and Transplant (NHSBT), Human Tissue Authority (HTA), the Human Fertilisation and Embryology Authority (HFEA), The Medicines and Healthcare products Regulatory Agency (MHRA), National Institute for Health and Care Excellence (NICE), NHS Digital (NHSD), Health Research Authority (HRA), the then joint organisation for digital, data and technology NHSX, and NHS Business Services Authority (BSA).

11. My priorities developed as the pandemic progressed and were revised in July 2020 (LB2/3 - INQ000486334) (LB2/4 - INQ000486335), which I summarise as follows:
    a) Offering mass testing for community and the workplace;
    b) Accelerating development of effective vaccines and therapeutic;
    c) Working with MHRA to navigate three big challenges: EU Exit; the Cumberlege Review (LB2/5 - INQ000486333); and COVID-19;
    d) Working with NICE to deliver 'Nice Connect', their vision for delivering guidance in user friendly pathway;
    e) Working with HFEA to ensure continued high quality and uniform care for those receiving fertility treatment;
    f) Working with HRA to encourage research that helps us to manage the spread of the virus as well as being at the forefront of the next pandemic;

g) Working to increase public confidence in NHS and HMG Health policy at a local and national level measured via robust research, especially targeting hard to reach groups;
h) Working on appointments to positions filled during first round along with the list of interested and inspiring candidates for future positions;
i) International leadership role (working with like-minded countries to improve WHO response, sharing best practice via roundtables);
j) Initiating key changes to make recruiting volunteers for clinical trials simpler;
k) Creating a data hub using the data that was already being procured, through the daily morning dashboard of positive cases, for example, to create visibility across the system to understand what is needed and where when making a central purchase for distribution;
l) Setting a sustainable and ambitious course for the life sciences industry – pharma, biotech, MedTech, digital and diagnostics which, in the area of manufacture of key healthcare equipment and supplies, meant addressing known bottlenecks to the manufacturing process, in particular the UK's ability to scale up at pace, which was an early identified weakness.

My role and responsibilities: the procurement of key healthcare equipment and supplies

12. One of the roles of Minister for Technology, Innovation and Life Sciences is to act as a liaison between industry and the Government. Although my ministerial responsibilities largely centred around testing (LB2/6 - INQ000497422), I was often brought in to engage with industry and energise their support for the national response and to encourage the private sector to come forward with their best ideas and resources. The Government needed the additional support from industry to help buy time before the vaccine arrived, this necessarily included areas such as diagnostics, hospital capacity, border control, therapeutics, PPE and ventilators. My approach was to find out what we (the Government) could do to help industry to help us in fighting the pandemic. This could take the form of: hosting roundtables; fielding senior-level calls from industry; reaching into other parts of Government to engage their networks and capabilities (e.g., the Department for International Trade (DIT) for sourcing materials from East Asia); one-to-one contact with industry leaders; unblocking regulatory and procedural bottlenecks; or handling general angst and concerns.

13. Central to the work of the Office for Life Sciences was engagement with industry. This was done both directly with businesses as well as through boards and associations

and sometimes a combination of the two. There were systems through which I would engage directly with long established contacts of the Office. One such system was through the Life Science Industrial Strategy Implementation Board (LSISIB), chaired jointly by government and industry. It has representation from across government, the NHS, industry and the charity sector. It meets quarterly to review progress on sector deal commitments and to consider wide implementation of the Life Science Industry Strategy, a sector-led document written with the help of the Board which made recommendations to Government on ways to ensure the UK remains a top-tier global hub for clinical research and medical innovation.

14. As an example of this more centralised engagement with industry, on 31 March 2020, I attended an LSISIB meeting with representatives from Other Governmental Departments (OGDs) and a number of industry associations such as: the Innovate UK Medical Research Council; the BioIndustry Association (BIA); the Association of the British Pharmaceutical Industry (ABPI); the Association of the British HealthTech Industries (ABHI); and representatives from companies such as Astrazeneca, Johnson & Johnson, and GlaxoSmithKline. We discussed the Life Sciences Industrial Strategy and focussed on the Government's response to COVID-19 and immediate issues facing the sector. I used the meeting to convey my thanks on behalf of the Government and express my enthusiasm to see such a response and cooperation from industry. I invited them to get in touch with me with ideas and appeals for help. I exhibit the agenda and minutes of the meeting as follows: (LB2/7 – INQ000528362 LB2/8 - INQ000528363) (LB2/9 - INQ000528364) (LB2/10 - INQ000528367).

15. I co-chaired the next meeting of the LSISIB with Professor Sir John Bell on 28 October 2020, for which I received a chair's brief, terms of reference, and full list of attendees (LB2/11 - INQ000528365 (LB2/12 - INQ000528366 . This meeting was focussed on delivering our Life Sciences Industrial Strategy, drawing on learning from the pandemic and the knowledge that being ambitious for our Life Sciences sector was more important than ever.

16. DHSC published details of all external ministerial meetings at the time, including the purpose for such meetings, in quarterly ministerial returns, which I exhibit as follows:
    a) January to March 2020 (LB2/13 - INQ000528372 ;
    b) April to June 2020 (LB2/14 - INQ000528371 ;
    c) July to September 2020 (LB2/15 - INQ000528369 ;
    d) October to December 2020 (LB2/16 - INQ000528374 ;

e) January to March 2021 (LB2/17 - INQ000528370);
f) April to June 2021 (LB2/18 - INQ000528373; and
g) July to September 2021 (LB2/19 - INQ000528368.

17. As can be seen from the exhibits above, I had a number of meetings in early 2020 with industry representatives on the subject of building up the UK diagnostics industry. At these meetings, a common focus point will have been the procurement of key healthcare equipment and supplies. Given the extent of the reach of the Office for Life Sciences with businesses both directly and through engagement boards and associations, I would be unable to provide an exhaustive list of businesses with whom I engaged directly on the subject but I would expect them all to be named in the above quarterly returns if I conducted any meeting with them where these substantive issues were discussed. Below, I have also provided and exhibit details on businesses with which I engaged directly in relation to the procurement of key healthcare equipment and supplies, some of whom I will have only engaged with via email, before passing on the referral to the relevant teams for triaging.

18. I do not believe 'sleeping contracts' would have a strong role to play in preparation for any future pandemic. The mothballing of laboratories to be used in an emergency, or the storage of large quantities of emergency PPE and other healthcare supplies, only works if you know which type of pandemic you are preparing for. Even with the resources to prepare for a whole variety of threats, you have to accept the wasted costs of those that never came to be needed. Such was the case with the Government preparing almost entirely for an influenza pandemic only to be confronted with the COVID-19 pandemic, which was caused by a coronavirus, on which the Inquiry has already heard evidence in Module 1. In my opinion, it is better to have the kind of ongoing relationships and regular engagement with industry as a base from which to build your emergency response. In my experience, the Office for Life Sciences had very good engagement with industry and for this reason. It was through such close and collaborative work with the private sector that we were able to identify the requisite industries that, with our support, could be stood up at pace to offer solutions to the crisis.

19. I provide a few further examples of my engagement with industry in relation to the procurement of key healthcare supplies below.

20. On 22 March 2020, I attended a meeting with representatives from GlaxoSmithKline (GSK), along with Lord Agnew, and colleagues from DHSC and CO. The meeting was to discuss a dedicated procurement team to be based at GSK headquarters described as the "Go Team". This would draw on their intelligence and market muscle to access the best suppliers to work in parallel and directed by the NHS procurement team, with a particular focus on ventilators, PPE, cardiovascular medicines and testing kits (LB2/20 - INQ000497105) (LB2/21 - INQ000497110). This kind of more general, collaborative engagement with the private sector continued throughout my role. I provide further examples below.

21. On 10 April 2020, I held a meeting with representatives from Roche for which I received a letter about the use of tocilizumab in the treatment of COVID-19 and the inclusion of the drug in various studies, including the UK-led REMAP-CAP and RECOVERY studies (LB2/22 - INQ000497143) (LB2/23 - **INQ000151731**) (LB2/24 - INQ000497145).

22. On 19 June 2020, I held a meeting between representatives from the Government, including the then Department for International Business (DIT) and the NHS, and representatives from Abbott. We received an update on Abbott's help with the testing regime, noting that they had provided over 600,000 PCR tests to date and were ramping up productivity and capacity in light of a contract to supply 5 million antibody tests to the UK each month. We discussed Abbott's scientific insight on diagnostics as I was particularly interested in their steer on the future of antibody testing (LB2/25 - INQ000497171).

23. At the end of January 2020, the Secretary of State for DHSC was in early discussions with Owen Paterson, who I understand was a paid consultant of Randox, about the possibility of producing COVID-19 PCR tests. I believe these discussions were welcome at the time given the fact that our domestic diagnostic capabilities were limited. Randox were a rare example of a large, experienced diagnostic company, based in the UK that might be able to produce the tests that we so desperately needed from their base in Northern Ireland. I remember that they were clear from the beginning that they were unsure if they would be able to make the kind of tests that we needed but were willing to explore the possibility. They suggested they could develop a test within weeks which they could test for accuracy with positive sputum samples, if we were able to provide these.

24. In the following months, DHSC officials entered into negotiations with Randox which resulted in the award of a contract on 30 March 2020 to supply around 2.7 million tests over a 12-week period. I was not involved in any contractual negotiations with Randox, leaving commercial discussions to the relevant teams within DHSC. I was, however, aware of and gave my authorisation for civil servants to proceed with negotiating the contract on 24 March 2020 (LB2/ 26 – INQ00000000). After consulting with the DHSC Accounting Officer on the value for money of the proposed contract, it was then signed by a deputy director from DHSC's commercial team. I set out all further involvement that I had with Randox below.

25. On 5 April 2020, a call was arranged between Dr Peter Fitzgerald (from Randox) and me to discuss general progress (LB2/27 - INQ000528296). Later that evening, I also received an update on an issue on which we were coming under political pressure to justify, in relation to the Randox home testing kits (LB2/28 - INQ000528297. This related to the fact that Randox test kits for home delivery were being sent to the Amazon distribution centre in Darlington before being distributed around the UK. This meant that those NI residents who received a home testing kit will have had their kit delivered to them via England. I was provided with a number of reasons why this would not affect NI residents' access to the kits as well as reasons for using Amazon, rather than waste time, resources and expertise by asking Randox to set up their own local distribution system from scratch.

26. On 9 April 2020 I had a call with representatives from Randox, which was also attended by Owen Paterson MP, to discuss the sourcing of lab equipment to support analysis of the samples (LB2/29 - INQ000528299). In the briefing note that preceded the call, I was told that as part of our original contract with Randox there was an agreement that we would help them source equipment if needed (LB2/30 - INQ000528298). I understand that several universities were contacted to request equipment loans for a number of suppliers, including Randox, and the necessary equipment was provided on loan.

27. On 24 April 2020, I joined a phone call with the Secretary of State for DHSC and representatives from key testing suppliers, including Dr Peter Fitzgerald from Randox, to thank them for their work and encourage their continued support and engagement (LB2/31 - INQ000528300) (LB2/32 - INQ000528301.

28. I am aware that on 19 May 2020, at a Government Commercial Function (GCF) daily briefing for testing, it was noted that we were having commercial and performance challenges with Randox (LB2/33 - INQ000563453). They were originally contracted to provide 60,000 testing kits per day and the associated laboratory capacity (with government support to source equipment, if required) to analyse all their own returned samples, based on an end-to-end, closed loop solution. On 4 May 2020 Randox informed us that 8 out of the 30 safety cabinets being used to store COVID-19 test swabs at their laboratory had malfunctioned. Prior to the issue with the safety cabinets, they had already reduced their forecasted capacity to 25,000 per day due to a shortage of laboratory equipment. The new issue with the safety cabinets reduced this capacity further to just 3,000 samples per day from 4 May 2020 onwards. As a result, by 5 May 2020, there was a further backlog of 19,000 samples, most of which had been sent or diverted to the Lighthouse laboratories in Milton Keynes, but approximately 1,100 samples had to be voided.

29. A submission that I received on 6 May 2020 sets out the ways that the operational problems were addressed (LB2/34 - INQ000528302 (LB2/35 - INQ000528303 , which I summarise as follows:
    a) An audit was to be carried out by Professor Dame Sue Hill (NHSE Chief Scientific Officer) into the Randox laboratory to provide assurance that Randox could continue to operate at their previous 17,000 per day capacity;
    b) NHSD to request that Randox bring their testing subjects into their portal, to support both the registration and issuing of results;
    c) The contractual position with Randox as to whether they would be able to meet their contractual obligation to deliver 2.7 million tests by the end of June was being considered;
    d) Randox were to contact all of those affected by the backlog who would have to wait more than 48 hours to apologies for the delay and further apologise to those whose tests had been voided.

30. In his response to the submission on 7 May 2020, the Secretary of State for DHSC agreed to the above recommendations except for the suggestion that Randox apologise to those whose tests had been voided, as communication had already happened (LB2/36 - INQ000528304 . He also suggested that I take forward the conversation with Randox *'about their long-term involvement in the testing programme and seeking assurances about resilience'*. I agreed to do so, suggesting a briefing from the team beforehand and a meeting with Owen Paterson MP beforehand.

31. I provide the briefing slides which I received for a telephone call with Randox on 13 May 2020 setting out the background to the commercial dispute and recommendations to support negotiations (LB2/37 - INQ000528305) (LB2/38 - INQ000534764). These are summarised as follows:
    a) Before Randox's operational issues had materialised, options were reviewed to address the imbalance between test kits supply and lab capacity and all recommended options were accepted but further contract changes were required to give effect to the full recommendations;
    b) A commercial dispute was ongoing in relation to payment over initial invoices and what these related to, with negotiations beginning on a new finance model to resolve the dispute;
    c) A number of requests were made to support the commercial negotiations, such as confirming that we would play no further role in requisitioning equipment for Randox labs. These were also summarised into key action points for my call with Randox in the email I received on 12 May 2020, dealing with the Secretary of State for DHSC's suggestion, which I summarise as follows:
        i. That Randox work with us constructively to get capacity up to 25k a day;
        ii. To break the commercial link between kit supply and the end-to-end process, so we can use them as a test kit supplier;
        iii. To break the closed loop offer and bring Randox into our network, so that they are not using their own digital system and results system.

32. Although I was involved in negotiations to support Randox in their operational issues and attempt to resolve performance challenges as set out above, I was not involved in any associated contractual negotiations. Where there were disputes about contractual performance and payment for services, these would have been managed and associated negotiations conducted by the appropriate DHSC officials. I am not aware of any dedicated contract manager being appointed, as suggested in the GCF slides referred to above, as such a decision would have been within the remit of the DHSC's commercial team.

33. During such a period of crisis, I sought to make the most of my ministerial influence and the network associated with my post to directly assist frontline efforts to source materials. For instance, by engaging with our embassies overseas, or by working with OGDs. When we received an offer of assistance, I wanted to support the process so

that we did not lose out on any help offered. As ministerial sponsor, I was often in the position of chivvying the system to move faster, and to act on a much larger scale. As the Inquiry has heard in previous modules, PHE was not fully prepared to deal with the scale and magnitude of the pandemic, and was, in my experience, slow to engage with the private sector at a time when massive expansion of testing capacity was necessary, where existing capacity was not scalable. At the time, I felt like I was pushing back on this approach and took the view that we needed to procure as much as we could, committing to purchase orders where necessary to ensure the industry had the necessary funds to expand their capacity.

34. By way of example of how I tried to make the system move faster and act on a much larger scale, I provide the summaries of talks I conducted at the end of March 2020 between the Chinese Embassy and decision makers from OGDs, such as the Cabinet Office (CO), DHSC and DIT, to encourage swift action in placing larger orders for testing kits with Chinese manufacturers identified by the Embassy Team in Beijing (LB2/39 - INQ000513306) (LB2/40 - INQ000497124) (LB2/41 - INQ000279753).

My role and responsibilities: NHS Test and Trace

35. As part of the build-up to the 'Operation Moonshot' mass testing programme, and NHS Test and Trace, into which it was later subsumed, I was involved in helping to set Government strategy in the scaling-up of UK testing capabilities. In March 2020, I produced a memo on how to industrialise UK testing where I set out the urgent steps to address the issues of limited availability and increase our testing capacity (LB2/42 - INQ000497126) (LB2/43 - INQ000497128). This was incorporated into a DHSC paper setting out the actions required for the scaling-up of testing shared at a meeting with the Prime Minister on 29 March 2020 (LB2/44 - INQ000497129).

36. A feature of the COVID-19 response was that ministerial responsibilities and priorities were updated on a regular basis. As set out above, my priorities were revised in July 2020 as the pandemic progressed. As far as I am aware there was no 'Minister for Test and Trace'. As part of my revised priorities in July 2020, however, I was asked to lead on a new 'strategic test and trace policy' (LB2/3 - INQ000486334). This was in collaboration with the Minister of State for Care, Helen Whately MP, on Joint Biosecurity Centre analysis and the Minister of State for Patient Safety, Suicide Prevention and Mental Health, Nadine Dorries on local infection control.

37. DHSC was responsible for setting overall test and trace strategy. As part of the DHSC, NHS Test and Trace was subject to DHSC's financial, information and staffing controls, but its chair, Baroness Dido Harding, appointed on 7 May 2020, reported directly to the Prime Minister and Cabinet Secretary, rather than to DHSC ministers or the Permanent Secretary. From 3 December 2020, NHS Test and Trace would report formally to DHSC, rather than the Prime Minister.

38. Where there was misalignment between DHSC and CO and HMT on their approach to spending controls, I sometimes took on an intermediary role. With the expansion of DHSC procurement during the pandemic came a greater need for collaborative mechanisms to draw on expertise of CO but also help DHSC respond at pace at the unfolding emergency. In my experience, however, there was often a lack of formal and thoughtful dialogue; we received a lot of push back from CO and HMT but did not always receive a detailed response with their refusals. It was very difficult to know what they were thinking and therefore how we could address their concerns. I had some intermittent engagement with Lord Agnew, who was Minister of State at CO and HMT at the time. He and I have known each other for many years and have a frank but respectful way of working together. I remember having informal discussions with him where I would listen to his concerns, which were often a reflection of wider view, and attempt to reassure him with reference to the extensive material already being provided by my colleagues.

39. HMT seemed to me to be making decisions without fully engaging in the information that had been given to them. There also seemed to be a resistance in central government to the idea of an impending second wave which resulted in a lack of clear decision-making. Protecting the taxpayer from fraud or waste and ensuring value for money was obviously extremely important but I do not think that was the issue. In any case, any hesitancy in the name of securing a good deal for the taxpayer was often counter-productive; leaving so many decisions to be made in haste, inevitably incurring additional cost. In future, I think there would need to be a fundamental overhaul of the capabilities and scope of CO to ensure that mechanisms were in place for reacting to emergencies. Without this, there is little appetite for engaging with the reality of the unfolding situation and applying the appropriate spending controls.

Key bodies and decision makers

40. I provide a summary of my working relationships with the following key figures and decision makers involved in matters within the scope of this module:

- Sir Christopher Wormald; Permanent Secretary and Principal Accounting Officer (PAO). We worked closely as he oversaw the DHSC response.
- David Williams; Director General (DG), Finance and Group Operations and Second Permanent Secretary. David was delegated sole Accounting Officer (AO) for the PPE Programme; he was my direct senior connection.
- Andy Brittain succeeded David Williams as DG for Finance in April 2021.
- Jonathan Marron; DG of Public Health and PPE. I had regular in contact and meetings with Jonathan, but not a direct report.
- Clara Swinson; DG for Global and Public Health (formally DG for Global Health and Health Protection). I had regular in contact and meetings with Clara, but not a direct report.
- Steve Oldfield; Chief Commercial Officer in DHSC. We had frequent direct interactions and I regarded Steve as the source of major commercial insight.
- The Rt Hon Matt Hancock MP; Secretary of State for Health and Social Care (10 July 2018 – 26 June 2021). We had frequent interactions, through my main three roles, (1) HOL handling, (2) departmental responsibilities and (3) political counsel.
- The Rt Hon Sajid Javid MP succeeded Matt Hancock on 26 June 2021.
- The Rt Hon Edward Argar MP; Minister of State for Health (10 September 2019 – 6 July 2022). Edward was an important ministerial colleague.
- Helen Whately MP; Minister of State for Social Care (14 February 2020 – 16 September 2021; 28 October 2022 - present). Helen was an important ministerial colleague.
- Jo Churchill; Parliamentary Under-Secretary of State for Public Health and Primary Care (26 July 2019 – 16 September 2021 – including Vaccines); Jo was an important ministerial colleague.
- Lord Agnew; Minister of State for Efficiency and Transformation (joint CO & HM Treasury) (from 14 Feb 2020 – 24 January 2022). Lord Agnew was an important ministerial colleague.
- Special Advisers with whom I regularly worked:
    i. Jamie Njoku-Goodwin (10 July 2018 – 20 September 2020);
    ii. Allan Nixon (8 October 2018 – 8 October 2021);
    iii. Emma Dean (2 September 2019 – 2 January 2022);

iv. Ed Taylor (21 March 2020 – 26 July 2020);
v. Damon Poole (1 September 2020 – 5 July 2022);
vi. Beatrice Timpson (9 November 2020 – 24 September 2021);
vii. Sam Coates (27 June 2021 – 5 July 2022).

- Other senior officials and contacts:
  - Emily Lawson; Head of PPE Programme (20 March 2020 – 9 November 2020. Following the departure of Emily, I was appointed to this role). I worked closely at the beginning of PPE problems, but less so later.
  - Lord Feldman; Unpaid Sourcing Advisor (24 March 2020 – 15 May 2020). We engaged regularly – he worked as an advisor to me and reported to me.
  - David Simmons; Director, Supply Resilience (1 June 2020 – Present); we engaged regularly in meetings.
  - Alex Sienkiewicz; Director of Public Health England. Alex was our main liaison point from Porton Down, the science and defence technology facility.
  - Beverley Jandziol; CO – procurement lead for testing.
  - Kathy Hall; Director of Digital Strategy and Transformation. Lead Director on COVID-19 Testing. Led work on disbandment of PHE and setting up OHID and UKHSA.
  - Sam Roberts; CO, Head of Open Data & Open Government (July 2020 – June 2022).
  - Alex Cooper; COVID-19 National Testing Programme – SRO (Pillars 2 & 3).
  - Sue Bishop; Deputy Director, COVID-19 Testing Programme.
  - Shirley Trundle; Programme Director, National Diagnostic Effort COVID-19.
- Key bodies with whom I engaged regularly (and key decision makers within):
  - The UK Health Security Agency (UKHSA)
  - Public Health England (PHE)
  - NHS England (NHSE)
  - MHRA
  - The NHS Business Services Authority (NHSBSA)
  - The Moral and Ethical Advisory Group (MEAG)

Key meetings

41. From 30 March 2020, and following a series of ad-hoc calls that I had been having with Steve Oldfield, bi-weekly supply chain meetings were scheduled between the two of us with the purpose of sharing live updates and issues and discussing our overarching approach to COVID-19 procurement (LB2/45 - INQ000497122). The content of these meetings covered a range of issues, some of which went beyond the scope of this Module, as with our meeting on 23 October 2020, where we discussed the National Institute for Health and Care Excellence (NICE)'s pricing model and the Voluntary Pricing and Access Scheme (VPAS) (LB2/46 - INQ000497175) (LB2/47 - INQ000497176).

42. I held a number of meetings in relation to the scaling up of the Government testing programmes where procurement was often part of discussions. These were divided into five workstreams which reflected the five pillars identified in the Government testing strategy published on 4 April 2020 (LB2/48 - INQ000106325), and summarised as follows:
    a) Pillar 1: Scaling up NHS swab testing for those with a medical need and, where possible, the most critical key workers;
    b) Pillar 2: Mass swab testing for critical key workers in the NHS, social care and other sectors;
    c) Pillar 3: Mass antibody testing to help determine if people have immunity;
    d) Pilar 4: Surveillance testing to learn more about the disease and help develop new tests and treatments;
    e) Pillar 5: Spearheading a Diagnostics National Effort to build a mass-testing capacity at a completely new scale.

43. I set out below examples of such meetings where procurement was discussed:
    a) Workstream 1:
        i. 23 March 2020: I held a deep dive meeting with representatives from BEIS, DHSC, NHSE, and PHE working on Workstream 1. A presentation was shared which set out the details of the programme to increase the PHE and NHS lab-based testing capacity from 5,000 to 25,000 per day (LB2/49 - INQ000497112) (LB2/50 - INQ000497113). A number of issues and actions outside of the scope of this module were identified. The need for ministerial engagement with Roche to secure additional testing kits was also discussed with a meeting to be set up between Steve Oldfield, Alex Sienkiewicz and me to discuss our ongoing relationship (LB2/51 - INQ000497114). This led to a meeting

between Alex and me on 17 March 2020 (LB/52 - INQ000497103), follow-up emails on the Roche/PHE partnership (LB2/53 - INQ000497120) (LB2/54 - INQ000508318), and a further meeting on 30 March 2020 (LB2/55 - INQ000508319).

ii. 3 April 2020: I held a stocktake meeting with representatives from BEIS, DHSC, NHSE, and PHE working on Workstream 1. A presentation was shared which set out a number of key challenges, including a shortage of swabs and other supplies. Addressing this, it sets out that a triage team had been established to manage 'offers'; an expert procurement group including industry representatives was to be set up; the lobbying of CEOs of main suppliers to increase UK allocation; exploring new supply routes; building relationships with smaller suppliers; and supporting domestic manufacturers to expand (LB2/56 - INQ000497134) (LB2/57 - INQ000497135) (LB2/58 - INQ000497136).

b) Workstream 2:

i. 26 March 2020: I held a deep dive meeting with representatives from BEIS, DHSC, and NHSE working on Workstream 2 to discuss coordination between workstreams. Much of the discussion centred around matters outside the scope of this module, like distribution (LB2/59 - INQ000497125). There was some discussion around procurement and supply, however, and a presentation was shared which set out a 9 day forecast of testing capacity by supplier (LB2/60 - INQ000497118) (LB2/61 - INQ000497119).

c) Workstream 3:

i. 26 March 2020: I held a deep dive meeting with representatives from BEIS, DHSC, and NHSE working on Workstream 3, as well as Professor Sir John Bell from Oxford University, to discuss the securing and supply of reliable antibody tests, as well as issues outside of the scope of this module, such as distribution and logistics. One of the items for discussion was the progress with procuring and assessing clinical validity of anti-body tests (LB2/62 - INQ000497115). A presentation was shared which set out the process for securing the supply of tests which included an expedited product triage process to identify the most reliable tests and buying those tests on bulk order, which then required validation before being rolled out as part of a national programme (LB2/63 - INQ000497117) (LB2/64 - INQ000508317). The triage team were told that emails that had been sent to Ministers would be flagged

when sending to ensure a swift response. I also reminded the teams to be *'open minded to all companies and people who approach at the first stage'* of procurement and ensure we were not taking a *'limited approach to tests'* (LB2/65 - INQ000497121).

44. From 8 April 2020, I attended regular meetings of the Testing Taskforce, which were chaired by the Secretary of State for DHSC and brought together other ministers, leaders and experts from across government, industry and academia and the wider healthcare sector. The terms of reference set out how the taskforce would help drive progress, unblock barriers and find creative solutions to deliver the UK COVID-19 Testing Strategy. It would coordinate its response under the five main pillars as set out above. Meetings were scheduled to take place three times a week, unless deemed unnecessary at the time by the SRO or Secretary of State (LB2/66 - INQ000497424).

45. While many of the meetings focussed on issues outside the scope of this module, such as logistics, procurement was often discussed. I therefore exhibit the readouts and accompanying material of the meetings that I attended below, and summarise any relevant issues discussed.
    a) 8 April 2020 (LB2/67 - INQ000497146) (LB2/68 - INQ000497142);
    b) 10 April 2020 (LB2/69 - INQ000497148);
    c) 15 April 2020 (LB2/70 - INQ000497151);
    d) 17 April 2020, where there was some discussion about sourcing new Abbot antibody and lateral flow tests and other procurement issues (LB2/71 - INQ000497154) (LB2/72 - INQ000497155) (LB2/73 - INQ000497156);
    e) 20 April 2020 (LB2/74 - INQ000497157) (LB2/75 - INQ000497158);
    f) 23 April 2020 (LB2/76 - INQ000497159);
    g) 27 April 2020 (LB2/77 - INQ000497160);
    h) 29 April 2020 (LB2/78 - INQ000497161) (LB2/79 - INQ000497162) (LB2/80 - INQ000497163);
    i) 4 May 2020, where a sourcing issue for PCR machines was raised with the prospect of assistance from Thermo Fisher (LB2/81 - INQ000497164) (LB2/82 - INQ000497165);
    j) 11 May 2020, where there were discussions about scaling up production and acquiring antibody tests from Roche (LB2/83 - INQ000497166) (LB2/84 - INQ000497167);
    k) 18 May 2020 (LB2/85 - INQ000497168);

l) 26 May 2020, which I co-chaired with Baroness Harding, and there was some discussion about the delivery of the Roche antibody tests (LB2/86 - INQ000497169);
m) On 28 May 2020, the decision was taken to pause the taskforce (LB2/87 - INQ000497170).

46. In April and May 2020, I attended regular meetings to discuss the trials and treatments supply, and received a routine updating paper, 'COVID-19 Trials and Treatments SitRep'. I exhibit these as follows:
    a) 24 April 2020 (LB2/88 - INQ000497465) (LB2/89 - INQ000497466);
    b) 8 May 2020 (LB2/90 - INQ000497467) (LB2/91 - INQ000497468) (LB2/92 - INQ000507129);
    c) 14 May 2020 (LB2/93 - INQ000497469) (LB2/94 - INQ000513020);
    d) 21 May 2020 (LB2/95 - INQ000497470) (LB2/96 - INQ000513021).

47. From 8 October 2020, I attended weekly Testing Supplier meetings where we discussed the status of suppliers that had been referred be tagged as 'VIP, 'Fast Track' or 'Priority', for the reasons I set out in further detail below. Prior to each meeting, a spreadsheet was shared which was updated on a daily basis with details on progress for those engaging with stakeholders, as explained in an email I received on 29 September 2020 attaching the latest version of the tracker (LB2/97 - INQ000497173) (LB2/98 - INQ000508344). Prior to the first Testing Supplier meeting on 8 October 2020, I received a new version of the tracker (LB2/99 - INQ000497174) (LB2/100 - INQ000508345). I attended further meetings on the following dates:
    a) 15 October 2020;
    b) 22 October 2020;
    c) 29 October 2020;
    d) 5 November 2020;
    e) 12 November 2020;
    f) 19 November 2020; and
    g) 26 November 2020.

SECTION TWO: HIGH PRIORITY LANE

Background: DHSC procurement

Pre-pandemic procurement

48. I think it important to set out, for context, the way in which the procurement model operated before the outbreak of COVID-19 as I believe it had a negative impact on our ability to procure vital supplies once there was a global breakdown in the supply chains.

49. To avoid the high storage costs and other issues associated with buying in bulk, such as product expiration or damaged and stolen stock, Just-In-Time (JIT) contracts operated on the principle that essential supplies and priority products were provided from suppliers only as they were needed. JIT contracts were planned to be used as a 'top-up' arrangement based on pre-determined costs and operational obligations from suppliers with capacity over and above the UK's business-as-usual needs.

50. I believe that the strategy of running low quantities of supplies, relying so heavily on production capacity in the far east and the arms-length bidding-out process, meant that we did not have the sort of long-term formal relationships with our suppliers you might expect. This approach had a particularly negative impact once there was a global breakdown in the supply chains.

The COVID-19 procurement programme

51. There were five 'pillars' within DHSC's procurement program: ventilators; testing; medicines; PPE and medical devices; and non-clinical goods and services. Procurement for each of these pillars was allocated between DHSC, NHS England & NHS Improvement, NHSX and CO. At paragraph 52 of the judgment of the 2021 judicial review case of *R(Good Law Project) v Secretary of State for Health and Social Care [2021]* EWHC 346 (Admin), a helpful summary of the scale of the COVID-19 procurement programme is provided which I set out below:

> *"These were not discretionary or long-term supply agreements, but predominantly contracts for vital products necessary to keep frontline health workers and the wider public safe and to treat those who were already infected. There were five "pillars" within the Department's procurement program: ventilators; testing; medicines; PPE and medical devices; and non-clinical goods and services. Responsibility for leading procurement on these pillars was allocated between senior leaders in the Department, NHS England & NHS Improvement, NHSX and Cabinet Office. Large numbers of additional personnel had to be brought in to support this work at very short notice. This included over 400 buyers from the Ministry of Defence and the Government Commercial Function to support the work procuring PPE alone. Test & Trace was launched on 28 May 2020 and now comprises some 3,987 civil servants and contingent workers, 307 of whom are*

members of the commercial team. The Department's core teams were involved in cross-cutting activities, such as demand forecasting, data reporting, supply engagement and contract/logistics support. All the various teams were also supported by number of external professional advisors brought in to provide additional assistance and expertise in the context of the crisis.

The High Priority Lane

52. I have been asked a number of questions about the 'High Priority Lane', which I take to mean the priority treatment of some referrals through the triage stage. The first thing to say is that, in my experience, high priority lanes, in some shape or form, have been a feature of the civil service in past responses to emergency situations. I am not aware of the existence of high priority lanes in the context of procurement specifically but where there is an acute interest in the Government response and some sort of prioritisation needs to take place, priority channels, such as dedicated inboxes or helplines, have often been created to manage the inevitable influx of requests for information or assistance. For instance, during the outbreak of the war in Ukraine, there was a high-priority lane for parliamentarians who were sponsoring refugees or somehow involved in the Homes for Ukrainians Scheme. There was an office in Portcullis House and dedicated email to help answer queries from parliamentarians about the processing of immigration papers.

53. For COVID-19 procurement, this was in operation in some form from the early stages of the pandemic and applied to referrals made within the range of all five pillars set out above.

54. I had nothing to do with the procurement of ventilators. As for PPE, I did visit Skipton House to speak with Emily Lawson, the CCO of NHSE who was on loan to DHSC as CCO for the Parallel Supply Chain and who was leading the PPE cell procurement operation. I very much took on board the need for leads for people who might be able supply PPE. However, the majority of my interaction with the COVID-19 procurement programme was in relation to the procurement of tests. As such, the focus of my answers to the questions posed will be largely on how offers for the provision of tests were treated by the relevant procurement teams. But as I did have some limited involvement with the procurement of PPE, and with the benefit of reading the corporate statements submitted to the Inquiry on behalf of DHSC, I set out a summary below of how the High Priority Lane operated within the context of PPE Procurement.

<u>COVID-19 PPE Priority Procurement</u>

55. As with any respiratory disease, whether airborne or touch or a combination, we were naturally focused on protective equipment from the outset. This was emphasised to ministers by the CMO's office and the NHS from the outset. Since the vector and style of transmission/communication was not clear for some time, we/PHE were constantly modelling the demand for PPE, the quantities needed bounced around a lot depending on the assumptions in the latest model.

56. In March 2020, there was increased media reporting on PPE alongside reports of supply chain distress being received with DHSC.

57. On 20 March 2020, the Prime Minister made calls for support directly with businesses and, in particular, manufacturers of PPE. Following these calls, a number of dedicated inboxes were set up for offers of help from businesses, in relation to PPE, ventilators and communication support (LB2/101 - INQ000497104).

58. On 10 April 2020, the Secretary of State for DHSC held an extraordinary press conference, issuing a call to the public to support the growing need for personal protective equipment (PPE). He stated, *"if you've got production facilities and you can meet our published technical specifications, we want to hear from you so we can make this kit here in Britain that will keep people safe."* (LB2/102 - INQ000478869).

59. A significant number of new suppliers responded, generating circa 26,000 new offers from potential suppliers. There were no restrictions on who could offer products. Any interest to supply could be registered by completing a questionnaire via a portal managed by CO. Each of these offers had to be processed, prioritised and progressed at pace by the cross-government PPE Cell to find products that were fit for purpose and commercially viable.

60. It is worth emphasising that many of these responses were either a duplication of the credentials of the same manufacturers, mainly in China, lacking bona fides or transparently fraudulent. There was considerable public and political pressure to identify the viable offers and respond to them quickly. A lot of time and energy was wasted, however, sifting through this dross; whole call-centres and processing units were stood up to handle this substantial workload, and we struggled to stay ahead of the flow of new offers. There were many genuine suppliers who felt that they could not get through, did not get a response or were not serviced to the level that they expected. Many of these had large volumes of PPE that was rapidly available. At a time of

national crisis, and in the context of news reports that responses to the public call for assistance were being ignored (LB2/103 - INQ000581858), those who were justifiably confident that they would be able to help were frustrated but many, thankfully, remained persistent. This bubbled over into creative approaches to reach decision-makers, which triggered a number of offers being made through Special Advisers, senior officials, ministers, MPs and senior health professionals. A view that I understand was shared by those working in the Opportunities Team was that many of these referrals were likely to be more mainstream or reliable and should therefore be given urgent attention. In my experience of what transpired to be bona fide offerors getting in touch with me after failing to get a response through the central portal, this view was justified. Initially, these were processed alongside other procurement opportunities by the PPE Cell, adding stress to their increasing workload as they dealt with a backlog of many thousand offers from the public. Given the need to respond more quickly, and the follow-up correspondence and requests for updates that inevitably followed the direct referrals, there was a risk that the PPE Cell was becoming distracted from the development and launch of the Parallel Supply Chain.

61. It was considered to be more efficient to have one team dedicated to processing these 'VIP' offers. From 1 April 2020, a 'Donations and VIP Assessment Team', also known as the High Priority Lane (HPL) Team, was set up within the PPE Cell. The global supply of PPE completely collapsed earlier in the year and, as a result, we relied on a very large network of contacts and informal arrangements in order to reach the people who could manufacture what we needed, often moving their manufacturing from one product to another. This was an administrative response to need that reflected a Government approach in times of national and international crises, and not necessarily a decision that could be attributed to one person or group. Lasting only until June 2020, it was also a necessary short-term fix for a triage system that was completely overwhelmed by the sheer volume of offers from individuals and companies offering to source PPE. Additional resources had already been allocated through call centres and processing teams that had been stood up to manage the influx but genuine offers were still getting lost in the noise and seeking different routes to be heard. There was a need to consolidate and streamline these referrals making their way through Special Advisers, senior officials, ministers, MPs and senior health professionals and stay on top of the more promising referrals. One of the ways in which I could be said to have had any role in the establishment of the HPL was by commissioning a working spreadsheet into which updates on referrals could be seen and reduce the need for ad-hoc chaser emails, which I explore in more detail below. The team allocated to

managing these offers did so through a dedicated email address, with the "VIP" route applying to the Opportunities stage only; the initial conversation to assess if an offer was potentially viable. The referrals were then progressed applying the same guidance, due diligence, technical assurance and financial controls as all other offers received by the PPE Cell.

62. On 6 April 2020, I was one of a number of recipients of an email from CO clarifying the routes through which referrals should be directed, according to the type of offer (LB2/104 - INQ000496810). From 14 April 2020, offers from large companies were also sent to the HPL Team, even if made through the main referral route. Being referred through the HPL was emphatically not a guarantee of success; only about one in ten suppliers ultimately obtained contracts (LB2/105 - INQ000477174).

63. Looking back, the term 'VIP' was a mistake as it seems to imply some sort of special or privileged treatment; this was not the case. If we did not have the High Priority Lane, offers to supply substantial bulk quantities of PPE may have been held up by smaller offers or those from companies who could not reliably manufacture and deliver. As Nigel Boardman concludes in his review of Government COVID-19 procurement, with which I agree, *'a number of organisations and individuals who were well-meaning but lacking the necessary competence responded to this call to arms and made the task of identifying the best likely sources of PPE more difficult.'* (LB2/106 - INQ000087235). The teams dealing with the main route for referral, via the portal, were indeed '*swamped by unsuitable offers'* as the review suggests, and we were all doing everything we could to ensure the more promising offers could be identified as quickly as possible. We needed a lot of PPE and we needed it fast, that was the priority; this was about saving lives and nothing else.

COVID-19 Testing Priority Procurement

64. As with PPE, there was significant global demand for testing supplies, so it was important that the Government moved quickly to procure the resources it needed. This was especially so with tests; at the start of the pandemic, existing procurement structures for PPE were already well established but almost non-existent for testing. Existing suppliers were engaged, and a call was put out to wider industry to provide goods and services to the testing network.

65. A large number of offers of support came in but, contrary to the approach to receiving offers of support for PPE, there was no separate VIP route or channel. This was, in

part, due to the fact that, contrary to the public 'call to arms' for PPE, the call for support for tests was targeted towards the industry, using pre-existing government networks and relationships. Further, the specialist nature of their production meant that manufacturers could not simply pivot from the production of one product to another, as they could with some types of PPE, so it was much less likely that we would receive so many well-meaning, but ultimately, unsuitable offers. as we did with PPE.

66. All offers were received through the purpose built GOV.UK portal and four dedicated DHSC mailboxes: 'COVID testing priority contacts', 'COVID19 innovation', 'COVID testing triage' and 'COVID19 offer triage'. Some suppliers emailed their offer directly to one of the mailboxes, others contacted ministers, parliamentarians and other individuals within Government who forwarded the offers on to one of the same mailboxes. As with PPE, civil servants were managing the increasingly overwhelming volume of offers from all corners of industry, searching for viable offers that could support the scaling up of the UK's testing network as quickly as possible.

67. Although there was no separate VIP route or channel for testing suppliers and ministers were not involved in the evaluation or procurement process for contracts, where emails came from a supplier with an established reputation in diagnostics or related to products or services of which there was an acute shortage, the email could be tagged by the triage team as 'VIP, 'Fast Track' or 'Priority'. As set out in the email referred to above that I received on 6 April 2020, we were also invited to pass offers on to the same 'COVID testing triage' inbox for the triage team to manage, but marking 'FASTTRACK' in the subject line. We were invited to mark the email as fast track in order that it could be tagged as such and to help officials to provide progress reports. Instructions were later updated to direct such offers to the dedicated 'COVID testing priority contacts' mailbox for processing as priority stakeholder enquiries by the pillar 5 stakeholder engagement team. The team would later provide access to a log of stakeholder interactions as well as regular updates detailing significant developments (LB2/107 - INQ000497147) (LB2/108 - INQ000497152) (LB2/109 - INQ000497153). I understand that one of the reasons for tagging the offers as 'VIP, 'Fast Track' or 'Priority', or processing them as priority stakeholder enquiries, was on the basis that corroboration from third parties increased the chance that the offer would be viable. It also ensured that progress reports, such as the updating tracker spreadsheets set out below and exhibited at LB2/110 - INQ000514067, could be shared with ministers and senior colleagues who were the initial point of contact. If an email was processed by the stakeholder engagement team, this was not a reflection of the status of the referrer

but rather the content and/or provenance of the offer. As far as I am aware, suppliers were not aware of the tagging system.

Receiving offers

68. On 17 November 2021, further to details already published in line with its transparency obligations, DHSC published further information about the Government's exceptional PPE procurement exercise in the early months of the COVID-19 pandemic (LB2/105 - INQ000477174). It sets out the purpose of the HPL in broad terms which aligns with my own understanding at the time, as set out above; that the HPL mailbox was set up to allow MPs, peers, ministers and senior officials to direct offers of support that they were already receiving to a dedicated location.

69. I do not believe there was a strict definition or criteria for those that would qualify as a 'senior referrer'. My experience at the time was that the term could loosely be applied to those already receiving offers of help through private offices, such as Special Advisors, senior officials, ministers, MPs and senior health professionals. As referred to and exhibited above, the email that I received on 6 April 2020 setting out the routes through which a referral could be made was sent to a number of recipients whom I assume would qualify as 'senior referrers'. As far as I understood, the instructions as set out in the email (and subsequent emails of updating instructions) were not widely published but may have been shared with other individuals.

Credibility of offers

70. For the reasons already outlined above, I believe these offers in this time of National Crisis that were already being made to Special Advisers, senior officials, ministers, MPs and senior health professionals were thought to be somewhat more reliable and from more mainstream manufacturers. I think it was expected that larger, more established suppliers, some already holding Government contracts for other medical supplies, would be more likely to make their offers through known contacts within Government rather than through the general online portal. One offer that I recall passing on was from the inventors and world's leading manufacturers of 'Transport Swabs', MedicalWire, that had been trying to make their offer of help known through the main portal with no success. Although previously unknown to me, a colleague from DHSC and I received the company's information via email and I was able to bring this to the attention of the right team for processing (LB2/111 - INQ000497137) (LB2/112 - INQ000497138). Where later talks with DHSC seemed to have stagnated, I received an email from MedicalWire's CEO expressing his frustration which I was able to bring

to the attention of the right team (LB2/113 - INQ000497471). This was a product that was very much in demand and although I was not a party to any contractual negotiations, my position enabled me to raise concerns at a high level and ensure that discussions to procure such vital equipment could remain constructive (LB2/114 - INQ000497472).

71. In the context of the deluge of thousands of offers pouring in, although generally well-intentioned, I believe the general opinion within Government was that those that came through contacts were more likely to be reliable or mainstream than those that came through the public portal. It was also a commonly held view at the time that there was a danger that some serious and large scale offers could be missed in the confusion and overwhelming response to the public appeal for support. This appears to be confirmed by the conclusions and recommendations of Nigel Boardman cited above, which were based on interviews with key people who were involved in the programme at a the time. By contrast, and to illustrate the point further, I understand that large numbers of potential suppliers that made offers through the portal subsequently failed to provide required information or failed to make further contact with the caseworkers at all. I am sure that this issue is reflected, to some extent, in the fact that a higher proportion of suppliers were eventually awarded contracts through the priority mailboxes.

Consideration of referrals

72. Ministers were not involved in the evaluation or procurement process for contracts (LB2/115 - INQ000528311); my limited understanding of the process is therefore based on the updates that I received on how offers were progressing. As set out in the email I received on 6 April 2020, referred to above, once an offer was passed on to 'Covid Testing Priority Contacts' inbox, the stakeholder engagement team would aim to log and respond to the offer or query within 48 hours (LB2/109 - INQ000497153). These offers would be prioritised and validated as per their process plan. I understand that a similar process applied to PPE contracts where once a referral was received, their HPL team would contact potential suppliers for further information. If the offer looked viable it would be progressed to the Technical Assurance Team. My understanding of the process for both PPE and testing is that all offers were processed by the teams using the same guidance process maps, due diligence, technical assurance and financial controls as those that had originated from the portal.

73. Save for receiving general updates on interactions with companies including company details, status of offers and next steps, which I would use to manage stakeholder queries and expectations, I was completed excluded from the processing of offers. As set out in more detail below, I commissioned a spreadsheet to manage the updates for each referral and save the teams from having to respond to ad-hoc chaser emails from me. If those that made their initial contact through me then felt they were not receiving prompt engagement from the teams, they naturally contacted me again to check on the progress of their offer. I might also be contacted by those that were unsatisfied with the quality of the engagement, receiving a simple refusal, for example, rather than, say, exploring issues that might be addressed to make the offer more viable. In such cases I might be able to seek further updates from the relevant teams to manage expectations. I am unsure whether my enquiries would have provoked any further or faster action, but I could at least reassure those that contact me for an answer, that issues such as these, that may have been lost in communication, were being looked at. Officials absolutely ring-fenced me from the decision-making process. As Minister for Technology, Innovation and Life Sciences, there were times when I had been involved in commercial conversations. For instance, I spoke to the company that made robots for our diagnostic labs to persuade them to prioritise supply to the UK. But for PPE and diagnostic contract awards, I was entirely protected from any decision to progress an offer towards the awarding of a contract. I therefore have very limited knowledge of the process.

Transparency and Propriety

74. As set out below, I passed on almost all offers that I received. I made only high-level enquiries to ensure the offer was directed to the right team and made very little value judgement on its credibility; sifting out only those that, taken at their highest, were plainly a dead end. Given my exclusion from the processing of offers once passed on to the relevant teams, I am not a party to any specific advice on the application of equal treatment or transparency obligations to the decision-making process, but I am aware that the same standards applied to all offers equally, whether made via senior political, NHS or Civil Service sources or through the Government portal.

75. The factors considered by the Accounting Officers when deciding whether to approve a contract coming from the supply chain were: regularity; propriety; value for money; and feasibility. The Managing Public Money Guidance defines 'propriety' as *'meeting high standards of public conduct, including robust governance and the relevant parliamentary expectations, especially transparency.'*

76. As is also set out in more detail below, when it comes to issues such as conflicts of interest, transparency, and bias, I take my ethical duties very seriously. I am subject to the Code of Conduct for Members of the House of Lords as well as the Ministerial Code, at the time, which I observed strictly.

77. While I appreciate the consideration of bias includes the appearance of bias, I am not aware of any concerns raised. DHSC separated out the contract consideration team from the ministers or other senior individuals who had initial contacts; we were all conscious that our actions would be carefully scrutinised when the emergency was over. The bottom line was that there was a pandemic; our systems were struggling to keep up and ministers were inevitably contact points for some businesses.

My role in relation to the High Priority Lane

78. As set out above, on 6 April 2020, an email I received from CO set out the routes through which referrals should be directed, according to whether the offer related to the provision of PPE, tests or ventilators. As with many of the private offices of other ministers at the time, I received offers of help directly from contacts which, for a number of reasons as outlined above, seemed credible and warranted a swift response. I was keen to ensure these opportunities were not missed by getting lost in any backlog of correspondence. For example, on 7 April 2020, I put Will Field from BEIS in contact with Pete Digger who is a well-known public affairs representative and who represented Avonchem, a company with a track record of delivery of diagnostic tests with established partnerships with organisations including the UN and WHO. Avonchem were progressing trials of a diagnostic test which they believed would be able to successfully test for COVID-19 antibodies and were seeking further information on the parameters of evidence required, to ensure their trials were not rendered irrelevant. In the following days, my office and I sent further emails enquiring as to whether a response had been given which led to the creation of a working spreadsheet into which updates on referrals could be inputted and reduce the need for the already overloaded team to respond to ad hoc chaser emails (LB2/116 - INQ000497150).

79. I exhibit each version of the updating spreadsheet as received within an index that I have prepared at LB2/110 - INQ000514067. For each version, I set out the date received and a list of the companies with me being named as either the lead or source of the referral.

Offers I received

80. I have been asked to consider whether the below list of suppliers is a complete list of suppliers whose provision of goods or services was either identified or referred by me:

    a) Abbott Rapid Diagnositics Ltd;
    b) Accora Ltd;
    c) LumiraDx UK Ltd;
    d) Optigene Ltd;
    e) Roche Diagnostics Ltd;
    f) Waters Ltd.

    Save for Waters Ltd, for which can find no record of being either identified or referred by me, I can confirm that I was approached in relation to the above suppliers as well as a number of other suppliers that I have identified as being referred on by me for consideration. For many of these companies, I was not the only official who was contacted by the company, nor was I the sole referrer, but I have included those with which I was involved. For each of these onward referrals made, I have provided further details in a tabular format which is exhibited at LB2/117 - INQ000514066. I feel it necessary to add that the list of suppliers provided within the table has been put together by searching through diary entries and communications to and through me at the time, which were extensive. I believe the list reflects the majority of suppliers, and certainly all those from major suppliers, whose approaches came through me, to the best of my recollection. It will be clear from the table, however, that I was, and still am, not aware whether many of these referrals resulted in contracts being awarded. I hope that I have been able to clarify the basis for any gaps in my knowledge, and therefore the table, in the following paragraphs which set out in more general terms my involvement, or lack thereof, in the consideration of offers.

Passing on offers to the HPL

81. I passed on almost every offer of help that came my way. Those within the dedicated processing teams were in a much better position to assess it for viability. I was conscious that I did not want to risk failing to pass on a crucial connection, however tenuous it might seem. I also referred plenty of people on without the need for further discussion. I would simply reply to the person copied to the officials and say, thank you very much, I am passing this on to officials. This was what I was advised to do.

82. As an example of the few that I did not pass on to the teams to be considered, I recall an offer of help relating to an anti-viral throat spray which would not be in production for some time and did not seem to be a priority to me. I passed on the email to Professor John Bell who confirmed this was a 'clear no' (LB2/118 - INQ000497127). I also remember one supplier who rang to say that he had great experience making plastic garden chairs but was prepared to 'give ventilators a go' if we sent him the specifications. To pass on offers such as these would have been a waste of precious time and resources.

83. We all did what we could when we could, and it felt like I spent a lot of time protecting the officials from over-zealous suppliers. As far as the teams that were processing the offers, I do not really know the process after the referral; it was a black box to me. My understanding of how each offer progressed was based on the stakeholder engagement updates I received through the spreadsheets and weekly meetings referred to above. I was not involved in any part of the decision to progress any offers through any stage of the process; I was merely updated on how things were moving in order that I could manage expectations where necessary. In the supporting material to a GCF briefing on 22 April 2020, it is suggested that a deal with Nanopore '*went ahead as directed*' by me (LB2/33 - INQ000496927). It is likely that these slides were prepared by one of our consultants, such as Deloitte. Given the sudden and steep increase to our workload in government, we relied on consultants in the early days of the pandemic to support us with this kind of material. Like these slides, much of the material was prepared at pace by people with varying levels of understanding of government procurement procedures or terminology. This is a mischaracterisation of my involvement and likely a simple error of language. The words, '*as signed off by*' would have been more accurate. I never directed that any deal should go ahead or not.

Considering offerors for interview

84. I was completely excluded from the progressing of offers once I had passed these on. Whether or not they were then interviewed by the relevant teams, who conducted the interview, or what questions were asked, were decisions and processes that I was not involved with.

The awarding of contracts

85. I had no involvement in the negotiation of the commercial terms of those contracts. Where the award of contracts was clearly within the remit of the relevant teams, as

most matters of procurement were, no ministerial sign-off would be required. The final decision as to whether to agree a contract or not was made by David Williams, the Accounting Officer, and his team who made these decisions. Where the award of a contract involved some issue of policy, such as with a proposal to run two community-based testing pilots by Optigene, a ministerial submission and sign-off was also required (LB2/119 - INQ000497425). In such cases, I relied upon the advice and recommendations of the relevant officials when deciding whether to sign-off the formal submissions with the recommendations that DHSC should enter into those contracts. Further, as can be seen from the table, there were many occasions where I was unaware of the stage that each offer reached, whether a contract had been awarded and if so, its value or terms.

Conflicts of interest

86. I had no personal conflicts of interest because I had no holdings or interests amongst PPE firms. I read and understood the Ministerial Code which I was required to adhere to and which covers actual or perceived conflicts of interests. As required by the code, I had given DHSC a full list of all my and my wife's interests which can be found at page 23 of the July 2020 List of Minister's Interests (LB2/120 - INQ000477162) and pages 77 to 79 of the DHSC Annual Report for 2020-2021 (LB2/121 - INQ000235008). When I became a peer, I had sold my company and, as can be seen in the above lists, by the time I became a minister, I had already backed off all my previous interests. I had absolutely no conflicts of interest with any of the companies that I dealt with.

87. When someone declared a conflict of interest within an approach, I passed that information on to the officials. There were plenty of people who were very transparent about their interests, and I did not regard this as a problem so long as I was confident that it was fully declared as the relevant due diligence would then be applied by the appropriate teams.

Value for money

88. As with all stages of the decision-making process, officials were responsible for value for money. I was not part of the contracting process. However, we did put in place measures to weed out the most egregious fraudsters and crooks, and worked with teams from CO to ensure our supply/procurement system was robust, as discussed at the Anti-Fraud Meeting which I hosted on 1 July 2020 (LB2/122 - INQ000497426).

89. I do not think there is a such a thing as "an acceptable profit margin" when the global supply chain breaks down in the middle of a pandemic. There is just the market and our need to protect our vulnerable from a horrible death from a deadly disease. The context of such extraordinary need and such limited global supply, and the public and parliament expecting us to secure whatever supplies that we could, obviously diminished our bargaining position. Imposing our own pre-pandemic ideals of value for money was a luxury that we were just not afforded.

Meller Designs

90. On 6 April 2020, following a call that day between David Meller, Lord Feldman and me (LB2/123 - INQ000497139) (LB2/124 - INQ000497177), my office contacted Jo Churchill to pass on David Meller's contact details in relation to a potential order of 35 million facemasks from China. Although he had been in touch with various teams within MHSC and MoD, he was seeking help on pushing the urgency of the task and securing a letter of intent that day to ensure the order did not go elsewhere (LB2/125 - INQ000497140). A response was received by Emily Lawson who reassured us that the deal was progressing and would be completed in time (LB2/126 - INQ000497141).

91. On 16 September 2020, I received an email from David in relation to a potential BioSafety COVID test system being supplied by the Tera Group, working with Meller Designs Solutions Ltd to which I replied, thanking him and suggesting we discuss further (LB2/127 - INQ000497434). We had a call to discuss this on 20 September 2020 (LB2/128 - INQ000497172). Following this, on 25 September 2020, David sent me an email with some headline information about the Tera Group Biosafety tests (LB2/129 - INQ000508346). I forwarded this email to a colleague in DHSC, copying in David to make the connection with the correct team, who connected him on 27 September 2020 with Luke Wainwright from the Innovation and Partnerships team who had been coordinating (LB2/130 - INQ000508348).

92. On 7 October 2020, I received an email from David, copying in the Secretary of State for DHSC, to share further details and results of the accuracy of the new test following discussions with the Tera Group (LB2/131 - INQ000497437). I responded setting out my understanding of the reasons that the Group are not being prioritised for discussions; that the information they provided to date is not as clear or as scientifically promising as the other vendors. I urged him to ask the Group to answer the questions from the team, stating that there was nothing I could do to help them if the team do not have the answers to the questions they have asked (LB2/132 - INQ000497435).

93. Between 13 October 2020 and 21 October 2020, I had an exchange with David via Whatsapp in relation to the further information that was being sought by the team. There seemed to be a particular issue with finding the details of the purchase in Germany so I asked him to provide further details as well as provide the data that the team were asking for as there still seemed to be information outstanding (LB2/133 - INQ000528306) (LB2/134 - INQ000528307) (LB2/135 - INQ000528308.

94. On 21 October 2020, David forwarded an exchange of emails between Tera and the Innovation and Partnerships team between 8 and 20 October 2020 which seemed to result in a suggestion that breathalyser tests may not be purchased centrally but a final decision would be made by scientific experts (LB2/136 - INQ000497427). Later that day, David forwarded me a further exchange and suggested he call me to discuss (LB2/137 - INQ000497428). I responded asking how his conversations with Germany had been progressing, to which he responded, saying they had committed to 5 billion units and 1 million machines (LB2/138 - INQ000497432). I sent a further email on 22 October to David letting him know that I had sought clarification from the Innovation and Partnerships team (LB2/139 - INQ000497431).

95. On 11 November 2020, David sent me some more detailed information on the test system and how it operated (LB2/140 - INQ000497429) (LB2/141 - INQ000497430).

96. On 28 November 2020, David sent me a message via Whatsapp asking for an update on how the information had been received, as he did not seem to know where talks were going (LB2/142 - INQ000528309

97. On 29 November 2020, David sent me further information via email about the tests they were running (LB2/143 - INQ000508347), which he followed up with a message via Whatsapp (LB2/144 - INQ000528310), and forwarded an email which Oren Sadiv of Tera had originally attempted (and failed) to send to me on 10 November proposing we meet to discuss the test which they were now planning to deploy in Germany (LB2/145 - INQ000497433).

98. On 9 March 2021, I received an email from David setting out the results of the discussions with Luke Wainwright that he had hoped would have been finalised by now but were subject to an apparent delay in MHRA approval. I responded to say I had asked officials to find out what has been happening (LB2/146 - INQ000497436).

99. I exhibit screen shots of all text messages between David Meller and me between 3 April 2020 and 11 February 2021 as follows (LB2/147 - INQ000513307).

SECTION THREE: PROCUREMENT

EU Joint Procurement Agreement

100. I was, on occasion, kept abreast of the very high-level reasons for the decision to not take part in EU Joint Procurement. On 2 April 2020, at my request, I received a summary update from my office on the issue (LB2/148 - INQ000497133) which noted that, although we had not taken part in the four procurements announced to date, we were actively considering whether the UK should participate in future opportunities. This will have been put together from general ministerial updates that I and other ministers received. I received an email on 14 April 2020 covering issues on EU corporation in general, in order that I may respond to specific questions from the Lords (LB2/149 - INQ000497149). Other than this, I do no recall receiving any communication on this issue from ministers or any other decision-makers that was specifically directed to me. I was not involved in any decision not to participate in any EU Joint Procurement Agreement nor any reasons behind the decision.

The effect of public announcements on procurement

101. I understand that the Inquiry has heard evidence that public announcements about increases to testing capacity affected the approach to procurement, in that those who were responsible for procurement were not informed prior to increases to testing capacity being announced. In my experience, I think it possible that some targets for testing capacity will have been announced without directly informing everyone responsible for procurement in advance. I do believe, however, that the targets as announced, although ambitious, were still based on consultation to form realistic projections, borne out at the very least by the fact that the targets for testing capacity, on the whole, were met.

102. I think it important to note that these announcements were made at a time where there was a need to galvanise the response and get everyone motivated towards a viable solution. Our route out of the pandemic relied so heavily on mass testing, particularly in the early months before the promise of a vaccine. It was important that the teams responsible for procurement and managing the supply chain were focussed on the large-scale orders that was so desperately needed.

103. One reason for setting the targets was to try to motivate industry and encourage them to think big. There were, of course, some that will have seen this as commercial opportunity but even if we had somehow managed to keep plans to increase testing capacity a secret, it is difficult to imagine how prices would have been materially affected. With or without public announcements, it was no secret that everyone was in desperate need of tests.

My role in relation to procurement of ventilators and related medical equipment

104. I was not involved in any decisions on the subject of procurement of ventilators, oxygen, and related medical equipment during the pandemic. I set out below the extent of my limited interaction I had with any teams working on the procurement of such items.

105. On 22 March 2020, I received papers and an invite to a meeting, to which I ultimately did not attend, for the COVID-19 Procurement Group (LB2/150 - INQ000497106) (LB2/151 - INQ000497107) (LB2/152 - INQ000497108) (LB2/153 - **INQ000412601**). On 23 March 2020, I received a notification that future meetings of the Group as previously constituted would be discontinued, citing 'a more streamlined version focussed on the Ventilator Challenge and Offers for Support from Business (LB2/154 - INQ000497111). I was not included in any further meetings of the COVID-19 Procurement Group.

106. On 30 March 2020, I attended an International Ministerial Implementation Group (IMIG) meeting, at which ventilator procurement was cited as an agenda item (LB2/155 - INQ000497130) (LB2/156 - INQ000497132), but this was directed at the FCO members only, and did not form part of my briefing note (LB2/157 - **INQ000049903**).

107. In relation to offers of help from industry, on 25 March 2020, I received information through Professor John Bell that one of GSK's top suppliers, Syneos Health, was offering to provide training for a non-invasive alternative for ventilator support. I passed this information on to the ventilator support mailbox within BEIS. Contact with the supplier was eventually made via CO who directed them to the relevant webform to allow the offer to be triaged and directed to the most appropriate team (LB2/158 - INQ000497123).

108. On 26 March 2020, I passed on an update I received from MHRA to the relevant teams working on ventilators in relation to a proposal from James Dyson for a new design of ventilator (LB2/159 - INQ000497116).

Procurement: lessons learned

109. I believe that the biggest problem we faced was that our supply situation was terribly lacking when we went into the pandemic. There was nothing in the store cupboard. We ran a just-in-time delivery system. We did not have direct relationships with the manufacturers. Everything was done through intermediaries, agents and networks. We did not even have the contact numbers of our top manufacturers. I believe that is why things felt so shambolic at the beginning and why we had to scramble to catch up. We did, of course, also make some mistakes along the way. Not everything was perfect or ran smoothly. For example, I do not understand why there was no clear system for handling such a high influx of offers in response to a 'call to arms'. I would have thought that someone would have a system ready to go. Further, we did not get the cross-government support we needed from people like the CO procurement team until much later (and when we did, things improved). It took far too long for the Government machine to swing into action, and the difficulties we faced with PPE were the worst example of this.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: **PD**

Dated: 20 December 2024