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COVID INQUIRY

WRITTEN STATEMENT OF BORIS JOHNSON FOR MODULE 5

Contents

Introduction

1. I provide this statement to the Covid Inquiry in response to a 'Rule 9' Request (issued pursuant to the Inquiry Rules 2006) dated 10 October 2025.

Opening Comments

2. As with the statements prepared for other modules of this Inquiry, I have prepared this statement with assistance from my legal advisers and having refreshed my memory from the documents I have exhibited. As I noted in my second written statement, it is now several years since the events and it is hard to recall the exact sequence of events. I have done my best to answer the questions put to me and to verify my recollections where possible from contemporaneous documents.

Overview

3. During the pandemic, I served as Prime Minister (from 24 July 2019 until 6 September 2022). In the two years before, I was Foreign Secretary until 9 July 2018. I was elected leader of the Conservative party in 2019. Annex E of my first statement sets out my career in fuller detail.

4. As Prime Minister, I had a fairly limited role in the procurement of key healthcare equipment and supplies. Generally, I would receive briefings about certain issues and be asked to approve a recommended course of action. I would intervene where I saw an issue, such as trying to rally troops or suggesting individuals for key posts and I also sought to promote ideas and innovations which I thought would help best manage the pandemic. Otherwise, I entrusted procurement to the responsible ministers (primarily, the Secretary of State for Health & Social Care, Matt Hancock) and the experts in the civil service, NHS and Public Health England ('PHE'). I set out below my main involvement in the procurement of PPE, ventilators, Lateral Flow Tests ('LFTs'),

Polymerised Chain Reaction ('PCR') testing equipment, and oxygen, below, as well as my involvement of the appointment of key personnel.

5. Annex A of my first statement sets out the key decision-making forums and groups. Discussions and decisions about procurement largely operated in the same fashion as other issues I dealt with through the pandemic. I have also explained how I used WhatsApp in my evidence to Module 2 (both orally and in my first statement at Annex B): we used WhatsApp to confer before or after decisions were taken but over 99 per cent of the important conversations took place in meetings, face-to-face or on Zoom, such as in Cabinet, in the Covid-O meetings or at the 9.15 meetings. The WhatsApp messages do not represent government decision-making: this was not 'Government by WhatsApp' (as per paragraph 736 of my first statement). Where applicable, I have given examples of this in this statement. I scarcely used text messages or email so I am confident that I sent few, if any, relating to procurement in any way at this time but those of relevance I have described.

6. Before turning to some more detailed discussion of specific areas about which I have been asked, below I have briefly described my role in five of the key areas relating to procurement: PPE; LFT and PCR testing equipment; ventilators and oxygen.

PPE

7. The lack of PPE was one of the first big shocks of the pandemic. We began the pandemic believing we were in a good position with our stockpile of PPE. We even sent goggles and gloves to Wuhan in the early days of the pandemic to help the Chinese, who were in desperate need. We initially seemed to have significant stockpiles of PPE, which were being held as part of the Pandemic Influenza Preparedness Programme ('PIPP') and EU Exit. On 24 March 2020, Matt briefed the Cabinet that '*part of the battle plan was to increase the supply to the NHS including vital equipment such as ventilators, personal protective equipment (PPE), and bed availability. There had been plenty of PPE in the UK; the military had started helping to get it to the right places.*' **[BJO3/001 - INQ000056136]**.

8. It quickly became apparent, however, that our PPE stock would be inadequate for the nature and scale of the pandemic. It was not simply a distribution issue: we were heavily reliant on overseas manufacturers to supply PPE, in particular China. National governments across the world were scrambling to get hold of

PPE. It was clear that we needed to increase domestic production and resilience at great speed. I remember terrible stories about doctors, nurses, front line workers and those working in social care not having adequate supplies and some being struck down by Covid. I was very worried about this.

9. In March 2020, I decided we needed someone to try and pull all our PPE efforts together, someone who would take the lead on overall procurement of PPE. We needed someone with the requisite skills and experience to manage this endeavour. That is why I proposed Lord Paul Deighton KBE to be put in charge of PPE. I knew Paul well from the work we had done together in 2012 when he was the CEO of the London Organising Committee of the Olympic and Paralympic Games, responsible for planning and delivering the 2012 Summer Olympics and Paralympics. Paul also had government experience because he had served as Commercial Secretary to HM Treasury from January 2013 to May 2015. I knew he had a genius for getting things done. He had the experience we needed and – bluntly – knew how to procure a lot of kit very quickly.

10. Paul was formally appointed by Matt Hancock on 19 April 2020 to lead the 'PPE Make Cell' and then, on 12 May 2020, to lead the PPE Taskforce (which was also called the Parallel Supply Chain) **[BJO3/002 - INQ000477929]**.

11. Within a relatively short space of time, Paul and his team had set up huge domestic supply chains. By the end of the pandemic, we produced phenomenal quantities of kit in the UK and built up the domestic resilience we needed. My briefing notes for my visit to the Northumbria Healthcare Manufacturing in February 2021 record that, by then, we had built a stockpile of 32 billion items and could supply 70% of the PPE need (excluding gloves) domestically, compared to 1% at the start of the pandemic **[BJO3/003 - INQ000564906]**.

Lateral Flow Testing and PCR Testing Equipment

12. In the initial days of the pandemic, the CSA and CMO emphasised the importance of testing and need to ramp up our ability to test (see, for example, at the 16 March 2020 Press Conference Q&A **[BJO3/004 - INQ000183894]**). This is why, at the 9.15 meeting on 20 March 2020, when I asked Matt to articulate a three month '*battle plan to tackle the virus*', it had to include '*testing and new technology*' because the '*current plans across the board were not moving quickly enough*'. The minutes record Matt saying, '*…on testing they had a number of workstrands – a surveillance project of sample testing;*

negotiations to buy antibody tests in bulk; expanding testing to 25,000; and working on a private sector solution to develop 100,000 thermo-fisher tests for key workers. He said that work to ensure enough reagents for the testing kits was also taking place. He said technology based solutions to identify those who have had contact with an infectious person were also being developed.' **[BJO3/005 - INQ000056265]**.

13. This is illustrative of my involvement in the procurement for testing; I would set out my concerns, Matt would set out the current position and I would seek an action to obtain assurance that any issues were being addressed. I then left the detail of the execution to Matt, who had ministerial responsibility for testing, and the DHSC to implement. I would intervene, if required, to help overcome any hurdles – such as making sure funds were available.

14. In the initial months, I put Matt under a lot of pressure to increase the testing capacity at great speed, because, despite early assurances that we had a robust test and trace capability, this quickly proved to be inadequate for the nature of the pandemic.

15. I threw my weight behind mass testing and recall speaking with diagnostics companies, such as Oxford Nanopore, about their equipment and its capabilities, as well as being shown the PCF diagnostics machine by PHE at Porton Down **[BJO3/006 - INQ000564905]**. By November 2020, there had been huge strides forward on testing and innovative mass-testing technologies were being rolled out in Liverpool as I describe below. In January 2021, my direction to the Covid Taskforce was that mass testing needed to feature more prominently, as part of the 'Proposition for National Intervention'.

16. Although my dream of mass test and release schemes never came off (not least because they were thankfully superseded by the success of the vaccines), a great deal of good came of the endeavour. We created a pretty massive diagnostics industry.

Ventilators

17. Ventilation procurement sat within the DHSC, which set up a ventilation and oxygen programme in early March 2020. However, by mid-March, there was still a crushing need for ventilators, which caused me to take a close interest and ensure that any obstacles to ventilator procurement were removed. I attended the 12 March call about NHS resilience where Sir Simon Stevens

sought No10's assistance a manufacturing drive for ventilators, which was the origin of the 'Ventilator Challenge'. I describe this in more detail below.

Oxygen

18. I was conscious that simply procuring more ventilators in itself would not be sufficient and that there needed to be an adequate supply of oxygen for them to work. That is why oxygen procurement and distribution formed part of oxygen and ventilation programme (as set out in the Ventilator Ministerial Brief I received on 30 March **[BJO3/007 - INQ000088316]**).

19. At the 12 March NHS resilience meeting, I asked if the manufacturing drive could cover oxygen bottles to help meet the NHS requirement to go from 4 billion to 20 billion litres of oxygen **[BJO3/008 - INQ000146639-001]**. In Cabinet on the 17 March 2020, I noted that there was a '*national effort to provide what was required, including an increase in the number of ventilators, oxygen supply and protective clothing*' **[BJO3/009 - INQ000056135]**. At the 9.15 meeting on 20 March 2020, it was noted that '*oxygen supplies were adequate*' **[BJO3/005 - INQ000056265]**.

20. I do not recall there ever being an issue with the supply of oxygen itself or being required to assist. However, I was made aware in early January 2021 that there were still some physical issues with the supply in old hospital estates (i.e. there was a limit to the amount of oxygen some hospitals could pump through their buildings) **[BJO3/010 - INQ000091649]**.

Key Appointments

21. I have been asked for the reasons, from my perspective, for the appointment of some individuals with respect to the procurement of key healthcare equipment and supplies. Generally speaking, the process was usually that I might suggest people where I knew we had a particular position to fill (such as Paul Deighton). More often, however, I would only be informed of a potential appointment after the process was well in train and I would usually give the proposed candidate my blessing unless I had any concerns. I have been asked in particular about the following:

    a. **The Lord Agnew of Oulton DL**: I do not now recall how Lord (Theo) Agnew came to be appointed. The documents I have seen, however, show that at the time he was brought in to assist on Covid-related

matters, Theo was Minister of State for Efficiency and Transformation with a role that was split across the Cabinet Office and the Treasury. He had been appointed to that position in February 2020 and I do not think it was not a Covid-related appointment **[BJO3/011 - INQ000563672]**. As did everyone working in government, Theo started to help with the Covid response, and in particular the ventilator challenge as I describe in paragraph 55 below. From 14 February 2020 until 24 January 2022, Theo was a Minister of State at the Cabinet Office with responsibility for deciding whether to agree recommendations made by the Strategy, Assurance and Standards Team (one of the Cabinet Office's Central Commercial Teams) that particular high value procurement spends should be accepted, rejected or accepted with conditions. I understand that Theo started chairing PPE Capacity meetings in March 2020 but I have no personal knowledge of this. The Government Chief Commercial Officer, Gareth Rhys Williams, reported to Theo as Minster of State for the Cabinet Office. On 22 April 2020, Malcolm Reid wrote me a submission about PPE Ministerial Oversight which recommended that I appoint Lord Agnew to a joint ministerial post across DHSC and Cabinet Office with the remit to oversee a new delivery structure for PPE **[BJO3/012 - INQ000563677]**. The original plan appears to have been that Lord Agnew would act as the lead minister overseeing three strands of delivery work: (1) demand, policy and distribution led by DHSC; (2) domestic supply led by Lord Deighton and (3) international supply led by Antonia Romeo. The recommendation of Lord Agnew came from the Cabinet Secretary and was supported by Dominic Cummings and Munira Mirza. The Cabinet Secretary recommended that I appoint Lord Agnew temporarily as a junior minister with a joint portfolio across DHSC and the Cabinet Office. I do not recall if I saw this recommendation (I note the copy I have been shown is not annotated by me) or if it was superseded by later events because at around the same time there was a slight change of plan: on 23 April 2020, Matt Hancock asked Paul whether he could take the lead for *all* PPE and not just domestic manufacture, rather than Theo **[BJO3/013 - INQ000222046]**. I do not think I had anything to do with this decision and I did not have a great amount of dealings with Theo personally. My

official PM diary records that between 2020 and 2021, Theo attended a Mass Testing Roundtable on 17 March 2020, he dialled in to strategy meetings on 22 March 2020, he attended a PPE update on 27 April 2020 and a Border Readiness call on 25 September 2020, a NERT delivery: Infrastructure call on 24 May 2021 and that was all **[BJO3/014 - INQ000226185]**. Theo also co-Chaired the Fraud Ministerial Board, which was formed in around July 2020 by the Cabinet Office. However, I do not recall being involved in this appointment.

b. The Lord Bethell of Romford: On 9 March 2020, Lord (James) Bethell was appointed as a Parliamentary Under Secretary of State in the DHSC. In November 2020, he was appointed as the DHSC Minister for NHS Test and Trace. I have only little recollection of this and do not think I had any role in the appointment. I do not seem to have had any meetings with him personally, according to my PM Diary **[BJO3/014 INQ000226185]**.

c. The Lord Deighton KBE (Paul): I have described Paul's appointment at paragraphs 9 to 10. Paul was appointed because we needed someone with his skill set to take charge of PPE and having worked with him before, I knew he was the best man for the job. I suggested that Paul be appointed and he was officially appointed by Matt Hancock **[BJO3/015- INQ000563681]**.

d. The Rt Hon. The Lord Feldman of Elstree: I understand that on 22 March 2020, Lord Bethell appointed Lord Feldman as a senior DHSC envoy to engage with the offers of support that the Government was receiving. I do not have any recollection of this and do not believe I played any role in the appointment and, again, according to my PM Diary, I do not seem to have had any meetings with him across 2020-2021 although we would occasionally liaise (for example, in the context of the ventilator challenge as I describe below): **[BJO3/014 - INQ000226185]**.

e. The Baroness Harding of Winscombe: on or around 7 May 2020, Dido was appointed by me to lead the UK's testing programme. I knew her to be a hard-working NHS executive but did not know her well. Matt had suggested her to me (in a WhatsApp message on 4 May 2020 to which I replied '*Yes all good*' **[BJO3/016 - INQ000129305]**). It seems that I

sought some advice on her role prior to announcing the appointment but I cannot now recall what this regarded **[BJO3/017 - INQ000273578]**. She was to report to me and the Cabinet Secretary with ministerial accountability remaining with Matt.

Preparedness for procurement in a health emergency

22. In the first few months of 2020, I received assurances that we were well prepared and well equipped to deal with the virus, but it transpired that we were not adequately prepared for this virus (as I explained in my first statement). It was not until it became clear that this was the case that I intervened, in the way I describe above, to ensure that we had sufficient supplies of PPE, testing equipment and ventilators.

23. I do not recall being briefed on what lessons may have been learned and implement as a result of past pandemics and epidemics, or pandemic exercises. However, it quickly became apparent that one of the central issues was a lack of domestic resilience – i.e., we were too dependent upon foreign supplies. My personal focus was on ramping up domestic manufacturing, which we did impressively with ventilators, testing and PPE in a very short period. This strategy helped to build up a resilience very quickly, as we engaged with a very willing UK manufacturing private sector, as exemplified by the Ventilator Challenge and Operation Moonshot, which I describe below.

Principal issues with procurement as the UK entered the pandemic

24. I have been asked to consider the principal issues with procurement as the UK entered the pandemic. Simply put, it was a shortage of the right kit and a domestic inability to make the right stuff fast enough. We needed colossal quantities of PPE to save lives and give people confidence at work.

25. As the reality of the situation became clear, there was, in my view, only one sensible strategy: to leave no stone unturned in ensuring we had sufficient PPE, testing equipment and ventilators. My directions to, for example, the Health Secretary and Lord Deighton were clear on this point. As I recall, my guidance to Paul was to make sure that doctors and nurses and other health and care staff had the protection that they needed; I was very worried about this.

26. Our industrial capability improved greatly over course of pandemic, as did the expertise and experience within Government and Civil Service which I believe is now very extensive. It is unsurprising, given the situation, that some people were learning as they went. As with any organisation facing a new challenge, there were some brilliant people who did a fantastic job. However, to put it frankly, when it comes to procurement, it is very, very hard to negotiate with somebody when people are dying and I believe it was always inevitable that the Government would enter some deals which proved bad.

27. I was not close enough to the detail of negotiations to comment upon the private sector's expertise for procurement during a whole-system civil emergency.

28. Perhaps the best snapshot of my concerns regarding the issues with procurement at the start of the pandemic were captured in an email sent by Dominic Cummings to Martin Reynolds, Tom Shinner and Sir Mark Sedwill on 18 April 2020 (it was also shared with Dominic Raab and others). This note captured views and directions that I had expressed the day before, when I was at Chequers and unwell with Covid myself:

> *5. He wants the CABSEC to lead extremely urgent action on* ***building domestic supply chains for all critical*** *products that might be vulnerable to international knife fights: e.g PPE including masks (and he is happy for us to reverse engineer the machines that make masks if we cannot do a reasonable deal), reagents and other raw materials needed for mass testing, ventilators (a good news story), generic drugs that we may run out of (NB there are already warnings about things like a coming shortage of standard drugs used in hospitals) and so on. He wants to see the Deighton Plan next week and for the CABSEC to ensure the best people are supporting this program. He also wants CABSEC to get people working on 'worst case scenarios for breakdown of international system / supplies over the next few months'. Lots of bad things have happened -- what if, say under pressure of the US election, supply chains get worse not better; what if basic materials are in global shortage (reagents, rubber, the stuff that makes paracetamol and PPE); what if food supplies go haywire / there are global food shortages (which Tom and others are increasingly worried about) --* ***we need urgent contingency plans and a plan for domestic production****. (In 1929 and 2008, there were huge second and third order domino effects like this, e.g food prices contributing to Arab spring etc.) He will call Trump to try to head off problems with testing materials if we think he should?? We also must ensure we are absolutely as efficient as possible re things like: buying whole factories in China and elsewhere, ensuring the buying process is hyper-efficient -- it's clear from the call this morning that things that should have been done 2-3 months ago (e.g 24/7 payments authorisation from DHSC) have only just been done, so what else has still not happened? There must be external checking of whether these processes remain suboptimal.*

[...]

*9. He was very punchy on **PPE** just before we left. He would like DR and the CABSEC to stress to Hancock how serious this is, ensure that we in the centre understand in detail how bad the situation is, and he wants **the CABSEC personally to check the calibre and number of critical people** and either assure the PM 'the best people are on it' or change the team. He also is clear on the direction with masks and wants us to get ahead of it -- we should start buying NOW, and preparing domestic production now, on the assumption the advice WILL change (what's our best low tech/max volume option?). Since I left he's texted MH and me on it so he is clearly very agitated. His last words to me were 'do absolutely anything to solve this PPE nightmare, pay more, anything'. So we've got very clear instructions on this and we must do whatever regardless of what toes are trod on...* **[BJO/018 - INQ000226628_008-009]**

EU Exit

29. My second statement to Module 4 sets out my views on the advantages of opting out of the EU procurement scheme for vaccines (see paragraphs 35 to 42). I believe that the same principles apply to procurement more broadly – in a time of crisis, the ability to be more flexible and faster in decision-making is an advantage.

30. I have been asked to explain the reasons for the Government's decisions not to voluntarily participate in any of the EU's procurement schemes. I do not recall being involved in any decision-making for these (unlike the vaccine scheme), but I understand that, originally, we either did not receive invitations or received the invitations too late.

31. I do not believe that Brexit negatively impacted on the suitability or resilience of supply chains for key healthcare equipment and supplies. Indeed, there were unintended benefits from the 'no-deal' preparations, such as the stockpile of PPE obtained for this purpose.

Calls to Arms

Operation Moonshot

32. 'Operation Moonshot' was the term used to describe an ambitious initiative to test the whole of the population regularly. The idea was that you would test yourself in the morning and if you were negative, you would go to work as normal. We imagined having testing facilities in every big workplace. With all your colleagues doing the same, you could be confident that your workplace was Covid-free.

33. Towards the end of the summer of 2020, when vaccines still seemed a longshot, I thought mass testing could allow life to return closer to normality. At this stage, I felt that we needed to bet on all the horses and one such horse was that the UK economy could test its way out of the problem. Together with Dido Harding and Matt Hancock, we conceived 'the moonshot': a massive scheme of 'test-and-release'. The moonshot would require a giant collaborative effort from government, business, public health professionals, scientists, logistics experts and many, many more.

34. The idea of the moonshot grew from a pilot that had been conducted by Professor Keith Godfrey at the University of Southampton to explore the effectiveness of weekly saliva testing on the population. Professor Godfrey had spoken to members of my team in No10 as well as the CSA, DCMO and others. On 23 July 2020, Professor Godfrey wrote to me seeing support for a mass testing programme **[BJO3/019 - INQ000137242]** and I met with him the following day **[BJO3/020 - INQ000218334]** and **[BJO3/021 - INQ000137243]**. I gave the idea '*my strong political support*'. It helped crystallised what had been forming in my own mind and I asked Dido Harding, with support from No10 and the Taskforce, to lead the NHS Test and Trace in taking this programme forward. We agreed to implement a '*very rapid rollout [of testing] to a specific geographic area with high prevalence*' in parallel with this plan, with Leicester and Blackburn raised as options but I also requested that we maintain a '*low public profile on this work as this stage to manage expectations appropriately*' **[BJO3/022 - INQ000233914]**. I was excited at the plan, but I did not want to overpromise and under-deliver.

35. On 2 August 2020, Matt wrote to me setting out a plan for population level testing **[BJO3/023 - INQ000062482]**. The plan was to test an entire city across all settings (including hospitals) and regardless of whether individuals had symptoms. We would use lower sensitivity tests and then confirm positive results with higher sensitivity PCR tests. The hope was that the pilot's success would allow us to roll out regular mass asymptomatic testing of the whole population and we hoped that it could be used to avoid national lockdowns. Matt recommended a dedicated team within NHS Test and Trace to lead the initiative.

36. Although I was not party to such discussions, I know that members of my team in No10 were liaising with Patrick Vallance and others to thrash out concerns

and ensure that the plans were properly framed and getting underway (see for example **[BJO3/024 - INQ000062471]**). Meanwhile, I was keen on the idea and sought to be kept abreast of updates (see for example my WhatsApp to Matt asking, '*How are the moonshot team?*' on 6 August 2020: **[BJO3/025 - INQ000129445]**).

37. On 5 August 2020, we held a population testing meeting to discuss this plan. According to the agenda, I asked Dido to make a presentation setting out the latest plans on what was then called 'Project Spitfire' and would later be called Project or Operation Moonshot **[BJO3/026 - INQ000564904]**. There was a plan to pilot the scheme for mass testing and we discussed whether to use one city in the rollout or multiple. One of the items that appeared on the agenda prepared for me was this question:

> *Risk appetite: Do we agree that our risk appetite extends to* ***preparing for a nationwide rollout before the results of the pilot are known****, including incurring costs that cannot be recouped if the pilot is unsuccessful? Specifically, during the pilot phase we would need to buy up all the necessary testing equipment and robotics, open new laboratories and recruit all necessary staff to enable nationwide roll-out.* [Emphasis original]

38. This is a good illustration of the sort of dilemmas we were facing each day: try something bold and audacious that might get the country back on the road but run the risk of huge, wasted costs if it did not work. There were no easy decisions. The readout of the meeting shows that I was clear that the Cabinet Office and HMT should provide all necessary regulatory approvals to allow the work to proceed urgently, with exemptions provided from usual processes where necessary **[BJO3/027 - INQ000471024]**.

39. The proposed timeline was seven weeks for the city pilot and No10 indicated an ambition to roll out whole population testing in October. A Task and Finish Group was to be convened by GO-Science with multi-disciplinary expertise **[BJO3/028 - INQ000070327]**. A Scientific Advisory Group was set up and chaired by Lord Bethell to advise on the endeavour (see for example **[BJO3/029 - INQ000269377]).** I was keen to ensure that scientists were embedded throughout the programme and that people who understood the technology side were on the senior advisory board (see for example **[BJO3/030 - INQ000062525])**. I also wanted to ensure that all impediments to this work were removed. On 12 August 2020 for example, I '*stressed the importance of moving every possible obstacle that might slow down our approach'* and I was

to do a call to arms with manufacturers to help things along **[BJO3/031 - INQ000062515]**.

40. I received regular updates in meetings called to discuss mass testing (see for example **[BJO3/032 - INQ000233956], [BJO3/033 - INQ000233975] and [BJO3/034 - INQ000062598]**) and also in the morning meetings (see for example **[BJO3/030 - INQ000062525]** where I was told that the moonshot was progressing rapidly). The moonshot was also discussed in Cabinet (see for example **[BJO3/035 - INQ000089011]**). It was in these sorts of meetings that decisions were taken.

41. In September 2020, we officially launched Operation Moonshot under the leadership of Alex Cooper in DHSC (the Mass testing Development Director who had been brought in from the MoD and had worked in the No10 Covid coordination cell) with Jacqui Rock (the NHST&T Chief Commercial Officer) accountable for all supporting commercial activities. On 9 September 2020, I described the 'moonshot' in a press conference **[BJO3/036 - INQ000086845]** but in fact the use of that term tapered off – it started to be unhelpful as it was used to refer to different things by different people.

42. We tried the moonshot first in Liverpool, with the help of Steve Rotheram, the mayor. On 6 November 2020, we launched the pilot with LTF testing available for everyone living or working in Liverpool. It involved a huge amount of work by the Liverpool City Council, NHST&T, NHS Liverpool Clinical Commissioning Group, Cheshire & Merseyside Health & Care Partnership and the University of Liverpool. Initial results seemed promising but we also saw socio-economic inequalities presenting huge challenges as test uptake was lower in more deprived areas and fear of losing income from self-isolating was a key barrier to testing. It was not a golden bullet.

43. I would sometimes have updates on the procurement side of things but generally speaking, these would rarely come across my desk; I trusted my team and Ministers to deal with matters and escalate them only when necessary. If a problem seemed to be developing, I would usually need to put someone at the helm to deal with it so, for example, at a meeting on 11 September 2020, the potential for delays in the procurement process were raised and it was suggested that Lord Bethell chaired a daily meeting in order to clear any outstanding commercial agreements **[BJO3/037 - INQ000471027]**. I was not involved in any negotiations but I was sympathetic to those that were. It is very

hard to negotiate when people are dying. It must have been very hard to decide what the right price was when the costs of *not* obtaining the supplies was so high.

44. We pressed on with efforts to get mass testing off the ground during November. By 17 December 2020, acutely conscious of the increasing numbers of cases and the pressures on testing and agonising over a Christmas lockdown, I agreed that '*it would not be right for major population testing above current plans*' before Christmas. Matt described the possibility of mailshot testing towards the end of January and I was attracted to that alternative proposal **[BJO3/038 - INQ000563680]**.

45. I have been asked to describe my experiences setting out issues I experienced, advice I received and explaining how these issues were resolved. While I have sought to provide an overview that answers this question above (and below for the Ventilator Challenge), I do not pretend this is a comprehensive account of issues I experienced, advice I received or how issues were resolved. Each day issues arose, I received advice in multiple fora from multiple teams and many people and issues were constantly emerging and being resolved. I cannot pretend now to remember each and every one and, even with the benefit of refreshing my memory from the documents, there are simply too many to describe. Furthermore, while 'Operation Moonshot' may seem like a distinct project, it blurred into our efforts on testing. It is not clear where one ends and the next begins (as is the case for all the topics about which I am asked) so it is impossible to identify specifics that relate only to this issue. I have given a detailed account of the broad issues, advice and resolutions in Module 2 and those remain, to my mind, the key matters.

The Ventilator Challenge

46. By 12 March 2020, it was clear that the UK would be badly hit by the virus and, as I described in my first statement, I felt I had to level with the public (see paragraph 158 et seq). The same day, I met with Matt, Simon Stevens and others to discuss NHS resilience. As the readout sent to Matt's Private Secretary records, Simon set out the NHS's plan which included increasing the aggregate supply of oxygen, reconfiguring hospitals, and getting the right numbers of machines and trained staff to operate. There was also an ask of '*No 10 to support a manufacturing drive for ventilators etc, including potentially a roundtable / national call to action soon to deliver the estimated 20k extra*

ventilators required...The PM asked if this could cover oxygen bottles too…' **[BJO3/008 - INQ000146639].** I believe that this is the origin of the of the 'Ventilator Challenge'. The next day I spoke with the Prime Minister of Italy where there was a desperate need for ventilators. I also spoke with James Dyson and Lord Anthony Bamford (of JCB) that day before requesting an urgent No10 summit to really get our manufacturers going **[BJO3/039 - INQ000048399**]. I then met with the heads of 60 leading manufacturers and suppliers on 16 March in a 'call to arms' encouraging them to participate **[BJO3/014 - INQ000226185_0063]**.

47. Events moved at great speed in this period, as I described in my first statement, as we prepared to enter the first lockdown on 23 March 2020 and the detail of the manufacturing call to arms was dealt with, I believe, by the NHS Chief Commercial Officer and the Government Chief Commercial Officer, with Matt's and the Chancellor of the Duch of Lancaster's ('CDL') oversight. I assisted where I could. For example, I received a WhatsApp message from Lord Feldman which I shared with Matt, Dominic Cummings, the CSA, CMO and others on 25 March 2020. James Dyson apparently had a ventilator ready to go, but it was apparently being blocked under some misapprehension about how it worked and he was concerned that, despite having raised it with Matt and Lord Bethell, the issue was not being addressed. I passed this concern on so that Matt could respond, as there seemed to be some sort of miscommunication **[BJO3/040 - INQ000048399].**

48. By 26 March 2020, the estimates indicated that there would be a shortfall of 7-8,000 ventilators by 13 April 2020 **[BJO3/041 - INQ000564903]**. I attended a further call (my diary states the call was led by Matt), with the heads of domestic ventilator manufacturers that day, who were '*bullish about their ability to produce ventilators at pace and in large numbers*' (which I duly told the 9.15 the next day).

49. At the 9.15 meeting on Friday 27 March 2020, I gave a clear direction that Government must use every lever at its disposal to ensure the requisite 8,000 ventilators would be manufactured in time. I expressed my concern that there was not currently a credible strategy in place to coordinate this work successfully. On procurement, I said I would press the issue with China in due course to help make sure that the UK could procure 4,128 ventilators. I also noted that we needed to ensure sufficient staff were in place to operate the

newly procured ventilators **[BJO3/042 - INQ000088602]**. The 'live actions' circulated after this meeting included:

a. The NHS (Chief Commercial Officer, Emily Lawson) to set out a single programme plan to secure an additional 8,000 operational ventilators, which was to be provided to me for the 30 March meeting.

b. As part of that plan:

i. the Crown Commercial Service ('CCS') (Government Chief Commercial Officer, Gareth Rys Williams) to press domestic commercial providers for their detailed production timelines in the next fortnight and to set an indicative production target; and

ii. the DIT (Permanent Secretary, Antonio Romeo) were to work with the FCO and NHS to press for an increase supply from China, including entering the intermediaries' market (even where there was a price mark-up) and any other overseas sources **[BJO3/043 - INQ000088310]**.

50. By 30 March 2020, I was in self-isolation and attended the 9.15 that day by Zoom in which we focused on ventilators. We received a 'Ventilator Ministerial Brief', which seems to have been the plan I had requested **[BJO3/007 - INQ000088316]**. It sets out the levers available: on the 'Procure' side 'Push suppliers for more, faster' and 'Find New Sources'; and on the 'Make' side 'Maximise domestic manufacture' and 'Create new products', with detail of both the completed and in progress actions. The plan identified immediate actions, as well as support required from No10 and potential future action. The plan also summarised the status of manufacturing and details of potential suppliers through the 'Make' workstream.

51. As the minutes record, I said that there had been a real effort to source ventilators to maintain supply but the Government needed to be in a stronger position to ensure it was confident that there would be a stream of ventilators. I also noted that the media had been commenting on ventilator rationing, which needed to be addressed through accurate communications **[BJO3/044 - INQ000088603]**.

52. In the meeting, Emily Lawson provided an assurance that there was strong coordination between the NHS, DIT and FCO on procurement and due diligence of ventilators, but they would have to be procured above market price.

2,000 ventilators had been purchased the night before and it was now expected that supply should meet the anticipated peak demand now forecast for 12 April 2020 **[BJO3/044 - INQ000088603]**.

53. The minutes also record an offer from the Chinese Government to donate 8-10,000 ventilators and a further offer from the Chinese Commercial Minister to sell 3,940 ventilators. Israel had also offered to support the UK. These international efforts would be dealt with through the FCO, DIT and DHSC and there was discussion of the military helping with transport and distribution **[BJO3/044 - INQ000088603]**.

54. In summing up, I told the NHS and CCS to continue working to expedite and increase domestic production of ventilators and directed the NHS CO to '*work to bring together the various strands of Ventilator Supply with a timeline for their delivery to the UK. This information would have to reflect all of UK demand and the safety margin and should be updated regularly to track progress.*' I also said that I would '*engage with international partners wherever necessary'* and with China and that '*The UK should work to expand on production of ventilators and become a leading manufacturer*' **[BJO3/044 - INQ000088603]**.

55. Through April, whilst I was hospitalised and then convalescing, Lord Agnew and the CDL oversaw the Ventilator Challenge. During this time, the urgent need for ventilators dissipated. This was primarily because demand was much lower than expected (due, I believe, to the effect of NPIs). Targets were reset accordingly, albeit I was not involved in this personally.

56. As I returned to work, I requested and received updates on the Ventilator Challenge (including quite a detailed note from Gareth Rhys Williams on the TTP / Dyson project – my billet doux noted that Munira Mirza had also been working with Gareth on the ventilator challenge) **[BJO3/045 - INQ000563678]**.

57. In mid-May 2020, I commissioned a report from Alex Chisholm to set out the lessons learned about procurement. The final report was dated 20 May 2020 **[BJO3/046 - INQ000496718]** and was accompanied by a cover note from Lord Agnew **[BJO3/047 - INQ000496717]**. It observed that the functional model was providing benefits and should be reinforced but also identified and sought to learn from various shortcomings. In an earlier draft from 17 May 2020 which it is highly unlikely I would have seen at the time, under the section on ventilators, it notes that just under 10% of the available ventilators came from the Ventilator Challenge (which reflected well on the government's other processes). Part of

its success was attributed to parallel workstreams with the recognition and acceptance amongst senior leadership and Ministers that some would fail **[BJO3/048 - INQ000409846]**.

Spending controls and the overall value of the contracts awarded

58. I am not well placed to describe the key processes and procedures introduced, adapted or overseen to ensure there was overall value in the contracts awarded in relation to procurement. I was involved in discussions and decisions about the overarching strategy (see for example **[BJO3/049 - INQ000478821]** where you can see in August 2020 a record of my enthusiasm for removing barriers to rapid delivery and support of increasing delegations for the NHS Track and Trace and DHSC for certain areas of expenditure and No10 proposing changes to delegated spending controls) but then you have to trust the government machinery to get on with its implementation. We had Accounting Officers in place to take the buying decisions and assess whether we were getting value for money and staff with different expertise were surged across from other areas of government to try to ensure that we had the right numbers of people with the right expertise in place. While I would get updates and try to galvanise support for particular endeavours or wade in to clear log jams, it was not the case that I had any role in devising or overseeing the procedures by which we awarded contracts or scrutinised their value for money. I heard of concerns about the value of contracts and people or companies profiteering but it was not the case that these issues were escalated to me – nor would I, in the role of Prime Minister, have been well-placed to deal with them. I might well have given directions to encourage the teams to ensure the processes and procedures were working effectively but I did not – nor could I have had – the feet-on-the-ground knowledge and experience to be prescriptive about how this was done.

59. I cannot judge the effectiveness of the systems that were in place during the pandemic, nor can I offer any insight into whether there was effective and timely coordination about spending between different HMG departments such as DHSC, HMT, BEIS and DIT. I cannot speak to the effectiveness of the programmes for procurement and whether they were adhering to conditions imposed on spending by the Cabinet Office or HMT and whether they were

effectively monitoring inventory and expenditure. These were not areas in which I had – or would have expected to have – any involvement.

60. I had great sympathy for those involved in this effort. They were working long hours in difficult conditions with the primary aim of saving lives. Of course, we did not want to be ripped off but we were operating in a sellers' market, everyone in the world was vying for the same healthcare equipment and supplies and that meant decisions often had to be made at great speed to secure our supplies. By way of example, I recall that in October 2020 we needed to buy global stocks of lateral flow tests immediately, some 180 million tests. This was escalated to a meeting which I attended and I agreed to the purchase, conscious of the huge quantities being bought up by the WHO and the US around this time (see the readout from a meeting on 2 October 2020: **[BJO3/050 - INQ000477942]**). This was a rare case of this sort of decision coming to me – no doubt because of the urgency and volume it entailed – and I was never involved in the negotiations or contracts. Those taking these decisions were always balancing the costs of buying the supplies against the costs of not buying them. While perhaps it now looks like we paid over the odds (I do not know and will let the Inquiry judge), it is essential to remember the much higher costs we would have incurred if we did not have the necessary supplies in place.

High Priority Lane

61. I did not have any role in the establishment of the High Priority Lane ('HPL'). At the material time in 2020, I do not recall being made aware of the creation of the HPL, nor was I aware of how the HPL came to be established.

62. I am now aware that the HPL was used from around March 2020 to June 2020 to manage the significant number of referrals for contracts that were made outside of the Portal that had been set up on the gov.uk website for businesses to make offers to supply PPE. These referrals were being made by MPs, members of the House of Lords, ministers and senior officials who had been contacted by suppliers, such as constituents or contacts in industry, following the call to arms for PPE. I understand that, given the clear need for urgent PPE, those referrers would frequently seek feedback or progress reports. In addition, I understand that it was felt that leads from these sources may be more credible or need to be treated with greater urgency. As a result, a team of HPL officials was set up within the DHSC to deal with such cases, including: to manage the

levels of contact they required, to minimise disruption to the management of Portal offers and also to ensure that credible, larger offers were dealt with appropriately.

63. The role of the HPL team was to provide an initial check to decide if an offer was appropriate to progress on to the next stages. I understand that the HPL teams made decisions to progress offers using the same criteria as those used for Portal cases. Moreover, HPL offers were subject to the same scrutiny as the Portal offers from the Technical Assurance Team, Closing Team, Clearance Board and Accounting Officers. In other words, HPL offers were subject to the same assurance process and due diligence as other referrals. Indeed, I understand that two conflicts of interest were identified for companies that secured contracts through the HPL which were considered by a PPE Clearance Board – resulting in mitigations being put in place. Referrals from Labour party MPs were dealt with in the same manner as those from Conservative party MPs (I have addressed conflicts of interest below) and the names of the suppliers and referrers to the HPL came to be published on gov.uk.

64. I understand that the HPL did receive a number of high volume and credible offers, as well as securing donations of around £45m worth of items. The rate of success for HPL suppliers was higher than those through the ordinary lane (National Audit Office's 'Investigation into government procurement during the COVID-19 pandemic' dated 26 November 2020), however, that may be due to the quality of leads provided by the HPL. In any event, it remains the case that the vast majority of HPL referrals were unsuccessful: it was far from the case that an HPL referral brought a guarantee of success.

65. I am now aware that the High Court held that: (a) the HPL did confer an advantage to those that used it because HPL offers received earlier consideration at the outset of the process and proceeded to technical assurance faster; (b) the fact that the offer had been sent from a 'senior referrer' was not a justifiable objective basis for early consideration meaning that the HPL was a breach of the obligation of equal treatment; but (c) the HPL offers in question were likely to have resulted in awarded contracts even if they had been made through the Portal meaning that the claim was dismissed (*R (Good Law Project Ltd and another) v Secretary of State for Health and Social Care* [2022] EWHC 46 (TCC)).

66. It does not surprise me that I was unaware of the creation of the HPL at the material time. It would be unusual for a Prime Minister to be aware of the creation of a sub-team of officials dealing with procurement and to be kept updated on their work. It simply is not feasible or practical for a Prime Minister to be appraised of this level of detail – unless or until an issue arises.

67. As noted by the Public Accounts Committee in its report 'PPE Medpro: awarding of contracts during the pandemic': '*[t]he overall picture is of civil servants trying to fulfil the normal requirements of good contracting but without the time or structures in place to allow them to do this*'. Clearly, given the urgent need for PPE, it was sensible to avoid the use of a slow tendering process that could have added delays of at least a few weeks. One downside of that approach was that there was decreased competition and less time to scrutinise offers. However, those were sacrifices that I would have agreed with at the time, given the urgent need for PPE to save lives.

68. I do not recall (a) having any role in the operation and supervision of the HPL; (b) taking action to inquire or monitor whether any potential supplier had been awarded a contract or contracts; (c) being asked to intervene in the process for the award or refusal to award contracts to potential suppliers; (d) actually intervening in the process of my own accord; or (e) being approached by any potential suppliers whom I refused to refer to the HPL

69. In preparing this statement, I have been made aware of various people sending me messages with offers to help. Whenever I received these, I sought to funnel them to the right people. For example, I have been shown a Whatsapp sent to me by Richard Barnes who had been my Deputy Mayor of London. Richard told me in his message that his nephew was a manager for Ricoh in Telford who were making 40,000 face visors a week. He stated that they had received no orders from UK hospitals or the NHS and were going to export them to the USA. For obvious reasons, I wanted the system to be aware of this and to maximise our supply of face visors – particularly those made in the UK. As a result, I forwarded the message onto Matt, with the necessary contact details. Matt said he would get the team onto it **[BJO3/051 - INQ000129274]**.

70. In my second statement (for Module 4 on vaccines), I described the steps I took to foster relationships with the pharmaceutical companies in order to secure vaccines for the country. I have described in this statement the efforts I made to ensure that there was sufficient PPE. However, I do not recall those efforts

including fostering any relationships with PPE suppliers (save that I have described below some minimal contact with Randox which I do not believe was connected to procurement). I imagine that this is because the market for PPE was considerably more fragmented and that, while the situation presented incredible challenges, those working on procurement felt that they were able to secure the contracts that they needed without my intervention. It appeared to be a very different situation to vaccines where there were only a handful of pharmaceutical companies able to produce vaccines and who were dealing with issues of international diplomacy. I would have been happy to assist in securing a contract for PPE if that had been necessary, assuming that there was no conflict of interest issue. Certainly, I was never approached by a colleague and asked to intervene in the award of a contract in which that colleague had a vested interest.

Conflicts of Interest

71. MPs, members of the House of Lords, Ministers, Civil Servants and Special Advisers are all subject to respective Codes of Conduct. Those Codes of Conduct contain various provisions that require them to act in the public interest, not be influenced by improper pressures and avoid conflicts of interest (see paragraph 740 of my first statement).

72. In addition to those Codes, there is a List of Ministers' Interests, the House of Commons Register of Members' Financial Interests and the House of Lords Register of Members' Interests. Civil servants are also required to declare any conflicts of interest and to report relevant business interests, under the Civil Service Management Code.

73. Finally, public bodies are also under a common law duty/ public law principle to act with procedural fairness, which includes acting without bias or apparent bias, and there are Regulations that require measures to prevent conflicts of interest during procurement (the Public Contracts Regulations 2015).

74. I first published a Ministerial Code on 23 August 2019. On 27 May 2022, I amended the Code to introduce a range of sanctions for breaching the code. I therefore knew that this, and the other measures I refer to above, were in place at the material time. I had faith in the Ministers that I had appointed and, as a result, faith that they, and their departments, would comply with the relevant Codes.

75. I do recall concerns being raised about contractors having links to the Conservative party. I cannot recall when this occurred but I do recall various issues being raised in the media, for example issues with Randox and PPE Medpro. I had nothing to do with any of those contracts and I do not remember issues with those contracts being escalated to me at the time that they were agreed.

76. I did meet with Randox, alongside a number of other organisations, such as Wellcome, Serco and Roche, for a roundtable on mass testing on 17 March 2020 **[BJO3/052 - INQ000183955]**. The meeting was to explore how the companies that attended might assist with our aim of expanding testing. I am also aware that the PM diary records a meeting with Randox, Matt, Chris Whitty and a number of others on 16 July 2020 **[BJO3/014 - INQ000226185]**. I cannot remember this meeting but suspect it concerned issues that had arisen around that time in relation to the safety of swabs in some batches of Randox testing kits (see Matt's oral statement to Parliament on the same date).

77. I also remember being made aware, once this issue was likely to be raised in Parliament, that Labour MPs had referred some potential contractors to the HPL who appeared unsuitable or unexpected in terms of their ability to provide PPE. That said, the identification of new suppliers was one of the Government's aims.

78. In hindsight, one can see the potential for at least a perception of a conflict of interest through the HPL. I am aware that the Public Accounts Committee report into PPE Medpro was critical of DHSC's procedures for handling of conflicts of interest.

79. The Public Accounts Committee also criticised DHSC's procedures for handling of conflicts of interest in relation to Randox. On the other hand, I note that Matt says in his third statement to the Inquiry: '*[t]here are also absurd conspiracy theories surrounding the government Covid-19 contracts awarded to Randox. For context, the UK testing capacity was very small at the onset of the pandemic. With my team we built the biggest testing system this country has ever seen, at speed and under exceptional circumstances. Randox was the UK's largest testing provider. While again I had no direct involvement in the contracts, for the team not to work with them during this unprecedented global pandemic would have been wrong*'. In his earlier (second) statement, he stated: '*I am aware that there was subsequent criticism of the Government's decision*

to award Randox a contract for testing, but without them and thousands more businesses stepping up to help in the national effort to increase testing, many more people would have unfortunately died. It was vital for Covid-19, and will be vital for future pandemics, that when businesses are called upon to help convert their supply chains to support a particular goal, they step up. I fear that the criticism that many businesses have faced during and since the pandemic will lead to businesses and people deciding to not go out of their way to help in the next pandemic'. He goes on to say that criticisms of the fast procurement process underestimate the scale of the challenge faced at the time.

80. From my own perspective, it was certainly a seller's market and we were desperate to ensure that we had sufficient supplies.

81. Under the Ministerial code, I was the ultimate judge of the standards of behaviour expected of a Minister and the appropriate consequences of those standards. During the pandemic I was not aware of any concerns being raised in relation to ministerial declarations of interests and potential conflicts of interest with regards to Covid procurement that were determined to warrant a formal, Prime Minister-commissioned investigation, under the process set out in the Ministerial Code.

82. I do not recall allegations of a breach of the Code ever being raised with me. I refer to the media reporting above but do not remember credible allegations of a conflict of interest on behalf of a Minister being raised with me. I am aware that the National Audit Office examined a series of contracts and '*found that the ministers had properly declared their interests, and … found no evidence of their involvement in procurement decisions or contract management*' (The National Audit Office's 'Investigation into government procurement during the COVID-19 pandemic' dated 26 November 2020).

Steps taken to eliminate fraud and the prevalence of fraud

83. I do not recall being told about any specific frauds, levels of fraud or measures to prevent the risk of fraud at the material time. That is not to say that there were no frauds, nor measures to prevent them. Rather, it is likely a function of the passage of time and the fact that a Prime Minister cannot be appraised of all issues. As I have set out above, while I was appraised of some of the wider issues in relation to procurement, it was not feasible to be across all of the detail.

84. In preparing this statement, I have come to understand the work of the Government Counter Fraud Function in assisting departments to understand fraud risk and to assist with due diligence in PPE procurement. I have also been made aware that there was a Fraud Ministerial Board which was to coordinate and advise on the response to fraud for Covid-19 with a focus on the public sector.

85. Again, with the benefit of hindsight, when considering the issue of fraud, one can see that it was a risk arising out of the large-scale procurement that had to be done at speed. I am not able to provide a meaningful view on whether the risk was successfully mitigated. However, I note that the National Audit Office's 'Investigation into the management of PPE contracts' dated 25 March 2022 stated: '*[t]he Department [DHSC] has told us it expects fraud and error to be between 0.5% and 5% of PPE expenditure. This is the Department's best estimate, and it expects to have finalised its estimate by early summer 2022. The Department is undertaking work looking at the risk of fraud on a sample of contracts, including some of those awarded through the VIP lane. Government's Counter Fraud Function advised the Department in May 2020 that "fraud and irregular spending will be happening – the question is not whether, but how much and how it can be limited". The Department estimates the checks it put in place have prevented £139 million of fraud occurring and recovered a further £18 million (paragraphs 3.14 and 3.16).*'

Contractual provisions and performance by suppliers and manufacturers

86. As Prime Minister, the details and enforcement of contractual provisions with individual suppliers is not something that, so far as I can remember, was brought to my attention. As I explained above, I had a fairly limited role in the procurement of key healthcare equipment and supplies. I would intervene where I saw an issue, but otherwise this was a matter for the relevant Secretaries of State and their officials.

87. I was, however, keen to ensure that lessons were learned quickly. For example, in mid-May 2020, I asked Alex Chisholm to produce a note examining how the government had learned from the prior twelve weeks of procurement activity. As I have described at paragraph 57 above, this was provided to me on 20 May 2020 **[BJO3/046 - INQ000496718]**.

88. During the pandemic, the Cabinet Secretary and Alex Chisholm (the Civil Service Chief Operating Officer) asked Sir Nigel Boardman to review Covid procurement **[BJO03/053 - INQ000564907]** (this was in addition to his earlier review of procurement practices conducted in December 2020, the recommendations from which, I understood were accepted and implemented – see paragraph 8 of the 1 April 2021 note from Alex Chisholm entitled 'Boardman Review of Procurement' **[BJO03/053 - INQ000564907]**). Sir Nigel did not consider reform of procurement law, as this was already well underway (and culminated in the enactment of the Procurement Act 2023, see below).

89. Sir Nigel conducted his review between January and March 2021. He interviewed key people involved in the procurement programme at the time and focussed on procurement activity in relation to PPE, vulnerable persons (food parcels), ventilators, service for test and trace and vaccines. He concluded that he had '*not seen evidence that any contract within the scope of the review was awarded on the grounds of favouritism*', but he also identified a number of factors which may have encouraged such a suspicion **[BJO03/053 - INQ000564907]**.

90. Sir Nigel published his report on 7 May 2021 and I accepted all 28 of his recommendations, as did the Cabinet Office. I was very grateful for his work, especially given that it was conducted at such pace. After Sir Nigel's report was published, I was keen for his recommendations to be implemented as quickly as possible and asked Alex Chisholm to oversee the implementation of Sir Nigel's recommendation **[BJO03/054 – INQ000471031].** I was aware that a cross-government Boardman Review Implementation Board was convened to oversee the implementation of his recommendations

91. In around June or July 2021, I was asked whether I agreed to the pace of implementing a number of Sir Nigel's recommendations being increased **[BJO03/055 – INQ000477947]**. My recollection is that I agreed to this.

Compliance with public law procurement principles and regulations

92. I do not believe that this is something that I was involved in and nor would I have expected to be. As I explained above, I was aware at the time of the existence of various principles and regulations governing procurement, but enforcement and compliance were not matters for me as Prime Minister. Of

course, what was a matter for me was the Ministerial Code, which I made more robust with the amendments I introduced in May 2022.

Operation and effectiveness of regulatory regimes

93. In December 2020, my government published a green paper entitled 'Transforming public procurement'. The goal was to create a regulatory framework that delivered the best commercial outcomes with the least burden on the UK's businesses and the public sector. As Lord Agnew explained in the executive summary, my government proposed comprehensively to streamline and simplify the complex web of regulations that governed public procurement. The existing rules and regulations were simply too complex and created unnecessary confusion for both buyers and suppliers. This stifled innovation and deterred start-ups and small businesses from ever bidding for public contracts. My government's goal was to get rid of the unnecessary bureaucracy that was stifling innovation. In May 2021, the Queen's Speech announced that legislation to implement my government's plans to reform public procurement would be brought forward when Parliamentary time allowed. The Procurement Bill was introduced into Parliament on 11 May 2022 and received Royal Assent on 26 October 2023. It is a source of immense pride that the most fundamental overhaul of the procurement regime in generations was commenced by my government.

Decisions as to what to buy at what cost

94. Decisions about what to buy at what cost were the purview of the responsible Secretaries of State and their officials. My impression was that the processes and procedures in place were generally effective. I was, however, keen to ensure that if there was any room for improvement, this was identified quickly, which is why I commissioned Sir Nigel Boardman to conduct his review. In terms of data, I felt by this stage that we had the retrospective data that we needed and that we were clear on the needs of the nation.

95. I have been asked for my views as to whether I consider anyone, including me, or any company, received preferential treatment as a result of their status as a donor of or with a connection to the Conservative Party. I have no recollection of anything like that happening. I note in this regard Sir Nigel Boardman's conclusion that he had '*not seen evidence that any contract within the scope of the review was awarded on the grounds of favouritism*'.

Disposal strategies

96. I do not believe I was involved in any strategies for disposing of overpurchased healthcare equipment.

Distribution of key healthcare equipment and supplies

97. The distribution of key healthcare equipment and supplies (such as PPE) was led by DHSC and MHCLG. I do recall issues arising about the supply and distribution of PPE, in particular in April 2020. This was something I was very keen to address. Between 14-17 April 2020, the Implementation Unit conducted a rapid review. On 27 April 2020, I chaired a 'deep dive' on PPE **[BJO3/056 - INQ000088678]**. In this meeting, I set out the moral and economic case for accelerating the disbursement of PPE to the NHS and other public sector workers which, as I have mentioned above, I saw as imperative. Jonathan Marron presented a paper addressing supply levels for different items of PPE, as well as how to both understand and manage demand **[BJO3/057 - INQ000088482]**. DHSC subsequently developed a plan for meeting the demand for PPE.

98. This was something I also raised in Cabinet. For example, in a Cabinet meeting on 25 May 2020, I said that progress had been made on key operational challenges including testing and the supply of PPE **[BJO3/058 - INQ000089074]**. This meant that it would be possible to begin to relax some of the social distancing measures which were then in place. I made this same point in a press conference gave on 28 May 2020, in which I acknowledged the difficulties in test and PPE the country had faced since the start of the pandemic. I shared the public's frustration with this. However, it is important not to lose sight of the phenomenal improvements that were made. As I have already mentioned, by February 2021 we had built a stockpile of 32 billion items and could supply 70% of the PPE needed (excluding gloves) domestically, compared to 1% at the start of the pandemic **[BJO3/003 - INQ000564906]**. This was a massive achievement.

Suitability and resilience of supply chains

99. The huge problem we faced at the beginning of the pandemic was the inadequacy of our supply of PPE. This came as a shock. We were simply too reliant on foreign manufacturers. We made enormous strides in this regard and

Paul deserves the nation's gratitude for his phenomenal effort to get us where we ended up by February 2021.

Response to specific comments

100. The Inquiry has shown me the comments made by Professor Philip Banfield to Module 2. His comments seem to be wide-reaching and go far beyond the issue of procurement if, indeed, he is raising procurement at all. In so far as he mentions that PPE was uncomfortable, I am sure he is right, especially when worn – as it was by many of our heroic health and care workers – for long hours. And I agree entirely that early in the pandemic there were shortages which affected these staff in particular. I was alarmed and deeply saddened by some of the stories that I heard which is why I emphasised to Paul and to others (as I have described above) that we had to make sure that doctors and nurses and other health and care staff had the protection that they needed. We worked desperately to make things better.

101. The subject of health inequalities is a complex one. I understand that there were issues such as agency staff being refused the PPE equipment that NHS staff were provided, inadequate fit testing and training on proper use of PPE and masks not fitting (for example on those wearing beards or headscarves for religious reasons), all of which some studies have suggested had a particularly acute impact on different sections of the health and care workforce. Any disparities across ethnicities, religions and other groups are something that we must all work hard to combat and I believe it was something we were aware of during the pandemic and took into account. But it is not an easy question – there were different vulnerabilities among different groups – and we were learning as we went along.

102. Sufficiency of hospital capacity and the availability of key healthcare equipment and supplies to meet the need created by the pandemic is another very difficult matter. People have different ideas of whether the NHS was overwhelmed and what that means. I think we came close and at times it was touch and go; the pressure was intense. I do not, however, think we were in the same position as some other countries where vast numbers of people could not be treated. We were never called upon to use the Nightingale Wards in the way we had feared we might need to and dreadful though it all was, the NHS and the health and social care workers did an amazing job.

103. It has been put to me that Helen MacNamara '*said that there were "institutional biases against women" in Covid decision-making*' quoting from paragraph 104 of the written statement that she made to Module 2. What she in fact wrote in that written statement was: '*There was also a failure to appreciate some of the longer-standing institutional biases against women e.g. in how data was collected*' and she then talked about data issues before saying that partly because of reading Caroline Criado Perez's book 'Invisible Women' and partly because of Twitter commentary, she:

> *raised issues about e.g. the inadequacies of PPE for women, and tried to make sure this was taken into account in any new supply. The Prime Minister raised this with Simon Stevens on April 30th and he reassured the Prime Minister and Ministers that the issues with PPE fitting women's bodies were mis-reported and there was not a problem.*

104. Insofar as they are relevant to issues in Module 5, I hope the Inquiry can see from the full context of what Helen has said that I listened to her concerns, took them seriously and raised them at the highest level with those I believe were in a position to ensure any problems were tackled. I have already responded to Helen's points in my oral evidence to Module 2. As I said to the Inquiry, *'I think that it is not right or fair to say that policy was conceived or driven forward without regard to the particular needs of women…We were very alive, very alive, and I was personally very alive to this issue…I believe that we did a lot on that'* (pages 163-164 of Inquiry's Module 2 hearing transcript, day 31, 6 December 2023). That was a general statement of our approach and it applies equally to procurement.

105. It is also fair to reflect that we were learning throughout about the implications of ethnicity, sex and gender and other characteristics and we always sought to improve systems to remedy any disadvantages; this applies not just to procurement but across all government work. As soon as any issue arose, it was my understanding that it was tackled. For example, after there were reports that certain PPE did not fit women, on 30 April 2020 it was raised at a 9.15 meeting and DHSC asked to confirm that the PPE procured was fit for purpose **[BJO3/059 - INQ000088643_0005]**. The Chief Executive of the NHS responded to this and was recorded in the minutes as saying '*There was ongoing work to investigate the suitability of PPE for all those using it, and testing to make sure it was suitable for – women, those who are Black, Asian and minority ethnic (BAME), and those with different face shapes or facial hair'* **[BJO3/059 - INQ000088643_0007]**. Although I do not recall this particular

occasion without reference to the documents, it would have reassured me that sufficient account was taken of the sex, gender and ethnicity of health and care workforce when procuring PPE and other key healthcare equipment.

Reflections on procurement

106. My overall view of what I saw of the procurement processes was that it was akin to pulling a brick on a string. At first, nothing happens but then – wham! – the brick shoots towards you. That was how it felt. It was very difficult in the beginning but by the end we had colossal quantities of the PPE and supplies that we needed. We were able to make a huge amount on UK shores. In a situation such as a pandemic, you need to be in the latter position, even if that means you find yourself with a glut of supplies.

107. I have been asked what steps I took to address data issues arising from my frustration in a Cabinet Meeting on 14 July 2020 about the availability of data. This was not the only time I expressed this frustration – it was my frequent refrain, especially in the early days of Covid. I have outlined, in my first statement (paragraph 230) my frustrations about the lack of up-to-date and accurate data in the initial days, and I had meetings with Matt, Chris Whitty and Simon Stevens to discuss NHS data and demand (see, eg., **[BJO3/060 - INQ000563674]**). At the 26 March 2020 9.15 meeting by way of example, I was shown the new 'C-19 dashboard' for the first time and requested more data to be available on the daily dashboard. This was to include intensive care capacity, ventilator capacity, PPE supply, roll-out of testing (including projections) and supply of necessary components (e.g., swabs and reagents). I also noted that the dashboard reflected largely figures from England and Wales, which was a limitation, and requested that Tom Shinner and the CCS team keep pushing for more data from Scotland and Northern Ireland **[BJO3/061 - INQ000056267]**. Much of this required a great deal of work behind the scenes and it was not until 8 April that the UK's existing ventilator stock (of 8,262) began to appear on the dashboard **[BJO3/062 - INQ000083400]**.

108. As I said in my first statement, I was appalled by the NHS provision of data and data-sharing (paragraph 712 and also for example 239). But much was done to address it (by me and others) as I have described in that statement:

a. my demands for better data led to the creation of the Digital Dashboard (see paragraphs 222-226) and throughout the pandemic I frequently asked for different data to appear on it or for there to be a change to its format (see for example, paragraphs 238, 257, 302);

b. a new team was set up demonstrating the benefits of data sharing (paragraph 432);

c. the Government changed the rules on sharing patient data (paragraph 432);

d. we directed all health bodies to share data to combat Covid (paragraph 432);

109. In the summer of 2020, one of my excellent SpAds, Ben Warner, set up the No10 Data Science and Analytics team with the aim to improve government decision-making by using data science; it helped the CCS to build the capability of the Dashboard (paragraph 745).

110. I have described above all my critical reflections and lessons learnt on procurement during the pandemic. It is inevitable in trying to save lives and in properly prioritising of human health, huge exertions were made and some people will say in retrospect that these were excessive or produced excessive results. There was no way of avoiding it. That applies to diagnostics, to procurement generally and to PPE.

111. I think we left the pandemic in a much better place than we went into it. When I left government, this country was in a much stronger position on supply chains, PPE, diagnostics and data. Our diagnostics capacity was bigger than anywhere in Europe at the end. As a result of our exertions, there were very considerable supplies and an incredible ability to build and create supplies on UK shores.

112. What changes do I think should be made to improve procurement by the UK government and devolved administrations for future pandemics? First, I think it is crucial to develop and maintain PPE supplies (and to do so on a rolling basis so that they do not expire and go to waste), especially to ensure there is always provisions for those working in health and social care settings. Second, I agree with a recommendation made by Theo (see **[BJO3/047 - INQ000496717]**) that all public authorities should be properly accountable for their inventories, whether this is numbers of beds in the NHS

or quantities of PPE. This will then allow central government to keep data on stocks of everything in times of crisis. That feeds into my third suggestion: I think our data capacities must be constantly updated and revised to keep up with and take advantage of new technologies. Finally, I believe that the Procurement Act 2023, which began as the Procurement Bill in 2020 when I was Prime Minister, started to put the lessons that we had learnt into effect by increasing the flexibility of competitive procedures, allowing direct awards when necessary to protect human life or public safety and greater transparency and conflicts of interest transparency. I think it would be sensible to have an off-the-shelf emergency package for how to deal with procurement should this happen again, which includes for example a plan for staff to be surged, red tape cut and processes in place to prevent conflicts of interest and undertake due diligence at pace to ensure we are able to secure the appropriate supplies.

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…….Personal Data……

Dated: 25 February 2025