1 Thursday, 27 March 2025
2 (10.00 am)
3 (Proceedings delayed)
4 (10.11 am)
5 **LADY HALLETT:** Good morning, Mr Sharma.
6 **MR SHARMA:** Good morning, my Lady. We are starting a little
7 later than usual, but we will complete Mr Williams's
8 questioning on time.
9 MR DAVID WILLIAMS (sworn)
10 Questions from COUNSEL TO THE INQUIRY
11 **MR SHARMA:** Mr Williams, before I start asking you some
12 questions, I understand there are some words which you
13 wish to say.
14 **THE WITNESS:** Mr Sharma, thank you.
15 I would just like to preface this session with an
16 acknowledgement of the deep and enduring impact that the
17 pandemic had on the people of this country, those who
18 were ill, the families of those who died, frontline
19 staff in the NHS, social care, the third sector. It's
20 the context, clearly, for this Inquiry, it's also the
21 context for the decisions that I and my teams in the
22 Department of Health were making during the period that
23 we are going to examine today.
24 I have looked at the impact video for the start of
25 this module, and the depth of emotion and impact not

1 only from five years ago, but how present and real that
2 remains with the families of those who died, with staff
3 working on the front line is, I mean, palpable, and
4 I think a really important context for evidence today.
5 In the context of PPE, clearly there's an impact
6 there around supply and confidence in our support to
7 frontline staff delivering difficult work in really
8 difficult circumstances, and how they approached that
9 job. Also an impact on families in terms of the ability
10 of institutions to offer access to family members whilst
11 maintaining infection control, and that's also a really
12 important context for me for how good a job,
13 collectively, we did.
14 But I'd also just like to acknowledge that staff
15 working on these deals, staff supporting the department
16 in its rapid procurement work, were themselves dealing
17 with the daily ins and outs of the disease. They were
18 either ill themselves or had family members who were
19 ill, dealing with the consequences of lockdown, all of
20 those stresses in their private life alongside really
21 demanding work.
22 The impact directly of Covid-19, the impact through
23 displacement of other healthcare -- the impact of
24 lockdown on social mental health wellbeing, as well as
25 the economic impact is the backdrop, in the end, for

1 a range of decisions that we were making at the time and
2 I expect we will explore that more fully in the session
3 ahead's thank you.
4 **MR SHARMA:** Thank you very much, Mr Williams.
5 Could I begin, please, with the two witness
6 statements you've provided to the Inquiry. They are
7 INQ000475015 and INQ000475014. Could you be kind enough
8 to confirm they're true to the best of your knowledge
9 and belief?
10 **A.** They are, yes.
11 **Q.** To begin by your background, you are, I understand,
12 a civil servant by career. You first joined the
13 Ministry of Defence in 1990 and it is there that you've
14 spent the majority of your career; is that right?
15 **A.** That's correct.
16 **Q.** In 2015 you were the Director General of Finance and
17 Group Operations at DHSC; is that right?
18 **A.** That's correct.
19 **Q.** And on 5 March 2020 you were made the Second Permanent
20 Secretary at DHSC?
21 **A.** That's also correct.
22 **Q.** And since 6 April of 2021, you have been a permanent
23 secretary back at the Ministry of Defence?
24 **A.** Correct.
25 **Q.** Just to begin, please, with your role as the Second

1 Permanent Secretary and then your role as an accounting
2 officer, could you please explain to the Inquiry what
3 that entailed during the pandemic?
4 **A.** Yes. So look, I was a member of the Senior Leadership
5 Team of the Department of Health and Social Care during
6 the period that you have set out. So my role as Second
7 Permanent Secretary was both providing direct support to
8 Sir Chris Wormwald, as Permanent Secretary, in the sort
9 of full range of activity that the department was
10 undertaking, ensuring, in terms of my sort of
11 pre-pandemic responsibilities, that the department
12 itself was organised and able to deal with the various
13 aspects of Covid-related regulations, so how we were
14 supporting remote working, how we were managing social
15 distancing within the workplace, ensuring the department
16 itself was able to function whilst being compliant with
17 the, sort of, Covid rules of the day.
18 Operating as part of the Senior Leadership Team in
19 setting direction for the department, supporting staff
20 in their work, ensuring that we were able to onboard the
21 resources that we had. And then specifically, as an
22 additional accounting officer, responsible for a range
23 of procurement and other activity through the pandemic,
24 including rapid procurement of ventilators, of PPE,
25 procurement of capacity, whether that was lab capacity,

1 through to individual test kits, to support the NHS Test
2 and Trace Programme, as well as broader financial
3 support, close working with NHS England and other parts
4 of the system.
5 **Q.** Thank you very much. Sorry to interrupt.
6 **A.** That's all right.
7 **Q.** But just to place your role in context, we are going to
8 focus this morning on one part of your role which is as
9 an accounting officer --
10 **A.** Yeah.
11 **Q.** -- but also acknowledging that whilst you were an
12 accounting officer you had a number of other important
13 responsibilities within the Department of Health and
14 Social Care?
15 **A.** Yes, that's correct. No one day was ever really quite
16 the same.
17 **Q.** The Inquiry has heard evidence from another accounting
18 officer, Mr Young, and has also received written
19 evidence from the third accounting officer, Mr Fundrey.
20 Just in terms of the differences between the three of
21 you, it's right, isn't it, that your authorisations in
22 terms of being an accounting officer were those above
23 £100 million, and those for Mr Young and Mr Fundrey were
24 those below 100 million; is that right?
25 **A.** That's correct. I was formally appointed additional

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1 accounting officer by Chris Wormwald, and that brings
2 with it a degree of personal accountability to
3 Parliament. Mr Young and Mr Fundrey were both directors
4 working for me, and I delegated those responsibilities
5 below 100 million in the way that you have set out.
6 **Q.** Just focusing in on that relationship between you,
7 Mr Young and Mr Fundrey, were you working collectively
8 in those decisions to make accounting approvals or were
9 they personally dealt with by you? How did work on
10 a day-to-day basis?
11 **A.** So, look, they were professional, highly competent
12 officials in whom I had a lot of trust. For issues --
13 for deals below that £100 million threshold, they had
14 freedom and flexibility to sign those deals off without
15 reference to me, but we were engaging and working
16 closely together on a day-to-day basis and if they had
17 concerns, or they wanted some guidance from me, they
18 would raise them.
19 Some of the deals that came to me would have been
20 through their assessment before they came to me. Some
21 of them came to me because the price or volume of the
22 deal changed, which meant that it came above the
23 threshold.
24 So we had distinct responsibilities, but we worked
25 closely together in a climate that I would describe as

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1 a high degree of professional trust.
2 **Q.** In terms of the numbers of contacts and volume, the vast
3 majority were below the £100 million threshold, and so
4 they were approved by Mr Fundrey and Mr Young. You, by
5 contrast, estimate that you were only involved in about
6 ten contracts; is that right?
7 **A.** Yeah, about ten is what I've said in my statement. It
8 might be a few more, a few more than that, but I'd be
9 surprised if it was more than 20.
10 **Q.** Managing Public Money, please. We've covered this
11 a little bit with Mr Young so I hope I can deal with it
12 with you briefly.
13 The principles of Managing Public Money, we don't
14 need to bring them up: regularity, propriety, value for
15 money, feasibility and deliverability, they're the
16 principles that Mr Young said he was abiding by. It's
17 the same with you, isn't it?
18 **A.** Yeah, it's the same set of principles, although,
19 clearly, as an accounting officer you bring an element
20 of personal judgement to how those principles are
21 applied.
22 **Q.** You make reference in your written statement, it's
23 page 6, paragraph 18 and 19, to two practical ways in
24 which Managing Public Money had to be applied. You make
25 reference to "the application of sheer common sense" as

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1 being one of the criteria or one of the principles that
2 you brought to bear; is that right?
3 **A.** Yes, indeed, Managing Public Money itself says that
4 nothing in that guidance should get in the way of
5 actually applying common sense to the decisions that
6 accounting officer's making.
7 **Q.** And you also make the observation from Managing Public
8 Money that the rules cannot be set for every situation
9 or every circumstance, and that's where what you've
10 described as your judgement being critical?
11 **A.** Absolutely, and look, clearly the circumstances of the
12 pandemic were unprecedented, and so whilst the
13 principles themselves remained unchanged, how they were
14 applied, the judgements that we made, the risk appetite
15 that we had, was not static through this period.
16 **Q.** Bearing that in mind, do you recall any of the PPE
17 contracts which arrived on your desk that you didn't
18 approve?
19 **A.** By the time they got to me, deals had been through quite
20 a rigorous process of commercial evaluation, quality
21 assurance and technical evaluation, deal making and
22 financial assurance. So normally, if there were issues
23 that would have prompted me to want to say "no", they
24 wouldn't have come to me. So I can't immediately think
25 of any deals that I personally rejected. I can think of

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1 deals where I've asked for further clarification or
2 confirmation of the terms or confirmation of the
3 requirement.
4 Q. You also refer in your written evidence to relying not
5 only on the content of the AO packs, ie, the
6 frontispiece and then all of the documents that come
7 behind it, but also on steers from Mr Marron and
8 Dame Emily Lawson. Could you help us, please, with what
9 steer or what assistance they provided you in the
10 assessment of deals?
11 A. So one of the important inputs to that accounting
12 officer judgement is an understanding of the
13 requirement, and what I really looked to Dr Lawson and
14 Mr Marron jointly, was their understanding, their
15 confirmation, that there was a requirement for the PPE
16 that we were buying within the timescales that we
17 expected it to deliver. Dr Lawson also brought an
18 element of additional, sort of, commercial nous to the
19 recommendations alongside the teams working below us.
20 Q. Setting aside, just for a moment, the individuals you
21 worked with, to focus on a theme throughout this module,
22 which is value for money.
23 A. Yeah.
24 Q. That being one of the principles in Managing Public
25 Money and also critical in your assessment of the deals

1 and the contracts which landed on your desk. In terms
2 of value for money, one of the areas in which DHSC
3 worked was on something called price benchmarking.
4 Could you help the Inquiry, please, with what price
5 benchmarking is and how that assisted in your
6 determination of the deals?
7 A. Yeah, if I might, understanding that time is precious,
8 let me just take one step back, though. At the macro
9 level, and we had set out in advice to the Secretary of
10 State in late March -- look, in a world where, at its
11 peak, hundreds of people were dying every day, there was
12 an impact on society through lockdown, and deep economic
13 cost, a willingness to spend money in the expectation or
14 the anticipation that it might shorten the pandemic or
15 shorten lockdown by a week was money well spent and
16 a risk that I was willing to take. So that's the macro
17 context of the value for money on decisions that we were
18 making.
19 But within that what you wanted to understand was
20 whether, you know, deal A was a better prospect than
21 deal B, if you had more than one option in front of you.
22 Price benchmarking was a way in a really volatile,
23 global market where prices were fluctuating, escalating
24 materially, was a way of understanding how the price of
25 a deal in front of us related to the average price that

1 we might have been paying over the previous week or the
2 previous 14 days. It was an important financial input
3 into the decision making, not the only one, the level of
4 prepayment, for instance, was also a factor. And the
5 financial calculus was itself only one element that I or
6 Mr Fundrey or Mr Young will have assessed in coming to
7 our accounting officer judgement.
8 Q. And just to make sure the price is not taken out of
9 context as it might be, you refer in your statement,
10 similar to what you've just described to the Inquiry,
11 that your decision having been taken and considered in
12 the round, and of the factors that you and others were
13 taking into account, you refer to the existing stock
14 levels, the quantity of the offer, the apparent quality
15 of the equipment being procured, the price for which
16 price benchmarking is relevant, the delivery time and
17 the particular terms and conditions, for example in
18 relation to prepayment.
19 And you were making a judgement call as an AO in
20 respect of each of those criteria to weigh up the offer.
21 A. Yes, that's correct. And look, in early April where we
22 were particularly worried about stock levels and you
23 could see the impact that distribution challenges was
24 having on frontline staff and their concerns about
25 availability of the PPE at the ward level rather than at

1 the national level, a focus on timeliness of supply and
2 our confidence of actually getting our hands on the PPE
3 was a more important factor than simple price
4 benchmarking.
5 Later in the process, as we had built up a greater
6 resilience in days or weeks of supply, then some of that
7 calculus would change.
8 Q. Could we have a look, please, at a document
9 INQ000496719. Thank you.
10 This is PPE Buy Cell pricing benchmarks. This one
11 is issued on 20 May, data, from 15 May. If we could
12 turn to page 2, please.
13 If we have a look, setting aside the chart on the
14 left to one side, on the right-hand side, looking down
15 the column at gowns, thank you. What this is setting
16 out are the sorts of prices in the first box, the unit
17 price in quarter 4, 2019, so the price pre-pandemic,
18 effectively. Looking at the average unit price between
19 April and May, £2.69, and then the changes in price is
20 156%. So I just want to have a look at that.
21 And if we can turn forward, please, to page 3, and
22 just to zoom in, please, we're going to look at gowns
23 and coveralls in the examples we're looking at. So if
24 we zoom in, please, to the top. Again, the price
25 pre-pandemic, £7.33, and then the increase in price

1 which is seen in April and May to £16.32, and then the
2 six-week pricing development, 123%.
3 Then I'm going to ask you some questions about this
4 but just to provide context to the fluctuations in
5 prices that you describe.
6 Could we have a look, please, at page 31. This is
7 for gowns. And this is showing, in that chart the
8 ranges of prices which are being paid for gowns from
9 March through to May, with the weighted average there
10 represented by the blue line going up and down.
11 This is what you're describing by looking at the
12 range of prices which are available and price
13 benchmarking; is that right?
14 **A.** Yes, I mean, this was a report done, as you say, in May.
15 We would look at reports like that. We would also just
16 look at knowledge that the team had about what were the
17 deals that we had signed off in the previous week, what
18 were the prices there and, of course, it was also
19 relevant about what were the prices being offered, what
20 could we negotiate down on the deals that we had in
21 front of us.
22 I mean, just on this particular table, two slight
23 caveats, although I think the general picture of price
24 volatility and substantial increases in prices across
25 all categories of PPE during this period is that it's

1 not fully data cleansed for whether or not the deal
2 included shipping. So a deal without transport would be
3 cheaper than a deal with, and if you were really worried
4 about early delivery and you were airfreighting, then
5 the price would be different than if you were shipping.
6 Within the gowns category, this covers non-sterile
7 and sterile gowns and, as you might imagine, the price
8 for sterile gowns is higher. So it is illustrative of
9 the kind of market we were operating in. It is
10 illustrative of the fluctuation in prices, in particular
11 you can see a lot of that in that first phase of late
12 March through to end of April, early May. But if you
13 wanted to know why there's a spike in prices right at
14 the end of April, beginning of May, then you would need
15 to look at all the other factors that went into the
16 decision.
17 **Q.** We're going to come on to some of those factors as we
18 look to at some of the AO packs.
19 Just to make it clear, I am not suggesting, as we go
20 through these AO packs, that this document was available
21 to the person who was considering them. And in fact,
22 just to follow on from the point that you've just made,
23 in terms of the information available to you, as the
24 accounting officer, or indeed to Mr Fundrey and
25 Mr Young, clearly it wasn't this document. This

1 summarises what the situation was over the course of the
2 previous month.
3 How were you able to make assessments about whether
4 the prices per unit were offering value for money for
5 the items on the AO packs which you considered and
6 authorised?
7 **A.** So we would have, in the packs, I mean, obviously an
8 indication of the price in the deal, together with
9 information on either the price that we'd been paying
10 over the previous week or two weeks, or what the price
11 had been in the last sort of handful of deals that had
12 been agreed.
13 We would also have a benchmark about other deals
14 that were in the offing, so the PPE buy team would be
15 managing more than one prospective deal at any one time.
16 So they could see what the range of market prices at
17 that time would be. But, of course, we would then also
18 have information on those other factors, as we have
19 discussed.
20 So there was, I would say, reasonable data on
21 pricing but not perfect.
22 **Q.** No. And also subject to many of those caveats which
23 you've illustrated. So shipping being the most obvious?
24 **A.** Yeah.
25 **Q.** In terms of the information available to you as the AO,

1 the description that we have had from Mr Marron is that
2 the deals were making their way through the eight-stage
3 process before they arrived on your desk for
4 authorisation; is that broadly right?
5 **A.** That's broadly right, yes.
6 **Q.** In terms of the visibility that you had on other deals
7 that may be coming down the pipeline, what did that look
8 like and how did that factor into your decision making
9 and those of Mr Fundrey and Mr Young?
10 **A.** So, firstly, a deal for my agreement or authorisation
11 wouldn't just -- I mean, it did end up in my inbox, but
12 it wouldn't just end up in my inbox without any notice.
13 There would be engagement with the team about, you know,
14 "We have a deal coming to you, we're expecting to get
15 you to buy here, these are the things that we are
16 currently looking at."
17 There would be data available -- I mean, I did not
18 attend the sort of daily stand-ups of the PPE buy team,
19 but there was data available in the system and from time
20 to time I would engage with it on the range of deals
21 that were also in development.
22 Sometimes, not often, normally I would be given
23 a single deal to sign off, but sometimes I would be
24 given a note which said, "We've been pursuing three
25 deals, we recommend these two but for reference here is

1 the third that we now propose not to take forward."
2 Q. Thank you. Let's look at some practical examples,
3 please. As we go through them, I'm not suggesting in
4 any way that these are the ones that you considered; I'd
5 just like to hear your reflections, please, on the
6 information which was available to the AO, particularly
7 around price benchmarking and the categorisation of the
8 items being offered. They are all -- just so that
9 you're clear, they are all about either gowns or
10 coveralls.
11 A. Okay.
12 Q. And we've just seen the two prices up on the screen
13 a moment ago. Have in your mind, please, that that
14 April to May average gown price was £2.69 and the
15 average price for coveralls was £16.32, just as we go
16 through this, so that we can obtain your reflections.
17 Could we have up on screen, please, INQ000521800.
18 Thank you. If we can zoom in, please, to the bottom.
19 "We have just been informed ..."
20 Thank you.
21 "We have just been informed that there is an extreme
22 shortage on gowns and coveralls. If we can expedite
23 this order through when would you be able to deliver as
24 a matter of urgency, like tonight."
25 Just before we unpack this, in terms of gowns and

1 coveralls, from your perspective, was that
2 interchangeable? Was there less demand for one and more
3 demand for the other? Did that change during the course
4 of the early stage of the pandemic?
5 A. So, they -- well, I mean, they were interchangeable to
6 the extent that if you didn't have access to gowns,
7 then, I mean, a coverall would be acceptable, but on the
8 whole what we were focusing coverall purchase on, as far
9 as I recall, was on specific workforce groups. So
10 paramedics, for instance, people out and about, in and
11 out of ambulances, needing more movement, coveralls
12 allowed them to perform the full range of their task
13 without constantly having to put gowns on and off, so --
14 Q. Sorry, I ought to have done this at the beginning, but
15 just in very brief layman's terms, please, the
16 difference between a gown and a coverall?
17 A. So -- and I'm probably at the layman end of the spectrum
18 here as well -- we were buying aprons which were, as
19 I say, I think, one size fits all, covers the front of
20 the body, ties at the back. We were buying gowns, both
21 non-sterile, really for protection in general usage,
22 sterile for use in surgical situations, which would
23 have, you know, more of an arm to it, would be closer
24 fitting and provide a greater coverage.
25 Coveralls are more like a-- I'm trying to avoid

1 saying a -- sort of a "onesie", which is now the only
2 word I can get in my mind, but, you know, trousers,
3 legs, zip, arms. So quite a different product.
4 Now, if you have an absence of lower spec but
5 satisfactory products, you could always use a higher
6 spec one, but on the whole, on coveralls, we were buying
7 those to target particular work groups that needed that
8 level of flexibility, freedom of movement, and just for
9 the ... well, the capability that a coverall offered.
10 Q. For the purposes of the questions I'm going to ask you,
11 there are differences, aren't there, between the prices
12 paid for each of those two categories of gowns you
13 describe, sterile, non-sterile, and then separately
14 again in respect of coveralls; is that right?
15 A. Yes, that's right.
16 Q. Could we have a look, please, at INQ000521799.
17 If we can zoom in, please, to "Market price
18 assessment". Thank you.
19 I'm just going to go through some of these documents
20 quite quickly. So:
21 "'Normal' prices ... [including] for Gowns £1.57 ...
22 negotiated unit price [in this case] is ... £8.00 ..."
23 And then you mention there the shipping cost.
24 Then if we can look at the final sentence, forgive
25 me. It then says at the bottom that:

1 "The delivered unit price for these Protective
2 Coveralls is average compared with other recent
3 purchases."
4 Then if we can turn over to page 2, thank you.
5 Then at the very bottom:
6 "Make all reasonable attempt to ensure prices [the
7 very bottom box] are [below] 25% above the average unit
8 price paid to date ... No (prices exceed 25%)."
9 Just on this document, it refers to gowns, and then
10 it refers to protective coveralls, then it refers to
11 benchmarking.
12 A. Yeah.
13 Q. And trying to come below the 25% limit. What are your
14 reflections, if you had a document like this, in terms
15 of what it was may have been being bought, what
16 enquiries would be made to make sure that the
17 benchmarking was at the right product at the right
18 price?
19 A. So, look, without knowing which deal this is, what
20 I take from the extracts that you've shown is that this
21 is for a purchase for a blend of gowns and coveralls,
22 and, as we've explored, there was quite a range between
23 the average prices for those two distinct items. What
24 I don't have here is a feel for the relative volumes
25 within this deal of those two different types of

1 product.
2 I think the language at the end of that paragraph
3 that you showed around -- for the protective coverall
4 element, it being broadly in line with average prices.
5 And of course the point about an average price is that
6 sometimes you'll be buying below, sometimes you'll be
7 buying above.
8 Look, there is information here, there will be more
9 information in the supporting packs, but, depending on
10 the date and the timing, factors like the level of
11 stock, our confidence in inflow from other deals, the
12 timeliness of delivery here, our confidence in the
13 supplier, was this was a new supplier or somebody we had
14 used before, would all be relevant -- the level of
15 upfront payment, for example, all of that would be
16 relevant to the decision.
17 And price -- price benchmarking was an important and
18 interesting input to that. Rarely on its own was it
19 decisive, certainly in the cases where -- by the time
20 they came to me. But there are, equally, examples of
21 the buy team, the Clearance Board rejecting deals on
22 basis of price, using price benchmarking.
23 **Q.** Forgive me, the Clearance Board is an entity that came
24 into being on about 4 May; is that right?
25 **A.** Yes, that was established in early May.

1 **Q.** And the purpose of that was to provide an additional
2 level of assurance, a sort of ninth stage in the
3 process, is that right?
4 **A.** So an additional level of insurance in part prompted by
5 some conversations we had been having with the
6 government banking service about their nervousness of
7 the -- I mean, it's a necessary feature of the deals
8 that we were doing, but multi-hundred-million dollar
9 deals in a foreign country -- in foreign currency with
10 substantial prepayment into third countries through
11 suppliers with not much track record is, if you have any
12 sort of fraud detection system, will set all of those
13 bells running. And of course, those were issues that we
14 were grappling with ourselves, but in conversation with
15 the government banking service over that first Bank
16 Holiday weekend, we agreed to establish this additional
17 level of clearance and, indeed, we got a better flow of
18 information with the banks themselves about their
19 understanding of some of the counterparties that we were
20 dealing with.
21 **Q.** So for somebody in your position, after 4 May of 2020,
22 presumably that's another level of assurance. It's been
23 through another group of people looking at the
24 contracts; is that right?
25 **A.** Absolutely. Look, it was three of our most senior

1 commercial officers and then the finance lead, deputy
2 director level, working for Jon and Chris, who in the
3 end made the payments.
4 **Q.** Thank you.
5 Another example, please. INQ000560854.
6 This is another April 2020 deal. We've seen these
7 documents in part before with Mr Young. These are the
8 documents which summarise, don't they, the content of
9 the AO pack and the --
10 **A.** Yeah.
11 **Q.** -- material features of the transaction for your review
12 or for the review of the other AOs. Here it says the
13 unit price delivered for gowns, on page 1, is £8.20 to
14 £8.40.
15 Forgive me, if we could turn over the page to
16 page 2. That's it, thank you.
17 The market price assessment. Again, here the guide
18 price for coveralls/gowns is £1.57, and the negotiated
19 delivery unit price is £8.20 and £8.45. Recent orders
20 for gowns had been £6 delivered, so under the current
21 conditions the negotiated delivered unit prices are
22 deemed to be reasonable.
23 If we could turn over to page 3 and then zoom into
24 the average --
25 **LADY HALLETT:** Sorry, you said £6, Mr Sharma, sorry to

1 interrupt.
2 **MR SHARMA:** Oh, I'm sorry.
3 **LADY HALLETT:** It says 16.
4 **MR SHARMA:** £16. Thank you, my Lady.
5 Then if we turn over to page 3, the average unit
6 price paid to date for these items. And as my Lady has
7 observed, the gowns, "Average UK price paid is £10.30,
8 though recent purchases have been £16 delivered. This
9 price is favourable."
10 So again, in this document a conflation between
11 gowns and coveralls it seems.
12 **A.** Yeah.
13 **Q.** Yet if we were looking at the benchmarking for gowns and
14 coveralls they'd be quite different, wouldn't they?
15 **A.** Well, yes, so one, I mean, the benchmarking data that
16 you were showing earlier takes a longer timeframe. So
17 it will start from late March, where before we saw an
18 awful lot of the price escalation. So that's not
19 necessarily comparing like with like. Though it's
20 a point of reference.
21 As I said, in my sort of responses earlier,
22 benchmarking in the terms of the deals that we were
23 doing against ones that we had recently done and our
24 most recent experience of prices over the previous week
25 or two weeks was really effectively how we were doing

1 this.
2 In this particular case, if it's the one I think
3 I am (sic), but I won't say which one I think it is,
4 there is a particular.
5 **Q.** Forgive -- just so it's clear, the reason why you're not
6 is because it's been redacted --
7 **A.** No, no, at our request. That's right.
8 **Q.** -- (overspeaking) -- commercially sensitive information.
9 **A.** Yes. So without going into any commercially sensitive
10 information, I think this deal came up at a time where
11 we were both concerned about the successful inflow of
12 deals that we had already done. We were concerned about
13 constraint on raw material supply in the future, and
14 therefore had one eye not only on the price that we had
15 been paying but where we thought the market might go in
16 the future. And at that moment in time this was
17 a decent price.
18 **Q.** Thank you. We'll come on to the assessment of all of
19 the criteria in respect of these transactions at the
20 end, if we may.
21 **A.** Yeah.
22 **Q.** Could I move on, please, to another example,
23 INQ000569902. And page 1 again. If we zoom in, please,
24 to "Value and Price":
25 "The average unit price for Gowns is £11.07 with the

1 minimum price being paid £3.75 and the maximum price
2 being paid £31.50. This unit price of £7.79 is
3 therefore below the average of price paid. Initially
4 the supplier proposed £7.90 per unit but I was able to
5 reduce this to £7.79."
6 Here an example, is it not, of an enormous range of
7 prices --
8 **A.** Yeah.
9 **Q.** -- for the item? If you were going to benchmark this
10 item, would you benchmark it against gowns or does this
11 look more like a benchmark against coveralls?
12 **A.** Well, what I don't know is whether the £31.50 was
13 a coverall price. So, again, I think this is -- the
14 summary here is probably conflating gowns and coveralls,
15 but you would expect more detailed information to be
16 available in the supporting pack.
17 **Q.** Could we have a look, please, at another example,
18 INQ000569906. If we zoom in to the box at the bottom:
19 "The price per unit ... £7.20 (No VAT) ..."
20 In this case it includes the shipment, so that
21 factor of the shipment has to be taken into account with
22 this one.
23 "The [minimum] price [revealed] has been £3.76 and
24 [again] ... maximum £31.50 with an average unit price at
25 £17.63. The price of £7.20 per unit is competitive when

1 considering the recent prices received to date."
2 Just -- it may be just a feature of that is
3 particular -- this particular AO pack, but here it looks
4 like, in order to arrive at the average unit price,
5 what's happened is that someone has added the £3.76 and
6 the £31.50 and then they've divided it by two and then
7 arrived at £17.63. That's what it looks like. I don't
8 know whether that's a coincidence or not. But just in
9 terms of the price, again, £31.50, here potentially the
10 conflation of gowns with coveralls again, bearing in
11 mind the higher price that's on here?
12 **A.** Yeah, considerably -- I mean, you're right, £17.63 is
13 indeed an average of those two numbers, and the
14 information we were looking at earlier was a weighted
15 average, which is when you are taking a longer-term view
16 for a benchmark. I would agree, I think, with your
17 inference that that's probably more useful, a useful
18 point.
19 Look, I mean, I think the challenge with all of this
20 sort of retrospective price benchmarking is that it was
21 an input into the decision making but in the end the
22 price that really mattered was what you could actually
23 do a deal for. Had we been able to negotiate the price
24 down? Were there other offers that were available with
25 similar quantities, quality, delivery, timescales? And,

1 you know, the ability to pay at what the price had been
2 two weeks previously simply -- I mean it simply wasn't
3 there.
4 So was the data perfect? No. We were making
5 decisions at pace, with imperfect data. On the data
6 that we had, I would stand by, you know, the majority,
7 if not all of the decisions that we made, but it was the
8 nature of the environment in which we were operating
9 that these deals were being done with the best data we
10 had available.
11 **Q.** Please don't infer from the questions I'm asking you
12 that I'm not accepting the pressure and the pace at
13 which you and your team had to work, and of course the
14 requirement to get PPE to the frontline of the NHS and
15 social care. The purpose of this is so that, as we'll
16 turn to in a moment, we can find out if there's a better
17 way of doing this in the future.
18 **A.** Yeah.
19 **Q.** Just one final example, please, it's one we've looked at
20 before in the Inquiry.
21 It's INQ000512396. And if we could turn to page 1.
22 And at the bottom, the "Description of [the] goods",
23 "Coverall -- Suit Non-Sterile", if we could zoom into
24 that, please. There the prices are expressed in
25 dollars.

1 If we can zoom out again, please.
2 Then over the page to "Market price assessment":
3 "The current price of PPE irrespective of the item
4 is increasing daily."
5 700,000 coverall suits.
6 Then if we can turn over to page 3.
7 If we can zoom in, please, to "Average unit price
8 paid to date for these items":
9 "£19.26 average for coveralls to date -- on an
10 ex-works basis."
11 Ex-works, is that a reference again to the
12 logistics, to the cost of transport? Or is that --
13 A. So I think that would be from the factory, excluding
14 transport.
15 Q. Thank you. And then, just underneath, this is
16 a slightly different example because in this case it
17 says:
18 "Gowns ..."
19 Which is what's in demand --
20 A. Yeah.
21 Q. "... (with coveralls as a substitute) ..."
22 And it's the gowns that:
23 "... are in a stock critical position."
24 But the decision here is taken to acquire coveralls.
25 Then if we can zoom out again, and then on the 25%

1 criteria:
2 "Make all reasonable attempt to ensure prices are
3 [below] 25% ..."
4 Yes, prices are within the 25% ratio.
5 Just to pause on this one for a moment, here the
6 demand data was that what ought to be being acquired
7 were gowns with coveralls only a substitute. Is that
8 right?
9 A. Yes, so as I said previously, we were trying to target
10 coveralls for those workforce groups that specifically
11 needed them, but where there were critical shortages,
12 using better quality against more demanding specs, PPE,
13 as a substitute for other products, was an approach that
14 we would take.
15 Q. Could I ask you a question, please, about the price
16 benchmarking of a transaction such as this in which the
17 item which is in demand is gowns but the item which is
18 being procured is coveralls. If you were to price
19 benchmark this transaction against that for gowns, one
20 would end up with the conclusion that this is
21 significantly above the price being paid for gowns,
22 broadly speaking, with the figure in mind that I
23 referred to at the beginning of questioning.
24 A. You would. So I would imagine that the factors in
25 signing this one off were extremely low levels of gowns

1 and the inability to secure gowns supply in a timely
2 enough fashion --
3 Q. So --
4 A. -- at quantities that we needed.
5 Q. Of course. So some one in your position in order to
6 make the -- forgive me for saying this, the
7 assumption -- of course it is, because we're looking at
8 this here --
9 A. Yeah.
10 Q. -- that in order to make the decision as to whether you
11 were going to acquire gowns or coveralls in this
12 situation, you'd have to make a judgement based on the
13 data available to you that there are no other gowns
14 being offered to you at the usual gowns price; is that
15 right?
16 A. Yes.
17 Q. Yeah.
18 A. If I may --
19 Q. Of course.
20 A. -- I think at that period in mid-April, and I think you
21 have this in other witness statements, the deals that
22 were being pursued, a number of them, you know, we would
23 have our 8.30 stand-up meeting. A number of those deals
24 would have fallen overnight because the stock would have
25 been bought up by somebody else, so it was a very

1 dynamic, fluid market. Purchase of, if you like,
2 over-specced PPE to ensure that we had some stock, even
3 if it's more expensive than ideally we would have liked,
4 I think in the circumstances is a reasonable judgement.
5 Q. Of course. And accepting what you've said a moment ago
6 about the pressure and the pace and the fact that this
7 was a system which had to buy that which was presented
8 to it. I mean, that was the way it worked, was it not?
9 A. Essentially, yes. That was the -- one of the challenges
10 that we were dealing with is that we were processing and
11 evaluating a very large quantity of bids into the system
12 rather than it being a targeted pursuit of deals that we
13 thought would deliver. I mean, in fact it was a blend
14 of those approaches across this period. But for the
15 parallel supply chain in particular, it was essentially
16 dealing with offers that were made to us.
17 Q. If we were going to look at this price benchmarking
18 system now to plan for a pandemic in the future, would
19 it not be preferable to have more granular detail about
20 the categories of the offers and the specificity of each
21 of the items being supplied so that the price
22 benchmarking could be more accurate?
23 A. Look, I mean, generally speaking in this area, I think
24 having better data, I mean, would clearly be helpful,
25 accepting that in a crisis there's always going to be

1 some limitations on it. Yes, if you are looking at --
2 I mean, as I think I suggested on the overarching
3 document that you shared previously, understanding
4 whether the deal has got logistics costs in or is simply
5 the purchase price, understanding the differentiation
6 between types of PPE within an aggregated description is
7 important if you really want to make the most of price
8 benchmarking.
9 I think it was sort of adequate, just about, for its
10 purposes, based on the fact that it was only one element
11 of the input into the decision making that we were
12 taking, and it's possible that even with more granular
13 information, that the decisions we would have made would
14 have been the same.
15 **Q.** That's very fair. If I could ask you finally this
16 question about value for money.
17 **A.** Yeah.
18 **Q.** In terms of making the decision of somebody in your
19 position with all of that information available to you,
20 weighing up all of those different factors, do you
21 think, or do you know of a system by which all of that
22 information could be automated and weighted and triaged
23 so that you're only able to focus on the most important
24 data so that you know, for example, in a transaction,
25 whether the risk on this transaction is price or the

1 risk on the transaction is in terms of due diligence?
2 **A.** There are definitely lessons that we can make about the
3 system support that we had in this area, not least
4 because we were bringing together teams from different
5 government departments who were used to working with
6 different systems. I think by the end of this, sort of,
7 phase in the summer of 2020 as we'd introduced in the
8 Department of Health a new Atamis system, that was
9 actually not in a bad place, but having joined-up IT
10 that both allows you to manage and triage and track the
11 offers that we are getting, monitor their progress
12 through the system, and give you decent prices -- price
13 information and other information on what is then being
14 done with those deals, getting that in and training on
15 it as part of preparedness for a future pandemic would
16 absolutely be in my, kind of, recommendations for the
17 future.
18 A single system that in the end can boil down all of
19 the factors that an AO needs to worry about, I think, as
20 I've (unclear), the judgement in the end is quite
21 contextual, and the factors that weighed more heavily
22 with me in the deals that I was looking at in early
23 April were not quite the same as the factors that I was
24 weighing in late May or June. And not quite the same
25 for PPE as when I was thinking about lateral flow test

1 procurement or whatever. So --
2 **Q.** Would I be summarising it fairly if I said that what
3 changed was that the weighting of those factors changed
4 so that whereas perhaps at the beginning of the
5 pandemic, the requirement was to just buy as much as
6 possible because of the scarcity of the resource,
7 whereas later on, a slightly different approach could be
8 taken once stockpiles had been built up?
9 **A.** Well, both about stockpiles, but also -- and I come back
10 to that point about my engagement with Jonathan Marron
11 and Emily Lawson -- that the requirement, based on our
12 expectations of demand, was generally difficult to --
13 genuinely difficult to predict, based on modelling about
14 how we thought the pandemic would progress, and
15 obviously in that first wave we were learning clinically
16 about the pandemic as well as about, you know, how it
17 evolved.
18 Nor did we have good usage data to start off with,
19 particularly from the NHS, and from the social care
20 system. Indeed, we went into this without really having
21 a comprehensive view of holdings of PPE across the NHS
22 at the national, regional and local level. So there are
23 a number of ways in which the data can be tidied up for
24 the future.
25 **MR SHARMA:** Mr Williams, thank you very much. I don't have

1 any further questions for you.
2 **LADY HALLETT:** Thank you, Mr Sharma.
3 Ms Mitchell, I think you have a question.
4 **Questions from DR MITCHELL KC**
5 **DR MITCHELL:** Yes, I appear as instructed by Aamer Anwar &
6 Company on behalf of the Scottish Covid Bereaved.
7 It's a matter which you touched on towards the end
8 of your evidence in relation to recommendations, where
9 you were talking about suitable IT to manage and triage
10 and track offers.
11 We've heard evidence in the Inquiry that people were
12 being taken away from the job that they needed to do
13 answer queries that were being given to people, and my
14 question had been for you: should it have been made
15 clear that after referrals there ought not to have been
16 any more feedback as it took people away from the job
17 they should have been doing?
18 Now, I imagine your answer to that is probably yes.
19 **A.** Probably, yes. So let me just very briefly expand on
20 that. I mean, there was important contact with
21 suppliers, sometimes through referrers, in order to fill
22 in gaps in the information that had been provided, to
23 ensure that we had the best information available. As
24 far as possible, you would want those contacts to be
25 initiated by the PPE team, rather than responding to, in

1 some cases, quite a range of, I think, unreasonable
2 pressure for updates on progress.
3 **Q.** It's really the latter that I was thinking of.
4 **A.** Yeah. So, look, evidence into the system responding to
5 queries from ministers, senior officials, that kind of
6 wider stakeholder management I think is a legitimate
7 part of the process. If we had had better -- I mean,
8 a sort of CRM-type system, a better IT system that would
9 allow that information to be generated automatically
10 rather than through manual intervention, I think that's
11 where we need to be next time round.
12 I think my personal regret is that some of the --
13 I think bordering on -- I mean, I understand the context
14 but bordering on unacceptable behaviour and pressure
15 that was being put on members of the buy team in
16 particular, whilst some of it was escalated to senior
17 officials working for me, not much of that got to me
18 very early in the period. And I think senior engagement
19 with some suppliers or with some of the more persistent
20 referrers, to say, "Enough now" -- so whether it's
21 a guidance or a set of protocols or whether actually
22 what it needed was senior intervention to say, "You've
23 just got to stop, we're going to process the deal, it's
24 going to be assessed fairly against criteria, we'll come
25 back to you when we need more information", I personally

1 regret that I wasn't more in that space.
2 In some ways it's only preparing for some of the --
3 you know, the session today and some of the witness
4 statements that I've fully appreciated some of that
5 pressure that my team were under.
6 **DR MITCHELL:** I'm obliged.
7 My Lady, the witness has answered in advance the
8 rest of the questions that I wished to answer (sic).
9 **Questions from THE CHAIR**
10 **LADY HALLETT:** Thank you very much indeed, Ms Mitchell.
11 That completes our questioning for you, Mr Williams.
12 Can I ask, when you were brought in, in March 2020,
13 from the MoD, had there been a second permanent
14 secretary at the DHSC or were you brought in especially
15 because of Covid, or was it coincidence or what
16 happened?
17 **A.** No, I was already working in the Department of Health,
18 so I'd left the Ministry of Defence in 2015 and had been
19 working there as a director general. I was then bumped
20 up to second PUS in role, not least to bring those sort
21 of formal accounting officer responsibilities alongside
22 Chris Wormwald.
23 **LADY HALLETT:** Thank you. Sorry, I misunderstood the dates.
24 I thought you'd arrived just before the impact of Covid
25 was being appreciated but obviously you'd been there

1 before.
2 **A.** It was, however, I think, the first time the department
3 had had a second permanent secretary, and there have
4 been two since me. There is a current role there still.
5 **LADY HALLETT:** Thank you.
6 And can I just say this, I know you don't need me to
7 add it but I think you're entirely right to emphasise
8 the really difficult circumstances that people were
9 under.
10 I think some people are inclined to forget how
11 difficult it was to work from a back room at home
12 without access to your colleagues under huge pressure
13 and trying, obviously, to get PPE out to save lives and
14 protect people. So may I thank you and your colleagues
15 for everything that was done to try to get the equipment
16 out.
17 **THE WITNESS:** Thank you.
18 **LADY HALLETT:** Thank you, Mr Williams.
19 That, I think, completes the evidence, Mr Sharma.
20 I've been asked to break now because there are one
21 or two things that need to be done, apparently, before
22 we start closing submissions. So I shall return
23 at 11.25.
24 **(11.11 am)**
25 **(A short break)**

1 **(11.25 am)**
2 **LADY HALLETT:** Mr Wald.
3 **Housekeeping**
4 **MR WALD:** My Lady, before we turn to closing submissions,
5 and very briefly, there are two matters on which I'd be
6 grateful for your assistance. The first is that in the
7 evidence just now a document was brought up on screen
8 which contained unredacted commercially sensitive
9 information.
10 We would therefore be grateful if you would grant
11 a restriction order over the sensitive information
12 within that document, and the document reference
13 is INQ000521800.
14 **LADY HALLETT:** I do.
15 **MR WALD:** Thank you, my Lady.
16 The second matter is that there is additional
17 material that we ask your permission to adduce into
18 evidence and to be published on the Inquiry's website.
19 That material runs to 14 items, and includes some
20 additional evidence in relation to the Meller contract.
21 If I could ask that the list of documents be brought
22 up on the screen now. Thank you.
23 The material provides important additional and
24 contextual information which it is anticipated will
25 assist you, my Lady, when considering the evidence that

1 you have heard in this investigation, and for your
2 report.
3 **LADY HALLETT:** Those documents may be published. Thank you.
4 **MR WALD:** My Lady, thank you.
5 I think we then move on to closing submissions.
6 **LADY HALLETT:** Thank you.
7 Ms Morris, I think you're up first.
8 **Closing statement on behalf of Covid-19 Bereaved Families**
9 **for Justice UK by MS MORRIS KC**
10 **MS MORRIS:** Thank you, my Lady.
11 My Lady, my submissions on behalf of Covid Bereaved
12 Families for Justice UK, start with reminding you that
13 at the heart of this module is the stark reality that
14 there was a failure by the Westminster government to
15 protect the NHS and save lives with the provision of
16 adequate PPE.
17 Politicians have told this Inquiry that only they
18 lived in the real world which the rest of us could never
19 understand in terms of the pressures, decisions, and
20 difficult phone calls they had to make in the
21 procurement exercise. They claim that this was an
22 unmitigated success and they would not do anything
23 differently.
24 However, the Inquiry has heard clear evidence from
25 the real world that clinicians and carers lived in that

1 supply of PPE to staff across the health and care
2 sectors was, as Professor Banfield from the BMA said,
3 "woefully inadequate".
4 This is despite the UK Government spending
5 £8.6 billion of public money on PPE but the government's
6 inadequate preparedness and inefficient procurement
7 systems resulted in a £3.8 billion of wasted PPE that
8 could not be used in the NHS.
9 In the real world this meant that there were
10 patients, clinicians, health and social care workers,
11 exposed to preventable infections from Covid-19.
12 Daniel Mortimer described his members being unable
13 to ensure the safety of their staff. Primary care
14 members reported having to rely on local shops, beauty
15 and tattoo parlours to access PPE supplies, at times
16 having to use crowd funding to buy equipment.
17 In the real world, this meant that people were
18 prevented from seeing their loved ones in hospitals and
19 care homes. In the real world, clinicians were faced
20 with difficult choices as to how to treat patients, and
21 as Professor Moonesinghe recognised, it is possible that
22 the pressure of a lack of essential life-saving
23 equipment like ventilators may have changed the way that
24 clinicians thought about how to escalate some critical
25 care patients. Something that many of the families that

1 we represent experienced.
2 But my Lady, the cost of inadequate PPE was not just
3 to people but to the public purse. In simple terms,
4 every pound we overpaid for PPE or wasted on contracts
5 for defective PPE was a pound that could have been spent
6 on the health and social care sector.
7 The UK paid an unacceptably high Covid premium for
8 its PPE. Chris Young told the Inquiry that the Cargo
9 Services Far East contract was 900% above benchmark
10 price. The DHSC told their accounting officers only
11 that they should make "best attempts" to stay within the
12 25% rolling benchmark.
13 And there was also a price for the waste of PPE on
14 a scale that, according to Lord Agnew, blocked the
15 Felixstowe docks. There was an estimated £4 billion of
16 wasted PPE that had to be disposed of or stored and at
17 a continuing cost to the public purse.
18 My Lady, the root cause of this failure in the
19 procurement response was a failure of preparedness. As
20 Professor Moonesinghe told the Inquiry, we were woefully
21 unprepared even for what was thought to be the
22 reasonable worst-case scenario. There were insufficient
23 stockpiles and a lack of centralised data in respect of
24 what was held by trusts in England or nationally. Any
25 stockpiles that were held were modelled on an influenza

1 pandemic and were difficult to access in deep storage.
2 The NHS Supply Chain was only ever designed as
3 a business-as-usual process with no contingency planning
4 in place for the increased burdens of a pandemic.
5 My Lady, there was a price for this poor
6 preparation. The total lack of preparedness meant that
7 when the pandemic hit, the DHSC were what Lord Agnew
8 described as "rabbits in the headlights".
9 Professor Sanchez-Graells was clear that at the
10 outset of the pandemic in the UK, the government had
11 a perfectly good legal framework and procedures for
12 procurement, including emergency procurement, but
13 because of a lack of preparedness, the system was
14 quickly overwhelmed. And when it became overwhelmed,
15 there was a choice. A choice whether to follow
16 a rule-based transparent and accountable process, to
17 develop a data-led foundation to identify what was
18 needed and to follow a principled and consistent
19 approach to inviting, managing, and processing offers.
20 But those in power took an opportunity, as
21 Lord Bethell said, to take away the 100 years of
22 conditioning within the Civil Service, no more Cautious
23 Charlies, as Mr Gove characterised. There was a new
24 risk appetite set by the Prime Minister, and Mr Hancock,
25 to take a more buccaneering approach and throw the

constraints of existing good procurement processes overboard. This 'whatever it takes' approach by the DHSC undoubtedly influenced the speed at which offers to the PPE Buy Cell were processed, the time spent on due diligence, and the price the government was prepared to pay.

As Mr Rhys Williams told the Inquiry, the government's call to arms only increased the overwhelm and caused huge problems.

At the heart of a failure to prepare was the lack of direct relationships with the PPE manufacturers or larger retail wholesalers. This meant that the UK simply didn't know where to turn to scale up supply, and into that void, aided and encouraged by the call to arms, stepped numerous intermediaries and agents. These new entrants into the PPE market moved quicker than the UK Government to locate the manufacturers and secure supply, sometimes gazumping the government in the process, thereby further contributing to the global supply pressures and price increase, whilst enabling those intermediaries to make massive profits from the pandemic.

My Lady, there was undoubtedly a roaring noise of people offering PPE, all with differing motives. Some philanthropic, some motivated by profit.

Professor Sanchez-Graells said at this point the senior leadership of the PPE Buy Cell should have taken appropriate steps to reassure all those making offers that their offers were being considered, and reduced the pressure on the Buy Cell. This was what he called the legitimate operational requirement.

This would have allowed them to develop and apply a consistent and criteria-based approach to rapidly triaging offers. It could and should have maintained a single point of entry, and build capacity to triage those offers.

Of course, my Lady, we accept there must be a way of triaging offers to enable the quick identification of legitimate offers. Companies that already supplied the NHS, already made PPE, or were large global suppliers of goods would have made it to the front of any sensible triage.

The choice, instead, was to create a VIP Lane, that allowed politically exposed people to jump to the front of the queue and to expose those civil servants working in the PPE Buy Cell to unbearable pressure. This was what Professor Sanchez-Graells said was dealing with the problem in the worst possible way.

There is no question that the VIP Lane was unlawful. Having already lost two legal cases and with levels of

public concern still high from what has been revealed in open source material and other investigations about profiteering and cronyism, those at the heart of the scandal had another choice to make at this Inquiry: act with candour, finally accept the failures of the systems they created, and assist the Inquiry with forward-looking recommendations for how best to perform emergency procurement to inform our responses to the next pandemic.

Instead, those politicians have attacked the Inquiry and rejected its scrutiny. There has been a chorus of denial that the public would expect them to have done anything differently. Any suggestion that there was any other way other than to let their friends and associates get to the front of the queue was branded wholly naive.

Mr Hancock accused the Inquiry of being hostile. Lord Agnew used even more choice language, and used exasperated examples of known crooks saving Britain in the past. Mr Gove even went as far as to say that it was a required aspect of a democratic accountability for politicians to refer and chase offers.

But it's important to remember that not all these referrers were democratically elected. Many were unelected peers appointed by the ruling party and able to wield their influence within government.

Lord Chadlington in his referral of SG Recruitment and Baroness Mone in her involvement in PPE Medpro are just two examples.

This is not ministers acting within their specialist portfolio checking that all that could be done was being done by civil servants on their policy area; this was ministers and politically exposed people, with no expertise in procurement, or, worse, politicians who were likely to directly benefit from the award of contracts, applying undue pressure to those processing offers within the VIP Lane.

In our opening submissions, we focused on the referral of SG Recruitment, one which came to Lord Feldman, a former Conservative Party chairman, from Lord Chadlington, another Conservative Party peer.

It must have been obvious to Lord Feldman from the emails that the Inquiry has shown to him that Lord Chadlington could benefit financially from any government contracts.

Lord Feldman triaged the referral and spoke to David Sumner of SG Recruitment. He thought he was a "good chap", and admitted that he had a "soft spot for someone who was ex-military and ex-SAS", and credentialised themselves in that way.

This was a recruitment company with no experience of

1 manufacturing PPE and with a pre-pandemic turnover of
2 under half a million pounds, that was then processed by
3 the VIP Lane and was ultimately awarded two contracts,
4 collectively worth just under £50 million.
5 SG Recruitment is reported to have made £1.1 million
6 profit from those contracts.
7 It is likely from the written material recently
8 disclosed by the Inquiry to Core Participants that
9 the Inquiry could conclude that both Mr Sumner and
10 Lord Chadlington had the intention of using government
11 contracts as a stepping stone to expanding their
12 business and thereby increasing their personal financial
13 benefit.
14 This profiteering was enabled by the VIP Lane in its
15 prioritisation of offers based on who was making the
16 referral and whether it was therefore a "trusted offer".
17 As we set out in the preliminary hearing to this
18 module, we've always maintained that this Inquiry needs
19 to investigate relevant contracts from offer through to
20 conclusion. This would have involved hearing from those
21 who are processing the offers in the VIP Lane, such as
22 that from SG Recruitment, at every stage.
23 In fact, the Inquiry hasn't heard any evidence from
24 those conducting the due-diligence checks, the Closing
25 team, or anyone within the Technical Assurance team.

1 The effect of this is that each of the witnesses the
2 Inquiry has heard from has been able to say that they
3 expected someone else to have ensured that all the
4 necessary checks were done.
5 My Lady, it is clear that the VIP Lane did have real
6 advantages to those who had their offers processed by
7 it. Professor Sanchez-Graells explained that the
8 emergency procurement should be, by nature,
9 a time-limited procurement exercise, as there's only
10 ever going to be a limited number of emergency contracts
11 in a window before you go back to business as usual,
12 therefore it matters who gets there first. There are no
13 prizes for second place.
14 Dr Hall accepted that a VIP Lane offer probably got
15 to Technical Assurance quicker, and Lord Deighton
16 confirmed that VIP Lane offers had access to
17 "handholding" to support them to navigate the workings
18 of government.
19 Mr James said in his written evidence that he
20 thought the VIP offers had a designated contact in the
21 Technical Assurance team, unlike the non-VIP Lane.
22 This, my Lady, conferred two benefits: first, the
23 VIP Lane team could ask for the highest priority offers
24 to be processed more swiftly by the Technical Assurance
25 even than other VIP Lane offers. Ms Matthias referred

1 to the existence of VVIPs. These were the very, very
2 important people: suppliers who had contacted them
3 directly via an MP, lord, lady, PM, private office, and
4 those within the Cabinet Office were keen that they had
5 a speedy response.
6 Second, they could find out the reasons for
7 rejection and feed them back to the supplier, which had
8 the benefit of them being able to improve their product
9 and continue the negotiations.
10 In addition, Mr Young told the Inquiry that within
11 the VIP Lane, contracts that would normally have had
12 weeks of due diligence went through a much shorter
13 process, the benchmark of which was whether it was
14 subjectively proportionate, taking into consideration
15 the urgency of the need, given the lack of preparedness,
16 the risk appetite set by the government and the
17 incredible pressure of the noise the processing team was
18 subject to whilst desperately trying to secure PPE.
19 No doubt as a result of all these processes, the
20 conversion rates of the VIP Lane were significantly
21 higher. Mr Marron's evidence was that 11.86% of
22 VIP Lane offers were awarded contracts compared to 1.13%
23 of non-VIP offers.
24 Importantly, Sir Chris Wormwald, then the most
25 senior civil servant within the DHSC and the principal

1 accounting officer, acknowledged that two great an
2 emphasis was placed on who made the referral as opposed
3 to the nature and the promise of the lead. He said the
4 problem was not with the differing standards of
5 assessment but who got to the front of the queue, and,
6 as a result, some less promising leads were given too
7 great a priority.
8 As Professor Sanchez-Graells concluded, the VIP Lane
9 was an affront to good procurement. Mr Gove, Mr Hancock
10 and other politicians have sought to undermine his
11 evidence, but they can't get around the criticisms in
12 his evidence; he is a pre-eminent expert. So they
13 resorted to personal diatribes, accusing hims of
14 a flawed analysis, without providing the Inquiry with
15 any proper legal or academic challenge to his findings.
16 The Inquiry should be concerned about this approach
17 and what it says about a culture of learning within
18 government. We endorse Professor Sanchez-Graells' view
19 that the fact that, all this time later, those involved
20 don't recognise that billions of pounds were spent
21 unlawfully speaks of a dysfunctional culture of
22 lesson learning.
23 It's also now well known that 50% of the companies
24 channelled down the VIP Lane provided PPE that was not
25 fit for purpose. And the Inquiry has not heard from

1 a single witness or a single supplier to answer to this
2 waste of money and resources.
3 Overall the government's inadequate preparedness and
4 inefficient procurement systems resulted in £3.8 billion
5 of wasted PPE that could not be used in the NHS.
6 My Lady, by way of conclusion, good governance
7 matters. Standards matter. Transparency matters.
8 Better procurement means that governments can spend
9 their money faster and better in times of emergency. As
10 the UK Anti-Corruption Coalition said in their witness
11 statement, the problems associated with the UK's
12 emergency response are more than just procurement
13 missteps and reflect something wider.
14 The recent decline in good governance and political
15 standards. The story of the pandemic requires us to
16 reflect on the conduct of ministers, Members of
17 Parliament, Members of the House of Lords, special
18 advisers, political donors and other actors.
19 My Lady, those I represent are not a small group of
20 people being whipped up into believing a politically
21 motivated conspiracy theory as Lord Agnew suggested.
22 The public did, as Mr Gove and Lord Bethell both
23 identified, have an expectation that the government
24 would rapidly source and supply sufficient and safe PPE.
25 But the public also expected its government to secure

1 adequate amounts of appropriate PPE to protect our
2 diverse health and social care and public sector, and to
3 protect the already stretched public purse from fraud,
4 profiteering and cronyism.
5 My Lady, your Inquiry should be clear in its
6 findings about the failings of the UK's pandemic
7 procurement. After four weeks of evidence at further
8 public expense to public funds, it cannot shy away from
9 making criticisms of the VIP Lane, and those who
10 profited from it. We also urge you to make clear
11 recommendations for the future that insist on
12 a foundation of good data, good governance, ethical
13 practices and transparency.
14 The public and the bereaved families expect no less.
15 **LADY HALLETT:** Thank you very much indeed, Ms Morris. I am
16 extremely grateful.
17 Ms Campbell, I think you're up next.
18 **Closing statement on behalf of Northern Ireland**
19 **Covid-19 Bereaved Families for Justice by MS CAMPBELL KC**
20 **MS CAMPBELL:** Thank you, my Lady.
21 The UK and devolved entities were not ready.
22 Procurement provision and supply chains were not set up
23 to enable effective responses to the pandemic.
24 Inventory management systems did not exist or were not
25 up to the task. Stockpiles were out of date or wholly

1 insufficient. Coordination across the UK and the
2 devolved administrations was, as ever, on the hoof,
3 superficial, and the source of frustration.
4 Response plans, certainly at the UK level, appear to
5 have been drawn up in a panic and put into action by
6 a small army of individuals operating, as you have
7 observed this morning, from back bedrooms, on laptops,
8 armed with Excel spreadsheets and their mobile phones,
9 and ultimately, working within a process that was more
10 focused on triaging people than product. A system that
11 was, giving it perhaps a most generous interpretation,
12 ripe to be hijacked by shysters and fraudsters and
13 operating at huge financial, political and human cost
14 that will be felt for generations to come.
15 While we did not agree with all of Lord Agnew's
16 evidence, he is right when he says that a huge debt
17 legacy has been left to our children's generation who
18 will have to struggle to pay it off.
19 The expression "it was worse than a crime; it was
20 a mistake" comes to mind, except it wasn't just one
21 mistake; the mistakes were systemic and prolonged and
22 enduring, and when it comes to the bereaved families,
23 their children will pay not just a financial debt, but
24 many will carry a huge emotional one.
25 My Lady, it has not escaped the notice of the

1 Northern Ireland Covid Bereaved, nor will it have
2 escaped your notice, we suspect, that for several
3 witnesses the answers to many questions in this module
4 has been more combative, more dismissive, even more
5 evasive than in previous modules. You have heard
6 staunch defences suggesting that the VIP Lane was
7 "necessary" and it was naive to think otherwise. That
8 should the need or opportunity arise in future it would
9 or even should be recreated.
10 Perhaps the rationale for that defensiveness comes
11 from having established a deeply-flawed system rather
12 than inherited one, as may have been the get-out in
13 previous modules.
14 But whatever the *ex post facto* justification, the
15 reality is, a system of triage for so-called VIPs was
16 not necessary. It was not something followed by the
17 devolved administrations, nor in other nations. The
18 problems faced in London were not unique. Shamefully,
19 the response to them was.
20 What was necessary was a proper, transparent and
21 decisive transparent system. Note the evidence of Karen
22 Bailey yesterday. BSO PaLS in Belfast received over
23 2,000 offers which, following triage and removing
24 duplication, were distilled into about 45 useful leads.
25 Some were referred by the politicians, some apparently

commended by the CMO, but all went through the triage system on a "first come first served" basis save for FFP3 masks which were triaged separately given the urgent need.

Contrast this with the evidence of Chris Young from the Department of Health and Social Care. In London, they got something in the region of 50,000 offers from 15,000 suppliers. In terms of comparative population size, that would suggest that the BSO in Belfast received proportionately more offers, or at least a comparable number of offers as the Department of Health and Social Care. 50,000 is, of course, a large number, but for many of those offers, the plums and the duff could have been easily separated on the evidence you have heard. Offers of nutritional advice and knitted goods into one category; offers of substantial quantity of PPE and equipment in the other.

The PPE Buy Cell, we know, grew rapidly to a team of 500 people. 50,000 offers and 15,000 suppliers amongst 500 is 100 offers per person, or 30 suppliers. Now, of course, that calculation is crude, and it was not that easy, but neither did it have to be so difficult.

You have been given, my Lady, no cogent reason why there could not have been a system of triage to consider relevant factors that were said to influence the special

treatment afforded to some, such as a background in invention, access to factories which could enable large-scale production, an assessment based on the viability of the lead and not the political weight of the referee or the political connections of the offeror.

My Lady, a glaring problem with the VIP Lane is that it should have been clear at the time of establishing it that a two-tiered system based on political connections or cronyism was wrong, but those making that decision did not or could not or will not see that.

But perhaps the most glaring problem is that the VIP Lane was not even successful, the consequences of which are felt and continue to be felt by those from whom you have heard. Those who worked 16-hour days, seven days a week, to try to make it work. The frontline staff who lacked necessary PPE, from whom you heard in Module 3 and whose evidence was revisited in this module through the Royal College of Nursing and others. And the bereaved families who willed things to be different at the time of the pandemic and still wish it to be different today.

These people are not, as Lord Agnew appeared to suggest, whipped up by false narratives or headlines of a heinous plan by those in power to enrich themselves or their mates. Theirs is a legitimate and deep-seated

anger borne out of the failings that they have witnessed and the loss they have experienced as a result.

But it is also an anger at the political failure to prepare, and the establishment of a system that enabled profiteering and cronyism while Rome burned.

And why shouldn't they be angry? The evidence that you have heard in this module does a disservice to the UK, to those who did their best within a rotten system, and to those who died and carry on in grief.

But my Lady, it also does a disservice to future generations, not only because they will have to pay for it, but as witnessed by this module the time spent unpacking and unpicking the controversy of the VIP Lane is time that would have been better spent asking questions and learning lessons from all the other issues within the list of issues for this module. But, in relation to which there has been insufficient time to at least publicly consider them.

What is the role of technology, of AI, of automation in future procurement? Do we have sufficient skills, expertise and experience and training to deal with future crises? What PPE might we need in a future pandemic and what ongoing efforts are being made to look at alternative approaches, such as re-usable PPE? How can we diversify our sources of supply domestically and

internationally to avoid vulnerabilities in a manufacturing system being concentrated in one part of the world?

How do we mitigate against forced labour, child labour, human trafficking, modern slavery and the other unethical treatment in our supply chains? How do we meet future demands whilst also adhering, as far as possible, to our environmental obligations and considering the climate crisis?

Previously the focus on procurement has been on securing items at lowest cost but at the expense of everything else, people, environment, and resilience. That was the case across the board in England, Scotland, Wales and Northern Ireland. But it cannot justifiably be the case in future.

These are all issues within your list of issues for this module. But given the public interest, and the significant public interest, in the aspects of the VIP Lane, there has been insufficient time for proper public scrutiny.

You will understand that I mean no criticism of you, my Lady, when I observe that, with reference to some of the filibustering in the evidence that you have heard, future generations deserved better from this module.

The UK Government and Senior Civil Service would do

1 well to acknowledge its own mistakes and to seek to
2 learn from others, and not just to politely entertain
3 and then dust off criticism, but to really listen, and
4 to really learn.
5 And on this, as it happens, they could look to their
6 colleagues in the devolved administrations where
7 systems, though far from perfect, were almost certainly
8 better.
9 It is striking that, whatever other faults may be
10 identified, Northern Ireland, like the other devolved
11 administrations, appear to have avoided conflicts of
12 interest and controversies that haunted England.
13 One reason might be found in the concept of
14 democratic accountability, a concept which appears to
15 have different meanings in different jurisdictions.
16 To Mr Gove, democratic accountability is boldly
17 advanced as a defence for the VIP Lane, leading, quite
18 remarkably, to a rejection of the idea that civil
19 servants should be protected from undue ministerial
20 pressure.
21 In Scotland, according to Ms Freeman, democratic
22 accountability acts in part as a defence from the
23 consequences of the VIP Lane, over which Scottish
24 Ministers had no say and with which they disagreed.
25 It will perhaps come as no surprise that we endorse

1 the evidence of Ms Freeman.
2 Local democratic accountability for procurement is
3 important, because of the difficult or invidious
4 positions into which devolved actors would be placed
5 where an issue is devolved but decisions are taken by
6 Westminster.
7 Of course there should be cooperation, exchange of
8 data, exchange of approaches, and a mutual aid
9 agreement, but it will be important, whatever the
10 recommendations the Inquiry makes in this module, that
11 the system of devolved democratic accountability for
12 devolved issues remains.
13 And as to the Northern Ireland and procurement
14 response, we highlight some aspects of the evidence
15 recently heard. The evidence of Tim Losty describing
16 procurement from CR Pharmaceutical, making it clear that
17 his role was not part of some master plan, though
18 neither was it just the luck of the Irish. There was an
19 element of good fortune that the Executive had opened an
20 office in the one country which could supply PPE,
21 enabling the role of Mr Losty to be occupied, borne more
22 out of circumstance and opportunity than design.
23 But there was also evidence of working hard to seize
24 the moment, enabling an individual from a small country
25 to secure a multimillion-pound deal on a global stage.

1 For reasons addressed in the Northern Ireland Audit
2 Office report, to which we will return more fully in
3 writing, the process was not as transparent as it might
4 have been, but it does appear to have been successful.
5 However, my Lady, and it is a significant point,
6 this is not a plan for what to do in a future pandemic,
7 because those pieces may not move so fortuitously into
8 place. And if it's not a plan for a future pandemic,
9 what is the plan?
10 Conversely, the proposed joint procurement with the
11 Republic of Ireland fell apart just shortly before the
12 CR Pharmaceutical deal, perhaps demonstrating that
13 Northern Ireland was too late to fully appreciate its
14 position, both within these islands and on the world
15 stage and therefore too late to respond.
16 And so, although the industry of BSO PaLS and others
17 in the north deserves due recognition, once again I have
18 to address you on pervasive issues in Northern Ireland.
19 A failure to recognise and remedy gaps in available
20 data. You've heard that, my Lady, before.
21 A lack of self-reflection and internal learning.
22 No review of lessons learned by BSO PaLS.
23 A wholly insufficient lessons learned document,
24 looked at very briefly yesterday from the Department of
25 Finance.

1 And, I perhaps rather boldly anticipate, we may yet
2 hear a departmental pat on the back from the Department
3 of Health.
4 Complacency or self-congratulation is unwarranted
5 and our concerns at the lack of self-reflection are not
6 merely theoretical, because the evidence received in
7 this module raises significant concerns which have not
8 yet received the consideration internally in
9 Northern Ireland that they deserve.
10 By way of example, whilst very significant amounts
11 of PPE may have been obtained, there is ample evidence
12 of failures to ensure the right equipment making its way
13 speedily to the appropriate end user.
14 The most glaring failure was the delay in ensuring
15 private care home staff and residents would have access
16 to PPE, an essential issue for ensuring protection of
17 the most vulnerable and preventing the spread of the
18 virus.
19 The written evidence indicates that Northern Ireland
20 paid more for equivalent PPE than other devolved
21 nations, and had PPE of greater value written off as
22 compared to other jurisdictions. Such failings should
23 not simply be dismissed. The loss of financial
24 resources in an already underfunded healthcare system is
25 measured in loss of care and ultimately in loss of life.

1 The lack of evidence of conflict of interest in the
2 jurisdiction must be seen against the inadequacy of
3 safeguards imposed to protect against such conflicts.
4 It relied exclusively on relevant officials
5 self-declaring conflicts with obvious difficulties in
6 detecting those that may have been undisclosed.
7 And, my Lady, the problems with modelling were never
8 resolved and it appears have yet to be resolved. Worse
9 still, the Public Health Agency, the very devolved
10 entity with responsibility for this issue, barely
11 addresses this in their statement to this module,
12 reinforcing our repeated concerns at the lack of
13 self-examination, and heightening the concern that such
14 fundamental errors would simply be repeated in any
15 future pandemic.
16 At the end of yesterday, my Lady, we heard evidence
17 that reminded us of the global upheaval in the last
18 five years. It's not just been the pandemic or measured
19 in pandemic terms, but politically, geographically, and
20 environmentally we are in an uncertain world. There are
21 many future challenges to be faced and there is no room
22 for stagnation.
23 The Northern Ireland Covid Bereaved stress that we
24 cannot just hope for the best and see what happens and
25 the recommendations from this module of your Inquiry

1 must enable us to prepare for the worst, while of
2 course, as always, hoping that does not come to
3 fruition.
4 Thank you.
5 **LADY HALLETT:** Thank you very much, Ms Campbell. I'm very
6 grateful.
7 Ms Parsons, I think you're next to go.
8 **Closing statement on behalf of Covid-19 Bereaved Families**
9 **for Justice Cymru by MS PARSONS**
10 **MS PARSONS:** Thank you, my Lady.
11 I make these closing submissions on behalf of the
12 Covid-19 Bereaved Families for Justice Cymru.
13 Five years ago, almost to the day, Wales reported one of
14 its first deaths from a hospital-acquired Covid
15 infection. Douglas Miles was admitted to the Holywell
16 Community Hospital in Denbigh for an operation. He
17 caught Covid whilst in hospital and tragically, on
18 29 March 2020, passed away.
19 His daughter, Sylvia Parry, said this:
20 "There was no PPE at the time, and my father was
21 just a sitting duck in the hospital."
22 She observed undertakers there in full hazmat suits
23 while healthcare workers, reliant on supplies from local
24 health boards, had nothing.
25 It would prove to be one of the first of many deaths

1 in Wales from nosocomial infection, and it is a story to
2 which many in the group will relate. Many of them
3 question why the Welsh Government was so slow to react.
4 Many of them questioned why the staff and patients and
5 residents were unable to take precautions necessary to
6 curb the spread of the virus.
7 They believe that the reason why Wales has the
8 highest rate of nosocomial deaths must have been due, in
9 part, to the lack of PPE or appropriate PPE and
10 equipment, resulting in mass cluster outbreaks in wards
11 and care homes across Wales.
12 I turn to some specific concerns raised in this
13 module.
14 First, pandemic stockpiles. Despite Pandemic
15 Influenza Preparedness Programme being a UK-wide
16 programme, it was the Welsh Government who were
17 responsible for procuring the pandemic stockpile, for
18 ensuring stock was kept in date and ready for use. The
19 Welsh Government failed to do this.
20 What was the nature and the extent of the failure?
21 The critical failure relates to a critical piece of PPE:
22 FFP3 masks. Of all FFP3 masks held in Wales as at
23 6 February 2020, over 90% were out of date.
24 By 12 March 2020, a Department of Health and Social
25 Care email records that, "Wales is in the most

1 challenging position of all the four nations, being down
2 to just 10,000 FFP3 masks."
3 Whilst Mr Irvine suggested stock may have been
4 re-tested within days, released on 25 March 2020, the
5 same cannot be said for the entirety of the stock which
6 the Welsh Government itself estimated would take
7 anywhere between four to 16 weeks to re-test.
8 We also know that in the scramble to re-test, 50% of
9 the retests did not pass the face fit tests, largely
10 because they did not fit women, 70% of the health and
11 social care workforce. And it was not just FFP3 masks;
12 surgical gowns, for example, were not in stock. Zero in
13 the stockpile despite a target of over half a million.
14 What were the reasons for the failure? Why did the
15 Welsh Government not even have that which it was
16 required to have as a result of the PIPP strategy?
17 Mr Irvine could not assist you. It was not that the
18 Welsh Government were unaware; there were regular stock
19 reviews carry out with Welsh Government officials
20 themselves. "I'm not trying to be evasive", he said,
21 "that would be a matter for the Welsh Government to
22 answer."
23 The Bereaved Families for Justice Cymru group
24 observes that the government have not answered that
25 question. Notwithstanding witness statements totalling

hundreds of pages and notwithstanding thousands of exhibits, the answer remains elusive.

Second, distribution and logistics. As we have heard repeatedly from the Welsh Government, Wales never ran out of PPE at a national level. But, my Lady, such a claim is artificial when those monitoring and distributing the stock, that's Shared Services, were also the ones managing requests for PPE and determining what percentage of the requests would be supplied.

Mr Irvine may not have liked the term "demand management" but that is the very process he described to you.

But regardless, even if Wales did not run out of PPE, that is of little comfort to those who experienced such shortages at a local level. What good is a long-sleeved gown and FFP3 mask in a warehouse in Denbigh when it is needed at the local hospital where Covid is spreading through the ward among staff and patients alike?

That brings logistics and distribution of PPE into focus. Mr Slade suggested to you, my Lady, that problems in supply and distribution related to the provision of information about what was needed and where, and what stocks were held at a local level.

There was apparently no system of knowing how much

stock hospitals had. They were starting from scratch. So it was about having better flows of information and intelligence.

Mr Brace suggested confusion was caused by IPC guidance, leading to tensions in staff understanding what was required and therefore what was to be supplied. A red herring, the group says, given there was just one change in guidance that affected mask wearing.

But, like Mr Slade, he suggested that there were also problems with information flows. He said there were coordination issues at the hospital end about what stock was held and where. So the stock was there, but healthcare workers just didn't know it.

Such explanations, my Lady, raise more questions than provide answers. Shared Services had been supplying PPE to health boards and hospitals for the best part of a decade when the pandemic started. Distribution paths and delivery points must have been well established. Why had not even the most basic stock management system been put in place?

And if the explanation is correct, that there was plenty of stock floating around the NHS estate in Wales, why did the problem go unattended or unsolved? Whilst the Welsh Government may have felt confident and assured they had a grip on the situation, by April/May 2020 this

was evidently not the case. Healthcare workers and members of the group alike witnessed shortages throughout 2020 and into 2021.

The reasons for supply and distribution failures are far from clear and, as such, there can be no confidence or assurance that lessons will have been learnt for the future.

Third, care homes. Here, again, the Inquiry has heard that, like the healthcare system, the social care system in Wales never ran out of stock. If that's right, again, the position offers little comfort to those who saw staff and residents in care homes unprotected, lacking vital PPE, oxygen, testing and so on. The group believe many died unnecessarily, avoidably in Covid outbreaks in care homes in Wales as a result.

One key issue is the issue of delay. The Welsh Government took until 19 March 2020 to expand Shared Services's remit to the care sector. Thereafter, supply was patchy at best. Some care homes had sufficient PPE, others did not. By May 2020, only two-thirds had their PPE needs met by Shared Services.

As to when the position stabilised, the Welsh Local Government Association suggests it was not until September 2020, when a service-level agreement was

reached. Care Forum Wales suggest later, November 2020, when it understood a new stock management system had been introduced.

Mr Slade did not accept that care homes had been overlooked while the NHS was prioritised. Nor did he accept that the Welsh Government could and should have acted more quickly to assist care homes. But the recognition, by both himself and Mr Brace, that in a future pandemic Shared Services must provide PPE immediately for the care sector, tells you that the response to supplying PPE to care homes in Wales was too slow.

A second key issue is distribution. We know that in theory Shared Services supplied PPE to joint equipment stores for onward distribution to the care sector by local authorities. We know that in practice this process failed.

Mr Irvine said, and I quote, there was:

"... more than enough PPE in the joint equipment stores, but ... the joint equipment stores ... or ... local authorities, more generally, weren't [necessarily] aware of what was actually there."

The suggestion is hard to understand. It seems to be being suggested that care homes desperately needed PPE, could have had what they wanted, indeed could have

1 had more than what they wanted if only they'd checked
2 their local joint equipment store.
3 The suggestion is also hard to understand, given
4 StockWatch, Shared Services' inventory management
5 system, was completely unfit for purpose and left Shared
6 Services, as Mr Irvine himself put it, unable to
7 understand if we were fulfilling their requirements and
8 with gaps in how much stock areas actually required.
9 If my Lady were to accept that joint equipment
10 stores were indeed fully to overflowing, that would be
11 by luck rather than by design.
12 I say "if", my Lady, because of course, the Inquiry
13 has not heard from the local authority and care home
14 providers. It might be that they would have provided an
15 explanation to counter the implicit suggestion that
16 distribution failures lay with them.
17 Fourthly, infection prevention and control guidance
18 on FFP3 masks.
19 I have already mentioned the deficiencies in Wales'
20 FFP3 stock, as noted on 12 March 2020. It was on
21 13 March 2020, one day later, that IPC guidance was
22 amended such that FFP3 masks were to be used only in
23 intensive care units or in aerosol-generating
24 procedures.
25 While the group is aware the IPC guidance was

1 considered in a previous module, the group urges the
2 Inquiry to address the issue afresh in the context of
3 cross-cutting issue of adequacy of PPE supply.
4 Professor Catherine Noakes from whom the Inquiry has
5 already heard, explained the reluctance to properly
6 acknowledge airborne transmission was in part because of
7 the significant resource and operational implications of
8 doing so.
9 If supply issues shaped the IPC guidance, as many in
10 the group fear, then the impacts of lessons learned
11 about PPE supply chains and distributions will be
12 reduced. What matters is not simply having PPE, but
13 appropriate PPE. PPE with the appropriate level of
14 protection.
15 Lastly, ventilators and equipment. My Lady, the
16 Bereaved Families for Justice Cymru's concerns in this
17 module have not been confined to PPE. Its members also
18 experienced shortcomings and failures in access to
19 ventilators and other key pieces of equipment. We have
20 heard evidence that much of the procurement activities
21 for ventilators took place on a UK-wide basis. Little
22 attention has been given to what happened in Wales.
23 Consistent with the Welsh Government's general
24 narrative for PPE, it has of course stated that Wales
25 was never short of ventilators. The members of the

1 group have good reason to doubt such claims. The
2 members experienced those shortages, problems in access
3 firsthand, and there has been no scrutiny as to the
4 reason why.
5 In conclusion, my Lady, just four witnesses have
6 given evidence from Wales. Much of their evidence was
7 dedicated to the technical and procedural aspects of
8 procurement. But for the members of the Bereaved
9 Families for Justice Cymru, the concern has always been
10 to understand why those that needed PPE and equipment,
11 such as ventilators and CPAPs, didn't have it. In
12 opening, the group asked why there was such shortages of
13 PPE, why access to ventilators and equipment was
14 inadequate, why the risk of nosocomial infection was so
15 high in Wales, why care homes were overlooked, whether
16 shortages in supply of FFP3 masks influenced guidance,
17 such that healthcare workers were inadequately
18 protected.
19 These questions, my Lady, regrettably remain
20 unanswered. Gaps remain. Areas of the Welsh
21 Government's conduct in respect to PPE and key equipment
22 remains unscrutinised.
23 And the point is an important one, if gaps remain,
24 if questions remain unanswered, there is, of course,
25 a real risk, my Lady, that the Welsh Government have not

1 learnt lessons for the future. Thank you.
2 **LADY HALLETT:** Thank you, Ms Parsons.
3 Ms Mitchell, I think your turn.
4 **Closing statement on behalf of the Scottish Covid**
5 **Bereaved by DR MITCHELL KC**
6 **DR MITCHELL:** My Lady, the Scottish Covid Bereaved came into
7 this module with concerns, doubtlessly shared by many,
8 that the governments in the UK had failed to ensure that
9 those working for the NHS staffing nursing homes and
10 care homes, the ill and the dying and their families
11 were provided with the PPE supplies that they needed
12 timelessly to face the pandemic.
13 What the bereaved have heard over the course of this
14 module shows that their concerns were wholly legitimate.
15 The bereaved wish to acknowledge, however, the hard
16 work and dedication of a great many public servants who
17 were trying their best to ensure that those most in need
18 could be provided with PPE that they so desperately
19 needed. While the beginning of the pandemic signalled
20 for many throughout the country a slowdown or stop of
21 the regular rhythm of the working week, there were those
22 who were going above and beyond the call of duty to try
23 and make sure that people whom they had never met, and
24 would never meet, were protected from the worst of the
25 pandemic.

1 The personal and professional toll that this took on
2 them has been obvious to the Scottish Covid Bereaved,
3 and they wish to thank them for their efforts.
4 The bereaved will provide the Inquiry with detailed
5 written submissions in due course. Those submissions
6 will seek to assist the Chair in reaching her
7 conclusions. While the bereaved will seek to be as
8 constructive as possible and provide recommendations on
9 how we can be better prepared and better equipped, in
10 every sense of the word, to face the pandemic, they will
11 not shy away from making what they see as deserved
12 criticism.
13 Many of the recommendations will now be familiar
14 from the Inquiry's other modules, the need to be better
15 prepared for the next pandemic, the need for
16 stockpiling, the importance of domestic production
17 capability, the importance of data. There will also be
18 recommendations unique to this module highlighting the
19 importance of fairness and transparency, of having
20 robust processes in place to guard against possible
21 conflicts of interest or corruption, the need for fully
22 integrated systems the importance of centralised
23 procurement processes, and the need to ensure that PPE
24 and other equipment is not only supplied to NHS
25 settings, but also to ensure that care and nursing homes

1 are properly considered.
2 The vast sums spent by the UK Government and
3 devolved administrations between January 2020 and
4 June 2022 would have been unimaginable for governments
5 to spend on PPE and medical supplies were it not for the
6 pandemic. It was essential that the spending was
7 carried out properly, that there were, where possible,
8 necessary checks and balances put in place, and that the
9 public were able to obtain the best possible deal.
10 The public, of course, were well aware of the
11 worldwide scramble for PPE and, as the pandemic spread
12 across the globe and healthcare systems, that people
13 were being swamped. The bereaved are also aware that
14 human nature being what it is, there will always be
15 those who seek to unjustifiably profit in moments of
16 national crisis.
17 There were undoubtedly those who saw offers of PPE,
18 whether real or imagined, as being a way to line their
19 own pockets. While those who sought to profiteer may
20 measure their profits in pounds and pence, our losses
21 have ultimately been measured in lives.
22 Mr Gove, both in his witness statement and evidence
23 to the Inquiry, was dismissive of those who questioned
24 the UK Government's approach to procurement during the
25 pandemic. Mr Hancock's equally dismissive evidence and

1 at times hostile manner was noted.
2 The Scottish Covid Bereaved do not share Mr Gove's
3 Nixonian belief that criticisms of the UK Government
4 were unjustified and politically motivated, nor do they
5 consider Mr Hancock's personal opinions on the work of
6 the Inquiry to be of assistance.
7 Rather, the evidence before this Inquiry has led the
8 bereaved to consider that, however bad they may have
9 thought the procurement situation had been, the reality
10 was worse.
11 It was the government's responsibility to protect
12 against profiteering and corruption and to ensure that
13 public money was being properly spent on the most vital
14 equipment. Not only did it fail to protect us in this
15 way, it created a system obviously vulnerable to
16 corruption.
17 Times of crisis are not times for the old boys and
18 girls network. Proper expertise was required. There
19 was no equivalent to the VIP Lane anywhere in the world.
20 The approach taken by the UK Government meant that
21 valuable time and resources were spent triaging people,
22 rather than offers.
23 The approach taken by the UK Government upended the
24 normal rules of public procurement. Basic approaches
25 and safeguards were not taken.

1 A proper triage system for a swamped system was
2 required, and that is not the focus of criticism. It is
3 the creation of a priority lane for offers referred by
4 politically exposed people which bred the risk of
5 corruption. Indeed, even if all had been examined by
6 this Inquiry had been above board, the failure of itself
7 was the creation of a system with that risk.
8 As with justice, which must not only be done but be
9 seen to be done, any system of triage ought not only to
10 have been fair, but should have been transparently so.
11 Module 5, of course, was not solely focused on the
12 VIP Lane. The bereaved, in their written submissions,
13 will have more to say on the Ventilator Challenge, of
14 the relationship between the UK and Scottish
15 Governments, and how that impacted upon procurement, and
16 the role of NHS NSS and what can be learnt and what
17 improvements can be made to that. The bereaved will
18 also supply submissions in relation to the evidence
19 heard during closed sessions.
20 We look forward to your Lady's recommendations to
21 help ensure that, when the next pandemic comes, public
22 money is properly spent and those on the front line, the
23 sick, and their relatives, are able to get the necessary
24 PPE and medical equipment to allow them to face the
25 challenges of the pandemic.

1 These are the submissions on behalf of the Scottish
2 Covid Bereaved.
3 **LADY HALLETT:** Thank you very much indeed, Ms Mitchell.
4 Very grateful.
5 I think we can get Mr Thomas and probably
6 Ms Murnaghan in before lunch.
7 Mr Thomas.
8 **Closing statement on behalf of the Federation of Ethnic**
9 **Minority Healthcare Organisations by PROFESSOR THOMAS KC**
10 **PROFESSOR THOMAS:** My Lady, we're at a juncture of
11 reflection and action, and it's crucial to acknowledge
12 the profound responsibility that this Inquiry bears.
13 We've delved deep into the heart of the procurement
14 systems during the most significant global health crisis
15 of our time, uncovering not just inefficiencies but
16 profound injustices.
17 These injustices, have disproportionately affected
18 those who are already at the margins, our ethnic
19 minority healthcare workers who have faced not only the
20 front lines of a pandemic, but also the system failures
21 of the system meant to protect them.
22 A question that you have probably asked yourself
23 many times during this module, and one that you will
24 undoubtedly weigh when you deliberate, is: did it need
25 to be this way?

1 Yes. There was a global pandemic. And throughout
2 this module, my Lady, if I may say so, you have been
3 very mindful of that, recognising the difficulties faced
4 by many of the witnesses, offering praise where it was
5 due, and showing kindness. However, while it is
6 possible to sympathise with those in charge of
7 procurement, can we really excuse the failings that we
8 have heard? Absolutely not.
9 You see, the urgency of a crisis does not diminish
10 the need for equity. Rather, it highlights and
11 amplifies it. Every decision that deprioritises the
12 Public Sector Equality Duty not only undermines legal
13 mandates, but also compromise the very lives it sought
14 to protect.
15 As we move forward, it's imperative that this
16 Inquiry not only acknowledges these failings but also
17 acts decisively to ensure that they're not repeated.
18 Not only as optional extras, but as indispensable
19 pillars of procurement to safeguard against
20 a magnification of risk to our most vulnerable
21 healthcare workers during future pandemics or crises.
22 You see, throughout this Inquiry we've heard
23 testimony after testimony, each painting a stark picture
24 of a procurement process fraught with lapses inclusivity
25 and transparency.

1 My Lady, I'm sure you'll recall Sir Chris Wormwald's
2 evidence in Module 1 which confirmed DHSC had stocked
3 lower levels of PPE, specifically respirators, suitable
4 for ethnic minority staff, and that little planning had
5 been done to consider the quality of PPE provisions.
6 You will also no doubt recall the powerful evidence
7 heard throughout Module 3 about the human impact and
8 harm caused by inadequate PPE supplies, and racial bias
9 in key equipment such as the pulse oximeters.
10 I do not intend to repeat or spend a lot of time
11 repeating or rehearsing this evidence, but we trust you
12 will have it in mind when reflecting on the process
13 evidence that we've heard over the past month. We ask
14 you in particular to remember the powerful evidence of
15 Professor JS Bamrah, who contributed on behalf of FEMHO:
16 "The consistent picture from across our [members]
17 was one of discrimination through unavailability or
18 inadequate PPE and fit testing rejection."
19 Our members were routinely expected to go on
20 high-risk clinical areas without adequate PPE, if any at
21 all. Many of our members felt they were pressured into
22 this and did not have a discretion to refuse. Even some
23 pregnant nurses were threatened with disciplinaries if
24 they refused.
25 These are not mere procedural failings. They are

1 breaches of trust. Breaches that have placed undue risk
2 on the lives of those dedicated to saving others.
3 From the evidence presented, it's clear that the
4 Public Sector Equality Duty, a cornerstone of our legal
5 framework, was often sidelined in a frantic rush to
6 secure supplies, leaving behind a trail of consequences
7 that we are only now beginning to fully understand.
8 But it's not enough to merely identify these
9 failings. As representatives of FEMHO, we are here to
10 not just critique but to catalyse change.
11 I've said it time and time again: FEMHO wishes to be
12 solution orientated and future looking. FEMHO wants
13 a procurement system that not only learns from past
14 mistakes but one that actively paves the way for an
15 equitable healthcare system, a system where safety and
16 the needs of every healthcare worker, irrespective of
17 their ethnic background, are not just considered but are
18 central to the procurement strategies that protect them.
19 Let me now turn to the evidence that we've heard.
20 In our initial week of testimonies we delved deeply into
21 the structural shortcomings of the pandemic response,
22 particularly focusing on PPE procurement process.
23 As Professor Sanchez-Graells, a pre-eminent expert
24 in procurement law, offered a damning critique of the
25 government's approach, he pointed out that the pursuit

of speed over due diligence let to a disregarding of the foundational principles of public procurement. Transparency was not merely sidelined, it was disregarded, creating a fertile ground for mismanagement and potential malpractice.

His testimony highlighted the need for a balanced approach that does not compromise essential transparency and accountability in times of crisis.

Additionally, the UK Anti-Corruption Coalition outlined how the deviations from standard procurement practices not only increased the risk of corruption, but also diminished the quality and suitability of supplies ask procured. The coalition argued for a return to a more stringent procurement regulations, emphasising the need for robust procurement laws. It's not just about restoring normalcy; it's about reinforcing the integrity of our entire healthcare system against future shocks.

The evidence presented by these experts brings to light significant flaws in the system, flaws that had direct consequences on the ground. For instance, it was revealed through witness testimonies that the lack of proper vetting and the hasty engagement with new suppliers led to numerous instances where PPE was either ineffective or wholly unsuitable. This not only

endangered healthcare workers, but also wasted valuable resources at a critical time.

Moreover, discussions during the first week also touched on the psychological impact on healthcare professionals, the uncertainty regarding the effectiveness of PPE they were provided added unnecessary stress to an already overwhelming situation.

As one frontline worker's testimony was shared:

"Every day we were unsure if our equipment would protect us, or if it would fail, exposing us to a deadly virus."

This palpable fear underscores the tangible human costs of the procurement failures. As we delve into the systemic failings in our healthcare procurement processes, it's crucial to acknowledge not only the impact on our members, but also on the patients they serve and the families affected by these shortcomings. The emotional trauma and grief borne by families who lost loved ones due to inadequate protective measures are profound and must be addressed.

This is not about playing politics; it's about recognising the full human cost of our shortcomings, ensuring that our advocacy speaks to and for the broader community affected by these issues. The need for action is clear and urgent. The testimony from the first week

compels us to critically reevaluate the procurement systems to ensure that they encompass enforceable safeguards that protect all participants in the healthcare system, particularly ethnic minority workers, who were disproportionately affected.

These workers often faced a dual challenge of being more likely to contract the virus, and more likely to receive inadequate protection due to the one-size-fits-all approach in PPE procurement.

It was alarming to our members that Max Cairnduff demonstrated an ignorance of the issue even today, saying, and I quote, "The PPE is itself, I think -- I may be wrong -- relatively agnostic, a mask is a mask."

The second week of testimony shed light on some of the most contentious aspects of the government's pandemic response, particularly through the examination of the VIP Lane operation. We heard from high profile figures, Michael Gove, Lord Feldman, whose involvement in this VIP Lane raised critical questions about transparency and fairness of the procurement process.

Amidst this backdrop of urgency and exception we heard poignant testimonies from Andrew Mitchell and Emily Lawson which brought to the forefront the human impact of those procurement strategies. Andrew

Mitchell, reflecting on the strategic risks identified during the pandemic, acknowledged that there was a failure to provide inclusive product specifications. He specifically noted that the standard PPE provided often did not cater adequately to a device -- to the diverse needs of healthcare workers, particularly those from ethnic minority backgrounds who reported significant issues with the fit of protective equipment.

Emily Lawson's testimony complemented this view by pointing out to the reactive nature of the adjustments made to accommodate these needs. She referred to efforts to rectify the oversights as the pandemic progressed, but was vague on the detail and conceded that initially the systems were not designed to handle diversity of needs, which resulted in preventable exposure to risks for some of our most vulnerable healthcare workers.

Dame Emily's evidence is particularly crucial as it underscores a significant shift needed within our healthcare systems from reactive to proactive inclusivity. The insights from these sessions paint a clear picture of procurement systems caught offguard, not just by the virus, but by its own operational blind spots.

My Lady, these discussions are not merely academic;

1 they have real world implications. They tell us that
2 the systems failed to consider the diverse needs of the
3 users, the consequences can be dire.
4 My Lady, I'm going to move on because I know time is
5 short and I want to come to my conclusions.
6 So let me conclude. It's clear that the Inquiry has
7 uncovered not just systemic failings but also a pathway
8 to substantive reform. The evidence compels us to act
9 not out of obligation but out of necessity, to address
10 the disparities that have come to light.
11 Public sector duty compliance. There were
12 persistent issues in complying with the Public Sector
13 Equality Duty that has revealed significant gaps in our
14 procurement practices.
15 Inclusivity in PPE design. The one-size-fits-all
16 approach failed many in our diverse healthcare
17 workforce.
18 The engagement and representation. The testimony
19 has also highlighted the need for greater representation
20 and involvement of groups like FEMHO in the
21 decision-making process. Jonathan Marron admitted that
22 this is an area where we can do a much better job.
23 As Rosemary Gallagher noticed, within PPE
24 procurement teams the clinical voice was completely
25 absent. This inevitably had a knock-on effect on the

1 distribution as without clear insights and data on the
2 needs of local workforces, decision makers lacked
3 valuable information.
4 Transparency and accountability. The lack of
5 transparency and accountability in the procurement
6 process has eroded trust and compromised the
7 effectiveness of healthcare response.
8 Learning and improvement for future preparedness.
9 This -- there is a clear consensus, my Lady, on the need
10 to integrate the lessons learned from the pandemic into
11 future emergency preparedness policies. This includes
12 ensuring that a reliable supply of appropriate PPE --
13 fitting PPE and developing responsive systems that can
14 adapt quickly to feedback from an evolving needs during
15 a crisis, and cultural and structural changes.
16 Finally, the testimonies have underscored the
17 necessity for cultural and structural changes within our
18 healthcare procurement services.
19 So, my Lady, as this Inquiry moves to its
20 recommendation phase, let us be guided by these
21 insights: the urgency for change is evident, and the
22 path forward is clear. It's incumbent upon all of us to
23 ensure that the lessons of this pandemic are real, and
24 lasting changes to protect and uphold the rights and
25 safety of every healthcare worker, irrespective of their

1 background.
2 Thank you, my Lady.
3 **LADY HALLETT:** Thank you very much, Mr Thomas. Very
4 grateful.
5 Ms Murnaghan, would you like to take us up to lunch?
6 **Closing statement on behalf of Department of Health,**
7 **Northern Ireland by MS MURNAGHAN KC**
8 **MS MURNAGHAN:** Yes, my Lady.
9 My Lady, I make this closing statement on behalf of
10 the Department of Health of Northern Ireland.
11 My Lady, in assisting this Inquiry, the department
12 has supplied number of detailed witness statements.
13 Just yesterday, the Inquiry heard oral evidence from
14 Chris Matthews, who was the deputy secretary of the
15 Resource and Corporate Management Group. By this
16 evidence it's hoped that the department has provided
17 a comprehensive picture of the procurement processes in
18 Northern Ireland and how those processes operated to
19 secure key healthcare-related equipment and supplies
20 during the pandemic.
21 It should now also be apparent that, in general
22 terms, the items obtained, including their
23 specification, quality, and volume, were sufficient to
24 meet the needs of the people of Northern Ireland, and
25 that all relevant organisations worked together to

1 ensure that these materials were effectively distributed
2 to those who needed them.
3 Now, my Lady, the department does not want to pat
4 itself on the back or appear in any way
5 self-congratulatory, as has been suggested earlier this
6 morning. But objectively, we contend that the
7 department has demonstrated that in the relevant period,
8 its public procurement processes met with the highest
9 standards of integrity, transparency, and good
10 administration.
11 At every juncture the department endeavoured to
12 ensure that the expenditure of public funds was
13 transparent, accountable, and provided value for money
14 to the maximum possible extent in all of the difficult
15 and exigent circumstances.
16 The department would also like to take this
17 opportunity, my Lady, to clarify any confusion which may
18 have arisen on foot of some of the questions posed to
19 Ms Karen Bailey yesterday by counsel for the Northern
20 Ireland Covid Bereaved Families for Justice.
21 My Lady will recall, of course, that Ms Bailey was
22 questioned in relation to an email chain which was
23 exchanged inter alia between BSO PaLS, the then Minister
24 for Health and the CMO. That email exchange is located
25 at INQ000503883.

1 Regrettably, it appears that, in joining the two
2 discrete issues in the one email, that the CMO's
3 approval for a business case has been conflated as
4 a specific approval or, as is put this morning,
5 commendation of a firm called NWT Distribution and their
6 supply proposal.
7 My Lady, we contend that is a misapprehension. As
8 is evident from the fact that the company,
9 NWT Distribution, offered 20,000 ventilators over
10 six weeks. It has tried to say that Northern Ireland
11 did not have the need, much less the capacity, for this
12 amount of ventilators.
13 The department would also like to clarify two points
14 arising from that email chain. The first point relates
15 to the role that the CMO took in relation to
16 procurement. The CMO, in his role as the chair of Gold
17 Command, and as is apparent in that email chain,
18 approved a business case, which was a legitimate part of
19 his role whereby he was required to authorise spending
20 proposals related to a range of areas pertaining to the
21 Covid response.
22 That approval should not be confused with the CMO
23 having had any direct or, indeed, active involvement in
24 the process of procurement or any specific contract.
25 The actual sourcing and procurement was a matter for

1 BSO PaLS. Therefore, we contend, my Lady, that the
2 CMO's statement to this module is accurate and he took
3 no active involvement in the procurement process,
4 including the means of procurement.
5 The second point, my Lady, to make relates to the
6 erroneous view that the CMO had commended or indeed, as
7 was suggested yesterday, given approval for the specific
8 contract proposal. The issue here relates to the
9 NWT Distribution proposal, and, in considering part of
10 the email in isolation, it appears to indicate that
11 within a matter of several hours, and without any due
12 process or investigation, the CMO approved that
13 proposal. However, on consideration of the entire email
14 chain, it becomes clear, particularly when one considers
15 the email written by Mr Liam McIvor, who was Ms Bailey's
16 predecessor in BSO PaLS, that the approval from the CMO
17 related only to spending on the specific business case
18 which had been put to him.
19 As I stated previously, my Lady, BSO PaLS had sought
20 that approval from the CMO in his role as chair of Gold
21 Command. This was distinct from the NWT proposal.
22 Liam McIvor's email demonstrates that, in addition
23 to acknowledging the CMO's approval, BSO PaLS would
24 separately actively explore the offer from NWT,
25 alongside that of another number of companies.

1 Now, more generally, my Lady, throughout the course
2 of these hearing sessions the department has reflected
3 on the evidence adduced and the issues that have
4 emerged. The department would like to highlight some
5 points pertaining to its work at the time, and the first
6 thing I would like to touch on is the issue of the
7 provision and availability of PPE to the independent
8 care sector.
9 I should be clear by now, in Northern Ireland,
10 BSO PaLS is responsible for Northern Ireland's Health
11 and Social Care equipment supply chain, and procurement
12 activity on behalf of the trusts.
13 Prior to the pandemic, the department had no role in
14 the provision of PPE for privately-run residential and
15 nursing homes. In fact, each independent healthcare
16 provider procured their own PPE.
17 The department acknowledges that there were
18 instances when concerns were raised by the independent
19 healthcare providers about concerns regarding a lack of
20 PPE being made available to them. However, the
21 department engaged with those healthcare providers, the
22 trusts, and the RQIA, and by early to mid-April 2020
23 these issues were resolved.
24 The department is also aware that there has been, at
25 times, a perception that there was confusion around the

1 messaging in relation to how the independent healthcare
2 providers would procure PPE at the early stages of the
3 pandemic. It is the Department's view that the interim
4 guidance, which was developed and published early in the
5 pandemic was unequivocal in its clarity of messaging.
6 That guidance clearly stated that if those
7 independent providers were unable to source items of
8 PPE, the trusts would work closely with them to ensure
9 that appropriate equipment was made available.
10 This message was reiterated and expanded on in later
11 versions of the same guidance published in March, April,
12 and September of 2020.
13 Moreover, the department was in regular
14 communication with representatives of the independent
15 care sector to help ensure that the guidance drafted not
16 only reflected their views, but was also understood by
17 them.
18 Indeed, the department is further assured of the
19 input that was provided to the independent care home
20 sector, given that, in the early stages of the pandemic,
21 there was a representative from their body who was fully
22 involved in the BSO PaLS structures.
23 In that role, the independent care home sector had
24 the opportunity to see at firsthand and so understand
25 BSO PaLS's work on the provision of PPE at those very

1 early stages of the pandemic.
2 Again, my Lady, and without wishing in any way to
3 appear self-congratulatory, we say it is reasonable to
4 assess that whilst playing a limited role in
5 procurement, the department took decisive and
6 coordinated steps to address the PPE supply and
7 distribution challenges that Northern Ireland faced,
8 both in the early days of the pandemic and in
9 preparation for subsequent waves.
10 This included using its best endeavours to ensure
11 that any surplus stock was fully utilised whenever
12 possible.
13 On another note, my Lady, the experience of the
14 pandemic has identified learning and prompted change,
15 change which we have already put into effect, such as
16 the dynamic purchasing system which is still available
17 for use today.
18 In that regard, it is fair to say that the
19 department has benefited significantly from a number of
20 reviews and lessons learned exercises. This morning
21 does not permit sufficient time for me to provide
22 a detailed list of all of the learning points, and the
23 implementation thereof, but if I may, I would briefly
24 summarise some of the key areas of work which we have
25 used to strengthen processes and improve resilience.

1 The rapid review of Covid-19 PPE, commissioned by
2 the then Minister for Health, identified learning points
3 across a number of key areas, including the management
4 of PPE, modelling, stock management, supply chain
5 resilience, PIPP release mechanisms and the appropriate
6 support for staff.
7 Whilst some of those actions were implemented in
8 a timely manner, others proved to be more challenging,
9 given their nature. That being said, all 17 actions
10 that were associated with that action plan were fully
11 implemented by the end of December 2020.
12 Secondly, my Lady, a Northern Ireland Audit Office
13 review on the supply and procurement of PPE to local
14 healthcare providers was published in March 2022. The
15 department and its arm's length bodies have all taken
16 action in relation to relevant learning points arising
17 from that report.
18 Finally, and as was referred to in much more detail
19 in the corporate statement, a review report identifying
20 key themes and lessons learned from the content of
21 emails received from the PPE mailbox was produced and
22 also shared with the sector for consideration and
23 appropriate action.
24 Now, my Lady, to conclude, the department would like
25 to place on record its appreciation of those staff

1 involved in the substantial efforts made to procure and
2 distribute PPE in Northern Ireland. While Northern
3 Ireland of course faced logistical and geographical
4 challenges, the department commends the dedication and
5 commitment of all of those who were involved in ensuring
6 that PPE was secured and distributed effectively during
7 the period of global supply chain pressure.
8 The department finally, my Lady, reiterates that it
9 remains committed to learning from all of the issues
10 raised in this module and will take on board any
11 recommendations from the Inquiry to help shape future
12 emergency responses.
13 Thank you.
14 **LADY HALLETT:** Thank you very much for your help,
15 Ms Murnaghan.
16 Very well, we'll break for lunch now. I shall
17 return at 1.45. Thank you.
18 **(12.47 pm)**
19 **(The Short Adjournment)**
20 **(1.45 pm)**
21 **LADY HALLETT:** Good afternoon.
22 Mr Byrne, I think you're next.
23 **MR BYRNE:** My Lady, I wasn't expecting to be, but I can.
24 **LADY HALLETT:** Oh, sorry. Why weren't you?
25 Anyway, why don't you have a go?

1 **MR BYRNE:** Thank you, my Lady.
2 **LADY HALLETT:** Sorry for the confusion.
3 **Closing statement on behalf of the Welsh Government**
4 **by MR BYRNE**
5 **MR BYRNE:** Good afternoon, my Lady, prynhawn da, I appear on
6 behalf of the Welsh Government.
7 The Welsh Government has listened closely to the
8 oral evidence and submissions you have heard this month.
9 The Welsh Government's written closing statement will
10 address in detail the important issues that Module 5 has
11 raised for Wales.
12 Today, I will focus on some of the principal points
13 that have emerged from the evidence, lessons learned and
14 recommendations.
15 One of the questions asked of Welsh Government
16 witnesses was why there were experiences of local PPE
17 shortages even if, as the evidence showed, stocks never
18 ran out at a national level in Wales.
19 The Inquiry heard from Alan Brace who, on
20 23 March 2020, led the Welsh Government's work in
21 sourcing and distributing PPE in Wales.
22 Mr Brace told the Inquiry that he was aware that
23 there were difficulties in the very early stages of the
24 pandemic in relation to the distribution of the pandemic
25 stockpile. He identified the problem that he saw: that

1 the emergency planning for PPE was based on a push
2 system whereby standard packs of stocks were pushed out
3 to the NHS. This was different from how the NHS in
4 Wales usually operated, which was a pull system, by
5 which local health boards requested stocks as needed.
6 One of the lessons he drew from the pandemic was
7 that it was unhelpful for the emergency PPE supply
8 process to work differently from the usual process of
9 supplying.
10 Mr Brace told the Inquiry that, on taking up his
11 role, he was in daily contact with the PPE leads of
12 local health boards, and throughout those meetings, they
13 assured him that the local health boards were receiving
14 sufficient stocks of PPE.
15 However, as was noted in our written opening
16 statement at the outset of this module, the Welsh
17 Government accepts the evidence heard during Module 3
18 that delivering PPE stock to the local health boards did
19 not necessarily mean that it always reached the right
20 hospital or the right ward.
21 An important lesson that therefore arises is the
22 need for local health boards and NHS trusts to ensure
23 they have robust, local stock management processes in
24 place which can be appropriately expanded during a time
25 of heightened demand, to ensure that supplies received

1 from the NHS Wales Shared Services Partnership can be
2 efficiently delivered to the right hospital and to the
3 right ward.
4 In relation to local PPE shortages within the care
5 sector, Mr Brace recalled an instance of a call in late
6 April 2020 informing him that a care home had run out of
7 PPE and that there was none available within the local
8 authority to replenish their stocks. Mr Brace told the
9 Inquiry that he contacted the NHS Wales Shared Services
10 Partnership, a van was duly sent to the relevant joint
11 equipment store and shortly thereafter, it was confirmed
12 that the store was in fact full of stock and that there
13 was simply a communication or distribution issue between
14 the local authority, the joint equipment store, and the
15 care home.
16 The Welsh Government accepted in its written opening
17 statement that the move to centralise NHS-led
18 procurement for the social care sector could have been
19 put in place earlier in March 2020. That move may have
20 quickened the improved availability of supplies for the
21 sector in the very early days of the pandemic.
22 That said, the care sector distribution difficulties
23 experienced early in the pandemic were exacerbated by
24 the fragmented nature of local government procurement in
25 Wales.

1 Mr Brace and other witnesses highlighted the
2 benefits of having, in the NHS Wales Shared Services
3 Partnership, an expert central NHS procurement function
4 with experienced personnel and well-established
5 processes which was able to ramp up its usual activities
6 without the need suddenly to develop new structures.
7 Coming into the pandemic, local authorities in Wales
8 had no such centralised procurement function.
9 Mr Brace's evidence illustrated the practical impact of
10 that absence. He told the Inquiry that: although
11 getting a clear picture of stocks held and usage rates
12 within local health boards was a challenge in the early
13 part of the pandemic, there was, nevertheless, a lot
14 more data, intelligence and insight with respect to
15 those matters within the NHS because of its centralised
16 procurement structures.
17 By contrast, in the care sector, those structures
18 and that data had to be generated from scratch and at
19 pace. Inevitably, that fact was a significant factor in
20 the local supply problems experienced by the care sector
21 during the very early months of the pandemic.
22 The Welsh Government will therefore discuss with the
23 Welsh Local Government Association the proposition that
24 they take action on behalf of the 22 Welsh local
25 authorities to develop a more collaborative approach to

1 the management of procurement and the collection,
2 sharing and use of data which provides a more resilient,
3 responsive and flexible structure in times of rapidly
4 increased demand.
5 Given the important evidence that you've heard
6 during this module, my Lady, we hope the Inquiry would
7 endorse such an approach.
8 The Inquiry also heard from Andrew Slade, whose
9 Welsh government responsibilities during the pandemic
10 included the Commercial and Procurement Directorate.
11 His evidence highlighted a number of positive lessons
12 which he recommended be reflected in a future pandemic.
13 These included the effective use of mutual aid
14 arrangements, the expanded role played by the Welsh
15 Government's Commercial and Procurement Directorate, and
16 the provision and procurement -- sorry, and the
17 provision of procurement guidance and advice, and the
18 mechanisms developed for quickly standing up the
19 domestic production of key suppliers.
20 However, he accepted that more should have been done
21 formally to measure the effectiveness of the efforts to
22 stimulate the domestic production of PPE during the
23 pandemic.
24 Mr Slade also indicated that the wider public sector
25 would benefit from more experts in procurement, supply

chain management and contract management, including during an emergency.

Finally, questions were put to witnesses from all four nations highlighting the importance of providing appropriately fitting PPE and other equipment for all who use them, including black, Asian and minority ethnic healthcare workers. This is a lesson that the Welsh Government recognises must be learned from the pandemic. Suitable PPE and other relevant supplies must be made available for the diverse range of users, both in terms of stockpile preparations and in the course of ongoing procurement.

My Lady, although the hearings for this module now draw to a close, the Welsh Government will continue to consider the evidence from all four nations to see how best to enhance procurement practice and procedure in Mr Wales. Thank you.

LADY HALLETT: Thank you very much, Mr Byrne.

Apologies, again, if I caught you by surprise. I think you may have forgotten that Ms Murnaghan went before lunch.

Now Mr Holl-Allen, I think. Not caught you by surprise?

Closing statement on behalf of NHS Wales Shared Services Partnership by Mr Holl-Allen KC

MR HOLL-ALLEN: My Lady, I make these submissions on behalf of the NHS Wales Shared Services Partnership or NWSSP.

NWSSP is firmly part of the NHS in Wales. It is not a Welsh Government body on an arm's length basis or otherwise.

Throughout the pandemic, however, NWSSP had a good working relationship with Welsh Government, which provided reliable and substantial funding to allow it to discharge the increased role which it was called upon to perform.

A key component of NWSSP's ability to respond to the pandemic was this good working relationship with Welsh Government, together with the timeliness of responses from Welsh Government colleagues over resources requests, contract approvals, and information sharing.

When the pandemic began, NWSSP was well established and integrated into the NHS in Wales. It does not stand as a separate board, but is hosted by Velindre NHS Trust. The Shared Services Committee, through which it discharges its functions, is required by regulation to have on its membership a representative of each health board, trust and special health authority in Wales. As its name indicates, it is intended to achieve its purposes through partnership working with those bodies. It has a directorate of procurement services

containing a group of dedicated and experienced procurement professionals working for the benefit of the NHS in Wales as a whole.

It was clear from the evidence of Alan Brace on behalf of Welsh Government that he valued that experience.

There were obvious advantages, in the fast-moving sellers' market in the spring of 2020, of NWSSP being able to enter into contracts on behalf of Wales as a whole. It assisted beyond the borders of Wales by contracting for a huge quantity of type 2R fluid-resistant masks on behalf of the entire United Kingdom. The sheer volume of masks purchased under that contract allowed a very favourable price to be negotiated.

In mutual aid, Wales was a net contributor. It gave out more than it received.

As the pandemic began, NWSSP was responsible for business-as-usual procurement in the secondary healthcare sector, but not for pandemic or emergency procurement. It was, however, sufficiently resilient and flexible to be able to take on, at short notice, not only pandemic procurement, but also to expand its operations to the social care and primary care sectors.

As you heave heard, procurement among the 22 local

authorities in Wales was, in contrast to healthcare, not centralised, and procurement expertise, accordingly, more thinly spread.

Nevertheless, Alan Brace was confident that by the summer of 2020, all those in the social care sector that required it was being sufficiently supplied with PPE by NWSSP. While a formal service level agreement was not entered into until September 2020, the arrangements which that SLA reflected had been in place for some time.

All offers to supply PPE in Wales during the pandemic were considered and assessed in the same way. There was no High Priority Lane. There was a list of critical items for which there was a pressing need, and which therefore needed to be prioritised, but this should not be confused with preferential treatment of any supplier.

The substantial volume of offers received was managed with the assistance of colleagues in the Life Sciences Hub. It was independently verified by the Auditor General for Wales that there was no evidence of preferential treatment in the award of contracts for the supply of PPE and in the case of all the contracts under review, there was a proper audit trail evidencing the decisions which had been reached.

1 The Audit Wales report found that there had been
2 delays in the issue of contract award notices. NWSSP
3 accepts the importance of transparency in the award of
4 contracts and regrets these delays, which were not
5 deliberate but due to oversight at a time of extreme
6 pressure of work. But the Auditor General found no
7 evidence of any substantive failures in the way in which
8 any contract had been awarded.
9 NWSSP accepts that there were genuine concerns in
10 Wales, as there were throughout the United Kingdom,
11 expressed by end users about the adequacy and
12 sufficiently of PPE. While it has been confirmed by
13 several witnesses that at no stage did Wales run out of
14 PPE at a national level, that of course does not itself
15 meet the concerns of frontline workers who had
16 difficulty in obtaining it.
17 The nature of the PPE to be supplied was specified
18 by the IPC cell at UK level and disseminated in Wales by
19 Welsh Government. NWSSP's role was to ensure that the
20 PPE which it procured and supplied was up to standard
21 and compliant with all regulatory requirements.
22 This Procurement Services did successfully, with the
23 assistance of their colleagues in the Surgical Materials
24 Testing Laboratory.
25 NWSSP's responsibility as a distributor was to

1 deliver PPE to each hospital's central receipt and
2 distribution point, or in social care, to each local
3 authority's joint equipment store. It did not have
4 responsibility for internal distribution within
5 a hospital, nor for deliveries to individual care homes.
6 In April 2020, Welsh Government asked the military
7 to review the overall robustness of the supply chain
8 nationally. Its report concluded that while national
9 storage and distribution was fit for purpose, there was
10 a lack of clarity as to what stock was available in
11 forward locations, ie, at the joint equipment stores and
12 within health boards.
13 NWSSP was not responsible for the procurement of
14 stock held in the PIPP stockpile, but for its storage
15 and distribution. On instruction from Welsh Government,
16 NWSSP distributed PPE from the stockpile, as you have
17 heard, on a push basis, having regard to normal levels
18 of demand, and in the case of local authorities, the
19 size and population of the local area.
20 Ongoing and accurate assessment of levels of demand
21 proved challenging, and NWSSP enlisted the support of
22 the military, and benefited from the input of Deloitte
23 under an arrangement initiated and funded by Welsh
24 Government.
25 NWSSP acknowledges the importance of having PPE

1 which fits a diverse health and social care workforce.
2 There were, however, practical difficulties in achieving
3 diversity of supply. Wales, in particular, was heavily
4 reliant throughout on the international market, and had
5 limited, if any, influence on the particular
6 specification of the product.
7 In the case of FFP3 masks, the supply of any new or
8 alternative products would require each user to undergo
9 further testing for fit, putting additional pressure on
10 health board resources which were already stretched.
11 Arrangements and systems for the procurement,
12 storage and distribution of PPE in each of the devolved
13 administrations was similar and all held up well under
14 the increased pressures of the pandemic. In each case,
15 on the evidence, there was a body with central
16 responsible for the procurement of PPE staffed by
17 experienced procurement professionals with
18 responsibility in normal times for the procurement of
19 the great majority of the needs of the secondary
20 healthcare sector.
21 The contrast was between the devolved
22 administrations on the one hand and, on the other,
23 England, where in normal times the system was much more
24 fragmented, with individual trusts being responsible for
25 a much greater proportion of their own procurement, and

1 NHS Supply Chain correspondingly less.
2 The systems in the devolved administrations were
3 able to scale up to the challenge of the Covid pandemic
4 without significant alteration in a way in which the
5 corresponding systems in England were not. It is
6 acknowledged that one of the reasons for this was the
7 relatively small size of the devolved administrations.
8 This allowed for greater agility in responding to the
9 challenges of the pandemic.
10 It was described in Mr Brace's evidence as
11 "small-country governance", and Wales certainly
12 benefited from it.
13 NWSSP and Welsh Government had to respond at short
14 notice to the failure of the UK-wide arrangements for
15 the procurement of PPE in a pandemic by taking on
16 responsibility for the procurement of their own PPE.
17 Following that experience, NWSSP understands that Welsh
18 Government expects it to continue to source, store and
19 distribute PPE on behalf of Wales, rather than reverting
20 to reliance on a central UK supply.
21 Welsh Government and NWSSP are actively working on
22 the forward plan for this provision to continue.
23 NWSSP would wish to conclude by putting on record
24 its gratitude for the hard work and commitment
25 demonstrated by its own staff and those of its partners,

1 and remembering the suffering and bereavement endured by
2 so many during the pandemic.
3 **LADY HALLETT:** [microphone muted].
4 **MR BYRNE:** Thank you, my Lady.
5 **LADY HALLETT:** Sorry, could you not hear me?
6 Mr Mitchell, sorry, maybe you couldn't hear? Sorry.
7 **MR MITCHELL:** I think you were perhaps muted there, my Lady.
8 **LADY HALLETT:** Again.
9 **Closing statement on behalf of Scottish Ministers**
10 **by MR MITCHELL KC**
11 **MR MITCHELL:** My Lady, this the closing statement on behalf
12 of the Scottish Government. I appear today on behalf --
13 along with junior council, Amelia Mah, and we are
14 instructed by Caroline Beattie and Callum McCue of the
15 Scottish Government Legal Directorate.
16 In our opening statement we highlighted the
17 keystones of the approach to procurement adopted by the
18 Scottish Government during the pandemic.
19 We identified those as collaboration, relationships,
20 innovation, and governance.
21 We said that by pursuing these principles,
22 remarkable outcomes were achieved. Now, as this module
23 closes, we submit that the central tenets were reflected
24 in the evidence. The Scottish Government does
25 acknowledge that at times, particularly in the early

1 days of the pandemic, the system was put under great
2 strain.
3 A sharper understanding now exists of many issues.
4 For example, as Ms Freeman described in such vivid
5 terms, the importance from the outset of wrapping our
6 arms around all of health and social care.
7 Undoubtedly there are lessons to be learned. In
8 Scotland, the implementation of many of these lessons
9 has already begun.
10 In this closing statement, therefore, we remind the
11 Inquiry of the achievements of the Scottish Government
12 and its partners, and we identify some areas that the
13 evidence has shown to be habile to change.
14 We begin with a brief resumé of the achievements in
15 Scotland. As we have seen in the evidence led, the
16 combined skills of the Scottish Government and NSS were
17 critical. Gordon Beattie of NSS praised the
18 collaborative working of the single-point-of-contact
19 strategic PPE group. This group brought together NSS,
20 health boards, Scottish Government, Scottish Enterprise
21 and others, and in his view was a really useful
22 mechanism.
23 Mr Cackette noted that the creation of the PPE
24 Directorate allowed NSS to get on with what they were
25 skilled and expert at in delivering.

1 Ms Freeman explained that the level of expertise
2 within NSS and its longstanding relationships with
3 suppliers and clinical advisers gave Scotland
4 a significant advantage.
5 The Scottish Government worked effectively with a
6 number of public sector bodies, as well as with Scottish
7 manufacturers to produce PPE. By April of 2021, 88% of
8 PPE by value, excluding gloves, was manufactured in
9 Scotland.
10 The PPE action plan aimed to ensure that the right
11 PPE of the right quality gets to the people who need it
12 at the right time. In March 2020 the Scottish
13 Government temporarily expanded the remit of NSS to
14 provide PPE to primary care providers and social care
15 settings at a time when they were unable to source
16 increased amounts of PPE from their regular private
17 suppliers.
18 This was done for social care primarily via a series
19 of localised hubs with the aim thereafter of local
20 distribution. In April 2020, a PPE supply helpline was
21 established by Ms Freeman for health and social care
22 staff, who needed PPE and to which clinical advice
23 entitled them.
24 As Ms Freeman put it in evidence: she wanted a means
25 by which staff on the front line could raise directly

1 with the Scottish Government issues that they were
2 experiencing whilst on shift. Whilst she and
3 Mr Cackette accepted that response times were initially
4 too slow, within a month those response times had
5 improved considerably.
6 In accordance with principles of good governance,
7 offers of help received by the Scottish Government were
8 triaged. To be clear, this was a triage of offers, not
9 simply a triage of people. As we said in our opening
10 statement, no concerns of fraudulent conduct arose in
11 relation to procurement or award of contracts. No
12 conflicts of interest by civil servants or ministers
13 were identified.
14 I turn now to other issues that were raised in
15 evidence, and looking firstly at data. The Scottish
16 Government recognises the importance of comprehensive
17 and reliable data. As Ms Freeman said, the Scottish
18 Government accepted that the quality of data needed to
19 be improved. An inventory management system was
20 discussed early in the pandemic when it became apparent
21 that there was not clear visibility of the level of PPE
22 stock within health boards or across Scotland.
23 In March 2023 such a system was rolled out across
24 all health boards. The system provides boards with
25 current data on consumable stock levels and will, in due

course, provide data on costing and clinical variation. All this will ensure less waste.

In relation to ICU equipment, Ms Lamb noted that there was not systematic visibility on the precise locations and types of equipment being used. However, by September of 2025 a national medical equipment management system will be operational. This will provide national oversight of NHS Scotland's medical equipment inventory, thereby improving patient safety and outcomes.

Turning now to diversification of supply chains. The pandemic demonstrated that just-in-time contracts for PPE were not effective in an emergency situation. They are not currently being considered in Scotland for use in pandemic planning. As the evidence has shown, during the pandemic, the Scottish Government worked very successfully with Scottish Enterprise, NSS and Scottish manufacturing to develop new supply chains and sources of PPE and equipment.

As Mr Beattie described it: this transformed what we were doing.

The urgent need of the country was met and greater self-sufficiency was created.

Since the pandemic, NSS have diversified their supply chains and reduced reliance, where possible, on

single production centres.

Under the Scottish Government Future Pandemic Preparedness Programme, a PPE delivery group has been established to provide continuing assurance to ministers that appropriate planning for the provision and distribution of PPE is in place across key sectors.

Further, all NHS boards now hold ICU equipment to support double ICU capacity.

Looking now at the stockpile. It is important to note that while in April 2020, stocks of PPE were low, these were stocks that were held centrally. In other words, PPE was being sent out to health boards as quickly as could be managed. As Ms Freeman confirmed, at no point did Scotland run out of PPE. That said, Ms Lamb recognised that the available stockpile was not big enough to deal with a pandemic of this nature.

To that end, Scotland now has an increased stockpile holding based on a 12-week peak demand level, and plans for rotation of NSS PPE stocks using business-as-usual use and surge capacity.

Ms Lamb said that change implemented a key lesson learned.

Looking now at funding issues. In our opening statement we mentioned the lack of a mechanism to request emergency or additional funding over and above

that generated by Barnett. This issue arose following the need early in the pandemic for the Scottish Government to procure PPE and supplies in addition to the limited amounts supplied by the UK Government. Scotland wasn't getting what it needed from the UK Government and so had no choice but to procure its own supplies to protect its frontline workers. As Ms Lamb explained, the balance of risk favoured ensuring that Scotland had the supplies to provide appropriate and adequate PPE to the NHS and beyond.

As the Inquiry has heard, the issue of funding was raised in a joint letter from the devolved administrations' finance ministers of 12 May 2020. Although there was constructive and collaborative working between governments to try to resolve this issue, the Scottish Government had to bear an otherwise unacceptable financial risk while a funding solution was being considered.

In a future emergency situation, a formal mechanism for emergency funding would provide considerably more resilience and allow for a more flexible and proactive approach.

Now turning, finally, to expert evidence and four nations procurement.

Professor Manners-Bell gave evidence as to the

desirability of having a control tower overview of the complete UK inventory of PPE and equipment. His evidence also covered the establishment of a structure to allow formal communication between the UK Government and the DAs on PPE. This structure would meet regularly in business-as-usual times to monitor the market and to plan for emergencies.

The Scottish Government certainly recognises the benefit of a shared awareness amongst the four nations of supply stocks. A four nations procurement group was put in place to facilitate engagement on PPE guidance, stocks and supplies, demand modelling, and communication.

The Scottish Government engaged in this process in the spirit of mutual collaboration. It did share information with DHSC, but received little in return, at least prior to the February 2021 and the establishment of the Four Nations PPE Collaborative Protocol.

The government submits that for a structure such as the one recommended by Professor Manners-Bell to be effective and efficient, it would require each of the four nations to attend as equal partners. There would require to be parity of esteem, otherwise, from a Scottish Government perspective, it would not materially improve our ability to respond effectively to

a future crisis.

The Scottish Government adheres to its position that it is not persuaded as to the benefits of a four nations body tasked with procurement. We must remember that health and social care in Scotland is devolved, as too is procurement. Thus, innovations or alterations to Scotland's existing procurement system should not be allowed to complicate those arrangements.

The current system draws upon NSS expertise and knowledge of Scottish requirements and is well matched to Scotland's size, population, and the close relationship that exists between the Scottish Government and health boards. Furthermore, as Ms Freeman noted, the current system provides for the necessary democratic accountability.

My Lady, in conclusion, we submit that the evidence in this module, both written and oral, has shown that throughout the pandemic the Scottish Government collaborated, innovated, and forged relationships. It has also learned valuable lessons, many of which have already been translated into positive action.

The Scottish Government would once again wish to pay tribute to all its partners with whom it worked and strove to keep the people of Scotland safe through the provision of essential supplies and equipment.

Before I sit down, my Lady, I would like, on behalf of the Scottish Government, to extend our thanks to the Inquiry for the work that has gone into this module. Those thanks, of course, go to everyone involved, to the legal teams, to the ushers, to witness support, and to RTS, and of course to you, my Lady, for your continued chairing of this Inquiry. Thank you.

LADY HALLETT: Thank you, Mr Mitchell.

Ms Doherty, I think you're next.

Closing statement on behalf of NHS National Services Scotland by MS DOHERTY KC

MS DOHERTY: Thank you, my Lady. Yes, I appear on behalf of NHS National Services Scotland, or NSS for short.

Having had the benefit of considering the evidence presented in this module, including that of Gordon Beattie from NSS, I'd like to take this opportunity to focus on two topics arising from the evidence before making short observations and then concluding thanks.

The first topic arising from the evidence that I mention is the effectiveness of National Procurement systems, which are distinct from those of the other three nations in the UK. As the Inquiry has heard, National Procurement has its own processes and systems in relation to procurement of healthcare-related

equipment and supplies in calls. Health has always been a devolved matter. National Procurement's processes and systems are appropriate for the structures and needs of the NHS in Scotland.

By the time of the pandemic, National Procurement already had an established core procurement team. Many of its members had been recruited in the early 2000s so had many years of experience working in the NHS and therefore had established networks across the NHS in Scotland and with key suppliers.

When the UK Government's just-in-time strategy for the UK PIPP stockpile failed due to the collapse of the international supply chain, National Procurement required rapidly to take steps to procure supplies to meet the needs of frontline services, care services, and unpaid carers in Scotland. It used its existing arrangements and processes for procurement with some adaptations.

It did not create a High Priority Lane for offers of supply of PPE and other key equipment. Instead, it was mostly able to rely on established contacts with key suppliers who were contacted to establish product availability within core categories of required PPE.

In addition, between 17 April and 19 June 2020, it operated an online supplier portal to receive and manage

the surge in offers to supply products. The Scottish Government led on modelling to determine what supplies were needed and in what quantities, which National Procurement then sought to procure.

Importantly, National Procurement sought to secure supply lines going forward for an indeterminate period of time, not just to buy items as a one-off, given the uncertainty as to the potential duration of the pandemic.

Objectively, my Lady, the evidence, including expert evidence, supports that National Procurement's systems during the pandemic were effective, the necessary supplies were procured and distributed.

The evidence also supports that there was collaboration by Scotland with the other three nations in order to support mutual aid and to ensure that actions in Scotland did not have a detrimental effect on the supplies of PPE elsewhere in the UK.

The second topic arising from the evidence that I want to mention is the evidence of the level of PPE in Scotland during the pandemic. As has been confirmed by Audit Scotland, at no point during the pandemic did the NHS in Scotland run out of its national stock of PPE or other key healthcare equipment or supplies. National Procurement always had replacement stock coming in

1 before its stock levels reached zero.
2 Despite having clear oversight of national stock
3 levels, at the start of the pandemic National
4 Procurement did not have oversight of local department
5 or ward levels of stock. In response to this situation,
6 a regular stock count was introduced in hospitals, and
7 this was followed by the introduction of a national
8 inventory management system across the Scottish Health
9 Boards which helped to ensure that the right stock was
10 in the right place at the right time and that it was
11 being distributed fairly.
12 Turning now to some observations. Given the
13 evidence presented in this module, the following three
14 matters are important to note going forward: first, the
15 just-in-time strategy whereby around eight weeks' worth
16 of UK pandemic stockpile was maintained, which was
17 expected to allow sufficient time to buy replaced stock
18 simply does not work in a pandemic. Such a strategy is
19 vulnerable to a sudden supply chain collapse, for
20 example, when countries close their borders.
21 Secondly, there is inevitably a cost associated with
22 maintaining a large stockpile of PPE and/or maintaining
23 manufacturing capacity in the UK only required in the
24 event of a pandemic. However, such maintenance is the
25 country's insurance policy and like an insurance policy,

1 if you do not pay the premium, you do not benefit from
2 the insurance.
3 Thirdly, collaborative work should continue across
4 the four nations on an equal partner status to share
5 best practice and to develop innovative solutions.
6 Finally, some concluding remarks, my Lady. National
7 Procurement's priority during the pandemic was to
8 protect frontline services, staff, carers, patients and
9 residents across health and social care. In my
10 submission, the evidence shows that National Procurement
11 systems and processes operated effectively to do so.
12 NSS wishes to take this opportunity to acknowledge
13 that those working in procurement during the pandemic
14 were working very hard, over long hours, for extended
15 periods of time, under enormous pressure. These
16 individuals, like everyone else, were also suffering
17 personally from the pandemic and its consequences.
18 In addition, most of them worked, and continue to
19 work, closely with frontline NHS staff. As a result,
20 they fully understood what was being faced and what was
21 needed in order to help to protect services and save
22 lives.
23 NSS is very grateful to them for their crucial role
24 at such an important time.
25 Thank you, my Lady.

1 **LADY HALLETT:** Thank you very much indeed, Ms Doherty.
2 Ms Idelbi.
3 **Closing statement on behalf of the United Kingdom Health**
4 **Security Agency by MS IDELBI**
5 **MS IDELBI:** Your Ladyship will recall that the opening
6 statement on behalf of the United Kingdom Health
7 Security Agency, or the UKHSA as I will refer to the
8 agency, referred to three areas to take into account
9 that are important for making recommendations for the
10 future.
11 Taking them in a slightly different order today,
12 they are transparency, partnerships, and capable
13 commercial systems.
14 UKHSA's written evidence details the extensive work
15 that has been done and is being done to take forward the
16 lessons from the pandemic in relation to procurement.
17 The lessons cut across modules because, as everybody
18 in this module will appreciate, the commercial cannot be
19 separated from the science. And in acknowledging that
20 the two are intertwined, my Lady will recognise that
21 future commercial systems will need to be as adaptable
22 as the science of a future pandemic requires them to be.
23 As both your Ladyship and UKHSA have acknowledged,
24 they need to be pathogen agnostic.
25 The practical consequence of not knowing what the

1 characteristics of the next pathogen is, how it might be
2 transmitted, how infectious it might prove, is that the
3 procurement needs of the next pandemic may well be very
4 different.
5 And it is for that reason why, when looking to the
6 future, and in examining what equipment, tests and
7 measures worked well for Covid-19, we all must avoid
8 creating the risk that your Ladyship identified in
9 Module 1: that is, a failure to consider a wider range
10 of public health scenarios.
11 For UKHSA, the need to avoid that risk means
12 adopting systems and processes in peacetime that would
13 allow it to be better placed to procure diagnostics and
14 tests that may be needed for pathogen X.
15 During the course of this module, your Ladyship has
16 asked witnesses about practical, cost-effective
17 recommendations, bearing in mind the difficult funding
18 decisions that will need to be made by the government in
19 relation to the allocation of resources. That links to
20 a factor that UKHSA has drawn to your Ladyship's
21 attention before: risk appetites changing.
22 By reference to those three themes we mention, UKHSA
23 want today to make the following observations, which we
24 will develop in our written closing statement.
25 Firstly, on transparency. In his opening statement,

1 Counsel to the Inquiry observed that the starting point
2 is that the public has a right to know how their money
3 was spent. And that is true regardless of whether the
4 country is in the midst of a pandemic or not.
5 It was explored with commercial officials whether
6 they had treated transparency requirements as
7 dispensable during the pandemic. That was not their
8 evidence, but they did accept that the priority was to
9 procure.
10 Of course, transparency in the commercial process is
11 vital, and the observations we make today is not
12 intended to dilute that point, but if, at the end of the
13 process, you have nothing to show for it, is that
14 a better alternative?
15 If the objective is for the public to know how their
16 money is spent, shouldn't the key question be: how can
17 we make that information more accessible to the public?
18 Your Ladyship will have heard in Module 4 the work
19 that UKHSA has done to make information accessible
20 around its services concerning vaccines, and in Module 7
21 my Lady will hear about the time and energy that was put
22 in to making information about testing and tracing
23 services more accessible to the public.
24 But in Module 5 the accessibility of procurement
25 information and the transparency of the commercial

1 pipeline is, as it necessarily must be,
2 a cross-government initiative.
3 We drew attention to the practical benefits of the
4 Procurement Act and so highlight, as a consequence of
5 the Act, the Cabinet Office has unified two separate
6 digital platforms into a single site which makes
7 procurement notices and related public procurement data
8 accessible to anyone.
9 The information to be published on the platform is
10 more wide-ranging than that required under the 2015
11 regulations. The data will be published in line with
12 the Open Contracting Data Standard. That means data
13 should be correctly attributed to specific parties,
14 processes, contracting authorities, suppliers,
15 procurements and contracts. Information associated with
16 the procurement will be linked together, and that
17 facilitates tracking and analysis of procurements.
18 My Lady, the importance of this step should not be
19 ignored. It enhances public understanding and scrutiny,
20 and so accountability. It allows for the public to
21 themselves answer the question: how is our money being
22 spent?
23 And it does so without the need for a new quango.
24 We have already highlighted the importance of
25 transparency in relationships between government

1 departments and with suppliers, so we would emphasise
2 the following points. Firstly, your Ladyship heard
3 evidence about the speed at which spending approvals had
4 to be sought, the specifics of which UKHSA will deal
5 with in its written closing. But looking forward, in
6 the event of a future pandemic, UKHSA would welcome
7 a cross-government agreement for the creation of
8 adaptable blueprints on how to run emergency spending
9 approvals, particularly involving high, large sums.
10 Those blueprints should include clear lines of
11 accountability, so for example, ministers will know how
12 and when to approach their peers for information, rather
13 than going direct to other departments, non-ministerial
14 executives, or civil servants, however senior.
15 They should include plans for the establishment of
16 investment or approvals boards, or processes that may
17 need to be set up again. The scope and membership of
18 such boards should be settled in advance, including the
19 standing expertise from the Treasury and the Cabinet
20 Office.
21 Second, with suppliers. Professor Sanchez-Graells
22 appeared to advocate for an approach where, in
23 a pandemic, the contracting authority goes out to market
24 with their maximum price and specific technical
25 requirements and says, "Whoever can meet this will get

1 a contract."
2 Anyone who has had to negotiate a plea or
3 a settlement in a Robing Room may well raise their
4 eyebrows at starting with your final offer, but even if
5 that approach is the right one in a pandemic for
6 established products, the unique challenge in tests was,
7 and continues to be, you cannot publish specifications
8 for something that does not exist.
9 Transparency is better met by having a clear front
10 door, a step that UKHSA has already embarked on. What
11 does that offer? It provides a single point of entry to
12 the commercial process where suppliers are aware of the
13 categories or types of products that they may be asked
14 to provide, and that in turn requires the development of
15 scientific and commercial partnerships, which brings me
16 on to the next theme.
17 In making recommendations, my Lady will have to
18 grapple with the obvious tension in the evidence that
19 your Ladyship has heard. On the one hand, your Ladyship
20 has heard extensive questioning about the flaws of
21 pre-existing relationships. But on the other hand, your
22 Ladyship has heard extensive evidence from commercial
23 professionals across the public sector and, critically,
24 from Professor Manners-Bell about the need for deep
25 strategic relationships with suppliers to maintain

1 supply chain resilience.
2 Recommendations must find the middle ground, and in
3 considering such middle ground it is beneficial to
4 consider the reasons why the High Court concluded the
5 operation of the PPE High Priority Lane was unlawful.
6 The flaw in that prioritisation system was not
7 simply to do with the names of the email inboxes, the
8 flaw was that the decisions on whether a supplier should
9 be prioritised, and so benefit from a faster process to
10 technical evaluation, included a freestanding criterion
11 related solely to the referrer.
12 In questioning, Counsel to the Inquiry relied on
13 UKHSA's own review, which showed that the largest sums
14 in testing were awarded to a supplier connected to the
15 priority named testing inboxes by one email through
16 Dominic Cummings at Number 10 in July 2020.
17 That point needs to be put in context. Exhibited
18 documents from that review, which the Inquiry will no
19 doubt review again, show that the supplier's agent had
20 been in touch with the Testing Commercial Team since
21 March 2020. They had already put a different test
22 through validation, which failed, in April 2020, and
23 that, at different points when testing products for the
24 lateral flow devices were awarded to them, they had,
25 one, passed technical validation which was not

1 a documentary exercise, but, as explained in UKHSA's
2 science and technical statement, an in-depth multiphased
3 valuation process undertaken by PHE.
4 Two, they were the first to offer boxes of tests in
5 threes, sevens, and 25s, which offered flexibility.
6 Three, they had the capacity to provide the amounts
7 sought.
8 And finally, as my Lady will see in our written
9 closing, that the timing of the contracts tracked the
10 shifts in policy position and discovery of variants.
11 Again, the unique challenges in the procurement of
12 tests included the absence of Covid-19 tests at the
13 outset of the pandemic. And so, in that scenario, not
14 only are you trying to acquire, you are trying to find,
15 and to find a test that works that can meet the
16 objectives of speed and quality, one must test
17 everything scientifically viable. An open approach is
18 necessary to create a competitive market that can
19 eventually drive towards the objectives on cost.
20 Creating market for tests in respect of pathogen X
21 will have some degree of scientific uncertainty again.
22 To be better prepared for the next pandemic, it is
23 important to know the market, maintain it, and keep it
24 warm.
25 As you heave heard from various witnesses in this

1 module, and indeed in Module 4, it is far more
2 challenging to build from scratch, but from the same
3 witnesses in this module, you have heard it is expensive
4 to do so standing face-to-face with that difficult
5 decision on funding priorities.
6 How has UKHSA confronted that challenge so far?
7 My Lady has already heard about the Vaccine Development
8 Evaluation Centre in Module 4, and from Ms Collins'
9 evidence the establishment of the diagnostics
10 accelerator.
11 Your Ladyship also heard from Ms Collins that UKHSA
12 are developing a new microbiology framework and
13 diagnostics research framework updating the previous
14 microbiology framework that had to be revisited during
15 the pandemic. It is also developing a partnership
16 framework for strategic relationship management, but
17 strong relationship management needs good quality
18 commercial professionals, leading us to the last theme:
19 capable commercial systems.
20 Hopefully what your Ladyship has seen through the
21 exploration of issues in this module is that the Civil
22 Service commercial workforce who served through the
23 pandemic were a group of committed and well-trained
24 individuals, who acted from the best motives, often
25 while confronting the very human impact of the virus

1 that they were experiencing in respect of their own
2 loved ones.
3 For specialist sectors such as diagnostics, one
4 needs a commercial workforce that understands the
5 markets and innovations. The realised benefit in
6 creating UKHSA has been the close ongoing working
7 relationship between the commercial professionals and
8 the science and technical experts.
9 But the challenge in the pandemic is: how do you get
10 50 of each of them? Or put another way, given the
11 inevitable need to surge your workforce, can you create
12 a reservist Civil Service? Even with the Complex
13 Transactions Team, the government's commercial
14 consultancy service, more commercial professionals were
15 needed to procure at scale and speed.
16 The Government Commercial Organisation allocated
17 commercial professionals to the testing commercial work
18 but those moves were based on individual choice, leaving
19 NHS Test and Trace reliant on external professionals,
20 and as your Ladyship heard, partway through the first
21 year of the pandemic, other departments asked for their
22 commercial professionals back from NHS Test and Trace.
23 We highlighted in our oral opening that planning for
24 a surge workforce is not a straightforward exercise. So
25 in the meantime, and bearing in mind your Ladyship's

questions about practical cost-effective recommendations for the future, UKHSA would invite consideration of this proposal: that an agreement be established by the Government Commercial Organisation whereby, in the event of an emergency, an appropriate mandatory allocation of workforce resource will be diverted to provide additional support to the procurement of diagnostics and medical countermeasures. Such can be implemented while difficult decisions on a surge workforce are taken by the elected decision makers.

My Lady, that concludes the closing submissions on behalf of UKHSA.

LADY HALLETT: Thank you very much indeed, Ms Idelbi.

Mr Stanton.

Closing statement on behalf of the British Medical Association by MR STANTON

MR STANTON: Thank you, my Lady.

My Lady, the BMA views the procurement and distribution failings during the pandemic in two parts: first, woefully inadequate preparation, and second, a lack of timely action in the early months of 2020 compounded by a series of flawed and ill-judged decisions.

Starting with preparations. The PPE stockpile was not fit for purpose. The quantities of stock were far

too low, and it needed far more than just a few weeks of supply to have mitigated the inevitable supply chain disruptions. The blinkered focus on an influenza pandemic was another serious flaw which resulted in a stockpile seriously deficient in respiratory protective equipment.

A further flaw was that the stockpile had not been properly maintained. Large numbers of items had either expired, or the expiry date was unknown. In Wales, for example, a shocking 90% of FFP3 respirators in the stockpile were out of date.

Health and social care staff across the UK were provided with PPE bearing multiple expiry date stickers which, exacerbated by a lack of communication, completely undermined trust and confidence.

To have relied upon such a small, inadequate, and poorly maintained stockpile based on a contingency of just-in-time overseas supply was utterly ludicrous. It was entirely predictable that supply chains would be disrupted in the event of a global pandemic and that this disruption could last for months, not weeks.

Three key mitigations would have been: a larger and more diverse stockpile, the ability to stand up domestic manufacturing capability, and stronger direct links with overseas manufacturers rather than relying on contracts

with distributors, which quickly collapsed.

Other failings of preparedness beyond the PPE stockpile include: ventilator shortages -- the UK had far fewer ventilators compared to other countries, a limited understanding of the number of ventilators we had available, and no existing domestic manufacturing. In the first wave of the pandemic, staff and patients did not have access to the ventilators they needed. Localised shortages meant that anaesthesia machines, which are only designed to be used for a few hours at a time, were repurposed and substituted for ventilators.

And as described by Professor Moonesinghe, this would have potentially impacted the quality of patient care. And Lord Agnew explained that ventilator availability played a role in whether ambulances could be sent to certain hospitals. In addition to impacting patient care, these ventilator shortages also caused additional stress, anxiety, and moral injury for staff.

Another example is the lack of an inventory system that recorded PPE and equipment meant that it was not known what each NHS Trust or board held, let alone other healthcare settings such as primary, community, or social care.

And as a final example, a supply chain that was unfit for purpose, with warehouses designed to hold only

three weeks' worth of stock and no plan at all to distribute items to the 58,000 primary, community and social care settings in England alone that were relying on this life-saving equipment.

Moving to the lack of action in the early months of 2020. Despite knowing about the threat of Covid-19 since late December 2019, it was not until early March that it was accepted that the just-in-time contracts would fail, and that the NHS Supply Chain would not be able to cope with the demand for PPE, leading to a desperate scramble to set up an entirely new PPE procurement and distribution system, whilst simultaneously trying to acquire and distribute PPE and respond to the avalanche of offers that resulted from the PPE call to arms.

In the words of Andy Wood of the Cabinet Office, "We had to build the aeroplane as we were flying it."

The Inquiry has heard that the additional procurement staff needed for the new system were not put in place until around 21 March 2020, just two days before the UK entered lockdown. As described by Sir Gareth Rhys Williams, this initial lack of procurement workforce led to the substantial backlogs, and a few hundred offers of PPE were left sitting unprocessed for a couple of weeks.

For the healthcare staff facing a potentially deadly virus without any protection, particularly in the early months, it is painful to think what difference these unprocessed offers may have made.

Similarly, no proper data management systems for managing PPE offers were set up until 9 April 2020, prior to which staff struggled with an Excel spreadsheet containing nearly 1.4 million pieces of data, which did not have the functionality needed for staff to be able to effectively prioritise and manage the offers they were receiving.

Alongside the lack of timely action, there were a number of seriously flawed decisions, and for present purposes, we focus on just two.

First, the High Priority Lane. It undoubtedly created the perception among both the public and healthcare workers alike that ministerial contacts were receiving preferential treatment at the expense of other potential suppliers. And it has caused significant damage to trust in public procurement processes.

This concern was entirely predictable and avoidable, and will, the BMA suggests, be a key area for future learning.

Another consequence of this perceived bias is that it has detracted from the tremendous contribution of the

many civil servants who were working 16-18-hour days to procure PPE for frontline healthcare workers.

The second area of flawed decision making is the restrictions on the use of respiratory protective equipment because of a lack of supply rather than for reasons of safety.

This is supplied within the DHSC's own PPE supply and demand report as a measure to "reduce demand with policy".

Within disclosed email correspondence and meeting minutes there is clear evidence that senior decision makers knew in January and February 2020 that the stockpile was lacking in FFP3 respirators, that there would be a worldwide shortage, with no means of procuring sufficient numbers for many months, and that fluid-resistant surgical masks would not protect healthcare workers against an airborne virus.

For example, emails sent during this period by Professor Jonathan Van-Tam and Dr Lisa Ritchie demonstrate awareness that, in the context of FFP3 shortages, staff access to this vital equipment would need to be managed.

What should have happened at this point was for senior decision makers to have had the courage to candidly explain to healthcare workers that the country

simply did not have sufficient quantities of this equipment, that equipment would be rationed to the highest-risk settings and procedures, and that everything possible was being done to procure adequate supplies.

As Mr Mortimer, of the NHS Confederation, told the Inquiry last week: healthcare workers "appreciate the truth and would have been, and would still be, much more accepting of a truthful approach".

A view that was also strongly expressed by Dr Parry-Jones of CATA in his Module 3 evidence.

Instead, healthcare workers were subjected to the following irrational decisions: first, FFP3 ordering restrictions placed on NHS trusts in February 2020 which inexplicably limited orders to the preceding 12 months business-as-usual demand, despite being on the cusp of a global pandemic.

Second, PPE demand modelling based on "real usage" of PPE.

This was illogical, given the known acute shortages of PPE and, as the oral evidence of Rosemary Gallagher identified, the fact that staff were very sparing in their use of PPE because they did not want to run down stocks for colleagues; all of which meant that "real usage" was not an appropriate measure against which to

procure.

And third, changes to the IPC guidance produced by the four-nation IPC cell on 13 March 2020 at the height of concerns about FFP3 shortages, which limited their use to ICU settings and aerosol-generating procedures only.

This was six days before NERVTAG declassified Covid-19 as a high consequence infectious disease on 19 March 2020, and it meant that a healthcare worker providing close care contact to a Covid-19 patient was only provided with a flimsy surgical mask rather than an FFP3 respirator.

This was in no way a decision that protected staff and patients, but was the rationing and demand management of essential safety equipment because of shortages, as set out in the DHSC's PPE supply and demand report at INQ000339131.

The failure to honestly and openly explain the nature of the problem had two profound consequences: first, those responsible for procurement did so based on false and suppressed demand, which incredibly led to a stop order of further FFP3 on 30 June 2020, whereas all that had been procured at this stage was sufficient FFP3 supply for ICU settings, not more general settings.

Second, healthcare workers knew that they were being

1 let down, that they were not being properly protected,
2 and that decision makers were not being open and honest
3 with them. This has caused a serious breach of trust
4 and confidence which is ongoing and will not be resolved
5 until there is an acknowledgement of the truth and
6 a change to the IPC guidance which, to this day,
7 continues inappropriately to only recommend surgical
8 masks for staff treating Covid-19, not the FFP3 needed
9 to protect against an airborne virus.
10 Turning to impacts on staff and patients.
11 Healthcare workers described living in constant fear for
12 their own lives, and the lives at of their patients,
13 colleagues, and loved ones. As one doctor told the BMA:
14 "I felt that my personal health and my life and the
15 health of my family didn't matter to anyone."
16 Access to PPE varied widely between healthcare
17 settings and the focus on secondary care meant that
18 primary, community and social care faced particular
19 challenges in keeping the staff and patients safe,
20 especially in the early stages of the pandemic.
21 As a result of a lack of protection, large numbers
22 of staff and patients were infected with Covid-19.
23 Significant numbers developed Long Covid and continue to
24 experience the effects on their personal and
25 professional lives.

1 A consultant told the BMA that: "I contracted
2 Covid-19 in my workplace due to a lack of appropriate
3 PPE. As a result, I have suffered Long Covid and
4 following relapse, have not been able to work for five
5 months. This has been devastating to lose my ability to
6 work in a job that I love."
7 Similarly, in Module 3, the Inquiry heard from
8 Nicola Ritchie, a physiotherapist who requested to use
9 FFP3 while providing Covid care but was denied this
10 protection based on the IPC guidance. Ms Ritchie
11 developed Long Covid, continues to experience poor
12 health, and is unable to resume her career.
13 Tragically, many staff who did not have access to
14 PPE or the right PPE, died, and there have also been
15 a significant number of deaths from nosocomial
16 infections.
17 In respect of equalities issues, female and ethnic
18 minority staff experienced disproportionate difficulties
19 in accessing well-fitting respiratory protection. Some
20 witnesses have suggested that this problem was not known
21 prior to the pandemic. However, guidance from the
22 Health and Safety Executive published in 2013
23 highlighted that one size of respiratory protection will
24 not fit all shapes and sizes and that differences will
25 be more significant along the lines of gender and

1 ethnicity.
2 It is important to stress that this is not simply
3 a preference for a specific mask, rather,
4 a properly-fitting respirator saves lives and is
5 fundamental to safety.
6 The Inquiry's Module 1 report concluded that
7 pandemic planning did not properly consider inequalities
8 and had too narrow a view of vulnerability. The lack of
9 diverse PPE procurement is a glaring example of this
10 failure.
11 My Lady, the BMA highlights the following
12 recommendations: first and fundamentally, the UK's
13 pandemic preparedness needs to take a precautionary
14 approach to the use of PPE and other equipment, and this
15 includes having a much larger stockpile of PPE with
16 a wider range of items suitable for a broad range of
17 pathogens. It needs to be properly maintained, its
18 contents need to reflect the diversity of the workforce,
19 and there needs to a plan to swiftly distribute key
20 equipment to all health and care settings.
21 Second, there needs to be a fundamental change to
22 the UK's reliance on just-in-time contracts. This
23 includes stronger links with manufacturers in a diverse
24 range of countries as well as domestic manufacturing
25 capability.

1 Third, there needs to be improvement in the
2 information available to decision makers during
3 a crisis, most obviously with inventory and management
4 systems.
5 Fourth, product specifications and procurement
6 processes need to incorporate frontline, clinical and
7 end user input from the outset.
8 Fifth, steps must be taken to ensure that in
9 a future pandemic, healthcare staff have access to the
10 vital equipment they need to protect lives. This
11 includes ensuring reliable oxygen supplies through
12 upgrades to hospital estates, as well as ensuring
13 sufficient ventilator supply, alongside the beds and
14 staff capacity needed to support their use in
15 a pandemic.
16 And sixth and finally, to reinforce the need for
17 transparency and honesty. Trust has been severely
18 damaged by failings in PPE provision, by the IPC
19 guidance being used as a tool to ration access to PPE,
20 and by perceptions of preferential treatment through the
21 High Priority Lane, and there is an urgent need to
22 restore it.
23 My Lady, that is the closing statements of the BMA.
24 This is the last module in which the BMA is a Core
25 Participant and it is grateful to have been given the

1 opportunity to participate. Thank you.
2 **LADY HALLETT:** [Microphone muted]
3 Sorry, again, I didn't unmute myself.
4 I have been grateful to the BMA for all the help
5 they've been giving. Thank you, Mr Stanton.
6 I think last but not least, Mr Hayman.
7 **Closing statement on behalf of the UK Anti-Corruption**
8 **Coalition by MR HAYMAN**
9 **MR HAYMAN:** My Lady. Thank you so much for allowing the
10 UK Anti-Corruption Coalition to make this closing
11 statement. We wanted to reflect on some of the keys
12 things we have learned over the last few weeks of
13 hearings.
14 Before I share those, I would like to refer to the
15 moving statement from Professor Fong, a doctor at
16 University of College NHS Trust in London in an earlier
17 module of the Inquiry.
18 He said:
19 "... things got so bad, they were so short of
20 resources, they ran out of body bags and they were
21 instead issued with 9-foot clear plastic sacks and cable
22 ties, and ... nurses talk about being really traumatised
23 by that because they had recurring nightmares of feeling
24 like they were just throwing bodies away."
25 This is a graphic figure example of human impact of

1 procurement failures during the pandemic. It seems
2 neither the living nor the dead were fully protected
3 from the past government's poor emergency procurement
4 practices.
5 Now, as UKACC, we have provided the Inquiry with
6 detailed data-driven analysis of our key concerns over
7 that poor purchasing and how it wasted huge amounts of
8 public money, how it distracted attention from more
9 credible suppliers and, even more importantly, how it
10 risked lives by purchasing defective items.
11 Former Secretary of State Matt Hancock dismissed
12 many of the counsel's questions in this module about his
13 procurement decisions, saying they were naive because
14 you had to be there.
15 Well, we were there. My organisation, the
16 Open Contracting Partnership, was directly involved in
17 helping other countries with their pandemic procurement,
18 and there were so many better emergency procurement
19 strategies the UK should have used but didn't.
20 Something Professor Sanchez-Graells also points out in
21 his expert report to the Inquiry.
22 Listening to witnesses during the module, I didn't
23 hear anyone say there was a considered emergency
24 procurement strategy at all. As Lord Agnew reflected,
25 "We were rabbits in the headlights", and that he was

1 a platoon commander defending Dunkirk but it was
2 a military disaster.
3 We heard how the unfocused, even amateurish, call to
4 arms by politicians overwhelmed the system and sourcing
5 of PPE. Rather than setting out clear specifications
6 based on "This is what we need", with an orderly,
7 structured, qualification process -- as someone said,
8 a clear front door -- and setting out open frameworks
9 for PPE procurement, which companies could then present
10 their credentials and get, kind of, certified supplier,
11 as many other countries did, the UK took a "What have
12 you got?" approach, based around prioritising political
13 referrals. Who you knew mattered much more than what
14 you knew and what suppliers you had.
15 And as we heard, you were over ten times more likely
16 to get a deal if you made the VIP Lane.
17 Dawn Matthias-Jackson, a PPE caseworker seconded
18 from the Department of Education, said in an email
19 disclosed to the Inquiry:
20 "Some days I feel like I am in a looney bin.
21 "I was promoted yesterday to the VIP Supplier Team,
22 basically allocated to dealing with suppliers who feel
23 it is important for them to contact Boris, Matt Hancock,
24 Gove, Gareth & other Minister[s] ... directly. So now
25 I'm basically jumping through hoops to get quick

1 responses to them before they complain that we are not
2 taking it seriously. Only one so far has proved [of]
3 any use."
4 We heard some senior ex-politicians double down on
5 their evidence that they were somehow inevitably going
6 to come across the best offers, but really, no evidence
7 of that has been shown during the hearings. Indeed, as
8 UKACC, we shared evidence with the Inquiry that VIP Lane
9 deals actually had a higher failure rate than other
10 sources.
11 You can't have it both ways. If you care about PPE
12 and savings lives, you need a professional, structured
13 process that delivers results, not hugely risky
14 contracts with untested suppliers.
15 Was it really the best we could do to order
16 mission-critical PPE contracts worth over £1 billion in
17 total to companies specialising in lingerie, drinking
18 straws, beauty and fashion accessories, confectionery,
19 investment management, and HR consulting?
20 We also heard that VIP Lane suppliers were, on
21 average, paid 80% more per unit than other suppliers,
22 and some contracts were agreed at more than four times
23 the average price.
24 "We will help you find less reliable companies who
25 will charge you a lot more money" is hardly an effective

1 mechanism for prioritising PPE sources and saving lives
2 during a pandemic.
3 And this approach of large, risky, direct awards
4 went on way past the initial stage of the pandemic. As
5 Lord Agnew acknowledged in his testimony, "there were
6 too many direct awards" and that "We took too long to
7 pivot to competitive tenders once the initial panic
8 subsided".
9 Lord Agnew told us about the runaway ordering and
10 the lack of any inventory management by the Department
11 of Health especially. He said it was over-ordering by
12 order of magnitude because we didn't have the data, and
13 that we had not got a clue what we had when we were
14 ordering more.
15 I note Matt Hancock dismissed our data, as UKACC, in
16 this regard, that showed how the UK used more direct
17 awards for larger amounts of money for longer than its
18 European peers. He said our charts were meaningless
19 because the UK had a different medical system from other
20 European countries. But he is wrong. The data is
21 comparative and the charts are meaningful.
22 We've shared a detailed rebuttal with the Inquiry of
23 his assertions, but NHS tenders in the categories of
24 medical equipment relative -- relevant to PPE, are
25 published across Europe relatively consistently.

1 In 2019, the UK was about 15% of European GDP and,
2 indeed, it accounted for about 14% of the total value of
3 published tenders across Europe in those PPE categories
4 we shared our analysis with you on.
5 Then, in 2020, such was the scale of its buying, the
6 UK shoots up to be over 65% of the total awards in those
7 categories across Europe, worth about, the UK spending,
8 about 28 billion euros in regards to those categories.
9 Let me also set the record straight on one other
10 thing Matt Hancock said under oath. He said the
11 government got into trouble in what he describes as
12 "a ludicrous court case" because a few contract award
13 notices were late by a couple of weeks.
14 I assume he is referring to the case of the Good Law
15 Project and three opposition MPs won in the High Court.
16 To my mind, the case was far from ludicrous because it
17 involved publishing timely contract award information at
18 a time when information on who had stocks of Covid PPE
19 is absolutely vital to help buyers and suppliers connect
20 in a disrupted marketplace.
21 If your objective is to save lives, you should be
22 prioritising publishing that information to help buyers
23 and suppliers connect, not delaying it or treating it as
24 an inconsequential afterthought.
25 Other countries openly shared buyers lists of

1 qualified suppliers whereas it appeared the UK hindered
2 that response and didn't share vital information.
3 Our own analysis of the UK Government's published
4 procurement data shows the average PPE contract award
5 notice was published over 100 days later, I repeat 100
6 days later, than all other contract award notices at the
7 time.
8 It takes about ten minutes to publish these notices,
9 and we've said how useful they are for buyers and
10 suppliers connecting, so why were they published so much
11 later than everything else, especially if the priority
12 was to save lives?
13 We're still not sure we've got to the bottom of all
14 those VIP contracts themselves. It appears that the
15 evidence to the Inquiry on VIP Lane suppliers from the
16 Department of Health conflicts with that of Clare Gibbs
17 and Gareth Rhys Williams of the Cabinet Office. The
18 Cabinet Office evidence appears to admit 20 other
19 suppliers who received 48 contracts worth about
20 a billion pounds in total that are recorded in the
21 Department of Health evidence.
22 I'm not sure who is right and who is wrong, but it's
23 bad we still don't know for sure five years later.
24 Hopefully, my Lady, you will get to the bottom of it.
25 Finally, we heard about the updated technology being

1 used to coordinate procurement. Excel spreadsheets,
2 SurveyMonkey, and a basic email address, as opposed to
3 digital tools available to other governments such as
4 e-procurement systems, structured digital workflows for
5 contracting and for qualifying offers, and realtime data
6 dashboards.
7 If, say, Colombia, Ecuador, Lithuania, Moldova, and
8 Ukraine can build public data dashboards, why couldn't
9 the UK? These primitive tools compounded the challenge
10 of triaging 25,000 offers from 15,000 companies that
11 gave birth to the VIP Lane.
12 The good news is that with the new Procurement Act
13 and its Open Contracting Data Standard provisions, we
14 will be in a much better situation to do this in the
15 future, assuming the government departments publish
16 their contracts accurately and on time.
17 Let me close on our recommendations to the Inquiry.
18 First, there should be a comprehensive emergency
19 procurement strategy for a UK-wide disaster drawn up,
20 including planning for cross-government coordination,
21 how to surge staffing, centralised purchasing, and with
22 clear leadership and accountability.
23 Other countries drew up proactive framework
24 agreements to scale domestic production and deliver
25 critical items in advance of an emergency, like, say,

1 Chile does for earthquakes. Maybe that's something the
2 UK should also consider.
3 Second, you should make a strong recommendation for
4 the adoption of modern digital e-procurement tools that
5 work for those across UK procurements, supported by
6 daft, AI, and digitisation, especially the Department of
7 Health, and for any organisation that would be
8 responsible for coordination emergency procurement.
9 My organisation has seen the value of such tools in
10 our work supporting Ukraine's reconstruction, and
11 I think it would be transformational for UK procurement
12 and emergency responses too.
13 Third, the Inquiry should conduct a comprehensive
14 review of the scale and outcomes from the VIP Lane.
15 It's essential to investigate whether prioritisation
16 granted by the Lane distracted attention from more
17 established PPE suppliers who were working through
18 standard channels, and it's also essential to establish
19 why VIP contracts had a higher failure rate and higher
20 prices than other routes.
21 Based on that analysis, we suspect the Inquiry would
22 want to make strong recommendations against any future
23 VIP Lane in government, and support new guidance on the
24 roles of ministers and political referrals in public
25 procurement, both in normal times and during an

1 emergency.
2 And I would add, simply declaring a conflict of
3 interest is not enough to mitigate it, as some senior
4 politicians seemed to suggest to the Inquiry.
5 Next, I think the Inquiry should examine the
6 decision-making process and apparent lack of
7 coordination in inventory management centered around the
8 Department of Health that led to the massive PPE
9 over-ordering and resultant issues with storage, waste,
10 and disposal on a huge scale.
11 And lastly, the Inquiry should recommend full and
12 proper resourcing of the Covid anti-fraud commissioner's
13 office, to get back some of the huge amounts of wasted
14 money. It's not a three-days-a-week short-term contract
15 job, in our opinion.
16 Again, we thank you very much for allowing us to
17 contribute. We look forward to your findings, restoring
18 public confidence in government procurement especially
19 in times of crisis.
20 The memory of those who suffered during the pandemic
21 and the bereaved families demand nothing less than
22 a comprehensive and truthful accounting of these events
23 and for recommendations of this Inquiry to be swiftly
24 adopted by the government.
25 Thank you very much, my Lady.

1 **LADY HALLETT:** Thank you very much indeed, Mr Hayman. Very
2 grateful.
3 That, I think, completes the evidence and the
4 closing submissions for this module.
5 Mr Wald, I think I'm right? Nothing else?
6 **MR WALD:** My Lady, I think that's right.
7 **LADY HALLETT:** Thank you.
8 Just to confirm, I know everybody present
9 understands this but I shall obviously be considering
10 the written closing submissions very carefully with the
11 assistance of you and the rest of the team. It's not
12 just the oral submissions, in case people misunderstand
13 the position.
14 So thank you all very much indeed. Work will now
15 begin in earnest on the report for M5. I hope it will
16 be published next summer. If we can do it sooner, we
17 shall. But this year is an extremely busy year. We
18 have four more sets of hearings, plus the preparation of
19 reports for all the sets of hearings that have finished.
20 So that means reports -- work going on on reports
21 for M2, 2A, 2B, 2C, and a report for M3 and a report
22 for M4 and, of course, now, a report for M5.
23 I'm extremely grateful to everyone who has helped us
24 complete this module on time. It hasn't been easy,
25 I know that. Most modules have problems but I think

1 this module has had more problems than most and I'm --
2 without the assistance of everybody, the material
3 providers, the witnesses, the Core Participants, their
4 representatives, and of course my wonderful Inquiry
5 team, it wouldn't have been possible.
6 I know that I set what I'm told is called
7 a demanding or challenging timetable, some could argue
8 it might be more accurately described as a punishing
9 timetable, but may I repeat why we have that timetable.
10 I'm sorry if I've said it before, but it has to be said:
11 we must complete this Inquiry before some memories fade
12 if we are to achieve our mutual aim of learning lessons,
13 saving lives, and reducing the huge cost to society, the
14 economy, and future generations, of the Covid-19
15 pandemic.
16 So thank you all very much. The next evidential
17 hearing will be on 12 May. Goodbye.
18 **(3.07 pm)**
19 **(Module 5 concluded)**
20
21
22
23
24
25

INDEX

MR DAVID WILLIAMS (sworn) 1
Questions from COUNSEL TO THE INQUIRY 1
Questions from DR MITCHELL KC 36
Questions from THE CHAIR 38
Housekeeping 40

Closing statement on behalf of Covid-19 Bereaved 41
Families for Justice UK by MS MORRIS KC

Closing statement on behalf of Northern Ireland 54
Covid-19 Bereaved Families for Justice
by MS CAMPBELL KC

Closing statement on behalf of Covid-19 Bereaved 66
Families for Justice Cymru by MS PARSONS

Closing statement on behalf of the Scottish Covid 76
Bereaved by DR MITCHELL KC

Closing statement on behalf of the Federation of 81
Ethnic Minority Healthcare Organisations
by PROFESSOR THOMAS KC

Closing statement on behalf of Department of 91
Health, Northern Ireland by MS MURNAGHAN KC

Closing statement on behalf of the Welsh 100
Government by MR BYRNE

Closing statement on behalf of NHS Wales Shared 105
Services Partnership by Mr Holl-Allen KC

Closing statement on behalf of Scottish Ministers 113
by MR MITCHELL KC

Closing statement on behalf of NHS National 122
Services Scotland by MS DOHERTY KC

Closing statement on behalf of the United Kingdom 127
Health Security Agency by MS IDELBI

Closing statement on behalf of the British Medical 137
Association by MR STANTON

Closing statement on behalf of the UK 149
Anti-Corruption Coalition by MR HAYMAN

DR MITCHELL: [3] 36/5 38/6 76/6
LADY HALLETT: [31] 1/5 23/25 24/3 36/2 38/10 38/23 39/5 39/18 40/2 40/14 41/3 41/6 54/15 66/5 76/2 81/3 91/3 99/14 99/21 99/24 100/2 105/18 113/3 113/5 113/8 122/8 127/1 137/13 149/2 159/1 159/7
MR BYRNE: [4] 99/23 100/1 100/5 113/4
MR HAYMAN: [1] 149/9
MR HOLL-ALLEN: [1] 106/1
MR MITCHELL: [2] 113/7 113/11
MR SHARMA: [6] 1/6 1/11 3/4 24/2 24/4 35/25
MR STANTON: [1] 137/17
MR WALD: [4] 40/4 40/15 41/4 159/6
MS CAMPBELL: [1] 54/20
MS DOHERTY: [1] 122/12
MS IDELBI: [1] 127/5
MS MORRIS: [1] 41/10
MS MURNAGHAN: [1] 91/8
MS PARSONS: [1] 66/10
PROFESSOR THOMAS: [1] 81/10
THE WITNESS: [2] 1/14 39/17

'

'Normal' [1] 19/21
'whatever [1] 45/2

-

-- and [1] 35/9

1

1 billion [1] 152/16
1.1 million [1] 49/5
1.13 [1] 51/22
1.4 million [1] 141/8
1.45 [2] 99/17 99/20
1.57 [2] 19/21 23/18
10 [1] 133/16
10,000 [1] 68/2
10.00 [1] 1/2
10.11 [1] 1/4
10.30 [1] 24/7
100 [3] 57/20 155/5 155/5
100 million [5] 5/23 5/24 6/5 6/13 7/3
100 years [1] 44/21
11.07 [1] 25/25
11.11 [1] 39/24
11.25 [2] 39/23 40/1
11.86 [1] 51/21
12 [1] 73/20
12 March 2020 [1] 67/24
12 May [1] 160/17
12 May 2020 [1] 119/13
12 months [1] 143/15
12.47 [1] 99/18
123 [1] 13/2
13 March 2020 [2] 73/21 144/3
14 [3] 11/2 40/19 154/2
15 [1] 154/1
15 May [1] 12/11
15,000 [3] 57/8 57/19 156/10
156 [1] 12/20
16 [4] 24/3 24/4 24/8 68/7
16-18-hour [1] 142/1
16-hour [1] 58/14
16.32 [2] 13/1 17/15
17 [2] 98/9 123/24
17.63 [3] 26/25 27/7 27/12
18 [1] 7/23
19 [20] 2/22 7/23 41/8 42/11 54/19 66/8 66/12 98/1 128/7 134/12 140/6 144/8 144/10 145/8 145/22 146/2 160/14 161/8 161/12 161/15
19 June 2020 [1] 123/24
19 March 2020 [2] 71/18 144/9
19.26 [1] 29/9
1990 [1] 3/13

2

2,000 [1] 56/23
2.69 [2] 12/19 17/14
20 [2] 7/9 155/18
20 May [1] 12/11
20,000 [1] 93/9
2000s [1] 123/7
2013 [1] 146/22
2015 [3] 3/16 38/18 130/10
2019 [3] 12/17 140/7 154/1
2020 [46] 3/19 22/21 23/6 34/7 38/12 66/18 67/23 67/24 68/4 70/25 71/3 71/18 71/21 71/25 72/1 73/20 73/21 78/3 95/22 96/12 98/11 100/20 102/6 102/19 107/8 108/5 108/8 110/6 115/12 115/20 118/10 119/13 123/24 133/16 133/21 133/22 137/21 140/6 140/20 141/6 142/12 143/14 144/3 144/9 144/22 154/5
2021 [4] 3/22 71/3 115/7 120/17
2022 [2] 78/4 98/14
2023 [1] 116/23
2025 [2] 1/1 117/6
21 March 2020 [1] 140/20
22 [1] 103/24
22 local [1] 107/25
23 March 2020 [1] 100/20
25 [7] 20/7 20/8 20/13 29/25 30/3 30/4 43/12
25 March 2020 [1] 68/4
25,000 [1] 156/10
25s [1] 134/5
27 March 2025 [1] 1/1
28 billion [1] 154/8
29 March 2020 [1] 66/18
2A [1] 159/21
2B [1] 159/21
2C [1] 159/21
2R [1] 107/11

3

3.07 [1] 160/18
3.75 [1] 26/1
3.76 [2] 26/23 27/5
3.8 billion [2] 42/7 53/4
30 [1] 57/20
30 June 2020 [1] 144/22
31 [1] 13/6
31.50 [5] 26/2 26/12 26/24 27/6 27/9

4

4 billion [1] 43/15
4 May [1] 21/24
45 [1] 56/24
48 [1] 155/19

5

50 [3] 52/23 68/8 136/10
50 million [1] 49/4
50,000 [3] 57/7 57/12 57/19
500 [2] 57/19 57/20
58,000 primary [1] 140/2

6

6 February 2020 [1] 67/23
65 [1] 154/6

7

7.20 [2] 26/19 26/25
7.33 [1] 12/25
7.79 [2] 26/2 26/5
7.90 [1] 26/4
70 [1] 68/10
700,000 [1] 29/5

8

8.00 [1] 19/22
8.20 [2] 23/13 23/19
8.30 [1] 31/23
8.40 [1] 23/14
8.45 [1] 23/19
8.6 billion [1] 42/5
80 [1] 152/21
88% of [1] 115/7

9

9 April 2020 [1] 141/6
9-foot [1] 149/21
90 [2] 67/23 138/10
900 [1] 43/9

A

Aamer [1] 36/5
abiding [1] 7/16
ability [6] 2/9 28/1 106/11 120/25 138/23 146/5
able [21] 4/12 4/16 4/20 15/3 17/23 26/4 27/23 33/23 47/24 50/2 51/8 78/9 80/23 103/5 107/9 107/22 112/3 123/21 140/10 141/9 146/4
about [72] 7/5 7/7 11/22 11/24 13/3 13/16 13/19 14/4 15/3 15/13 16/13 17/9 18/10 21/5 21/24 22/6 22/18 25/11 25/12 30/15 32/6 32/19 33/9 33/16 34/2 34/19 34/25 35/9 35/10 35/13 35/16 35/16 36/9 42/24 47/2 52/16 52/17 54/6 56/24 69/23 70/2 70/11 74/11 83/7 85/16 85/16 86/21 86/21 87/20 95/19 109/11 128/16 129/21 129/22 131/3 132/20 132/24 135/7 137/1 140/6 144/4 149/22 150/12 152/11 153/9 154/1 154/2 154/7 154/8 155/8 155/19 155/25
above [9] 5/22 6/22 20/7 21/7 30/21 43/9 76/22 80/6 118/25
absence [3] 19/4 103/10 134/12
absent [1] 89/25
absolutely [5] 8/11 22/25 34/16 82/8 154/19
academic [2] 52/15 88/25
accelerator [1] 135/10
accept [6] 46/12 47/5 72/4 72/6 73/9 129/8
acceptable [1] 18/7
accepted [6] 50/14 102/16 104/20 116/3 116/18 140/8
accepting [4] 28/12 32/5 32/25 143/9
accepts [3] 101/17 109/3 109/9
access [17] 2/10 18/6 39/12 42/15 44/1 50/16 58/2 64/15 74/18 75/2 75/13 139/8 142/21 145/16 146/13 148/9 148/19
accessibility [1] 129/24
accessible [4] 129/17 129/19 129/23 130/8
accessing [1] 146/19
accessories [1] 152/18
accommodate [1] 88/11
accordance [1] 116/6
according [2] 43/14 61/21
accordingly [1] 108/2
account [3] 11/13 26/21 127/8
accountability [14] 6/2 47/20 61/14 61/16 61/22 62/2 62/11 85/8 90/4 90/5 121/15 130/20 131/11 156/22

A

accountable [2] 44/16 92/13
accounted [1] 154/2
accounting [18] 4/1 4/22 5/9 5/12 5/17 5/19 5/22 6/1 6/8 7/19 8/6 9/11 11/7 14/24 38/21 43/10 52/1 158/22
accurate [3] 32/22 94/2 110/20
accurately [2] 156/16 160/8
accused [1] 47/16
accusing [1] 52/13
achieve [2] 106/23 160/12
achieved [1] 113/22
achievements [2] 114/11 114/14
achieving [1] 111/2
acknowledge [8] 2/14 61/1 74/6 76/15 81/11 86/15 113/25 126/12
acknowledged [5] 52/1 88/2 112/6 127/23 153/5
acknowledgement [2] 1/16 145/5
acknowledges [3] 82/16 95/17 110/25
acknowledging [3] 5/11 94/23 127/19
acquire [4] 29/24 31/11 134/14 140/13
acquired [2] 30/6 66/14
across [25] 13/24 32/14 35/21 42/1 55/1 60/13 67/11 78/12 83/16 98/3 116/22 116/23 118/6 123/9 125/8 126/3 126/9 127/17 132/23 138/12 152/6 153/25 154/3 154/7 157/5
act [5] 47/4 89/8 130/4 130/5 156/12
acted [2] 72/7 135/24
acting [1] 48/4
action [12] 55/5 81/11 86/24 98/10 98/16 98/23 103/24 115/10 121/21 137/21 140/5 141/12
actions [3] 98/7 98/9 124/17
active [2] 93/23 94/3
actively [3] 84/14 94/24 112/21
activities [2] 74/20 103/5
activity [3] 4/9 4/23 95/12
actors [2] 53/18 62/4
acts [2] 61/22 82/17
actual [1] 93/25
actually [8] 8/5 12/2 27/22 34/9 37/21 72/22 73/8 152/9
acute [1] 143/20
adapt [1] 90/14
adaptable [2] 127/21 131/8
adaptations [1] 123/18
add [2] 39/7 158/2
added [2] 27/5 86/6
addition [6] 51/10 94/22 119/3 123/24 126/18 139/16
additional [14] 4/22 5/25 9/18 22/1 22/4 22/16 40/16 40/20 40/23 111/9 118/25 137/7 139/18 140/18
Additionally [1] 85/9
address [6] 63/18 74/2 89/9 97/6 100/10 156/2
addressed [2] 63/1 86/20
addresses [1] 65/11
adduce [1] 40/17
adduced [1] 95/3
adequacy [2] 74/3 109/11
adequate [6] 33/9 41/16 54/1 83/20 119/10 143/4
adequately [1] 88/5
adheres [1] 121/2
adhering [1] 60/7
Adjournment [1] 99/19
adjustments [1] 88/10
administration [1] 92/10
administrations [9] 55/2 56/17 61/6 61/11 78/3 111/13 111/22 112/2 112/7
administrations' [1] 119/13
admit [1] 155/18
admitted [3] 48/22 66/15 89/21
adopted [2] 113/17 158/24
adopting [1] 128/12
adoption [1] 157/4
advance [3] 38/7 131/18 156/25
advanced [1] 61/17
advantage [1] 115/4
advantages [2] 50/6 107/7
advice [4] 10/9 57/15 104/17 115/22
advisers [2] 53/18 115/3
advocacy [1] 86/23
advocate [1] 131/22
aeroplane [1] 140/17
aerosol [2] 73/23 144/5
aerosol-generating [2] 73/23 144/5
affected [5] 70/8 81/17 86/17 86/24 87/5
afforded [1] 58/1
affront [1] 52/9
afresh [1] 74/2
after [4] 22/21 36/15 54/7 82/23
afternoon [2] 99/21 100/5
afterthought [1] 154/24
again [26] 12/24 19/14 23/17 24/10 25/23 26/13 26/24 27/9 27/10 29/1 29/11 29/25 63/17 71/8 71/11 84/11 97/2 105/19 113/8 121/22 131/17 133/19 134/11 134/21 149/3 158/16
against [17] 24/23 26/10 26/11 30/12 30/19 37/24 60/4 65/2 65/3 77/20 79/12 82/19 85/17 142/17 143/25 145/9 157/22
agency [5] 65/9 127/4 127/7 127/8 162/14
agent [1] 133/19
agents [1] 45/15
aggregated [1] 33/6
agility [1] 112/8
Agnew [9] 43/14 44/7 47/17 53/21 58/22 139/14 150/24 153/5 153/9
Agnew's [1] 55/15
agnostic [2] 87/13 127/24
ago [4] 2/1 17/13 32/5 66/13
agree [2] 27/16 55/15
agreed [3] 15/12 22/16 152/22
agreement [6] 16/10 62/9 71/25 108/7 131/7 137/3
agreements [1] 156/24
ahead's [1] 3/3
AI [2] 59/19 157/6
aid [4] 62/8 104/13 107/16 124/16
aided [1] 45/14
aim [2] 115/19 160/12
aimed [1] 115/10
airborne [3] 74/6 142/17 145/9
airfreighting [1] 14/4
Alan [3] 100/19 107/4 108/4
Alan Brace [3] 100/19 107/4 108/4
alarming [1] 87/10
alia [1] 92/23
alike [3] 69/19 71/2 141/17
all [72] 2/19 5/6 9/6 13/25 14/15 17/8 17/9 18/19 20/6 21/14 21/15 22/12 25/18 27/19 28/7 30/2 33/19 33/20 33/21 34/18 45/24 46/3 47/22 48/5 50/3 51/19 52/19 55/15 57/1 59/15 60/16 67/22 68/1 80/5 83/21 87/3 87/9 89/15 90/22 91/25 92/14 97/22 98/9 98/15 99/5 99/9 105/3 105/5 105/15 108/5 108/11 108/23 109/21 111/13 114/6 116/24 117/2 118/7 121/23 128/7 140/1 143/24 144/23 146/24 147/20 149/4 150/24 155/6 155/13 159/14 159/19 160/16
Allen [3] 105/22 105/25 162/5
allocated [2] 136/16 151/22
allocation [2] 128/19 137/5
allow [7] 37/9 80/24 106/8 119/21 120/4 125/17 128/13
allowed [7] 18/12 46/7 46/19 107/14 112/8 114/24 121/8
allowing [2] 149/9 158/16
allows [2] 34/10 130/20
almost [2] 61/7 66/13
alone [2] 139/21 140/3
along [2] 113/13 146/25
alongside [6] 2/20 9/19 38/21 94/25 141/12 148/13
already [20] 25/12 38/17 46/14 46/15 46/25 54/3 64/24 73/19 74/5 81/18 86/7 97/15 111/10 114/9 121/21 123/6 130/24 132/10 133/21 135/7
also [70] 1/20 2/9 2/11 2/14 3/21 5/11 5/18 8/7 9/4 9/7 9/17 9/25 11/4 13/15 13/18 15/13 15/17 15/22 16/21 35/9 43/13 52/23 53/25 54/10 59/3 59/10 60/7 62/23 68/8 69/8 70/10 73/3 74/17 77/17 77/25 78/13 80/18 81/20 82/13 82/16 83/6 85/12 86/1 86/3 86/16 89/7 89/19 91/21 92/16 93/13 95/24 96/16 98/22 104/8 104/24 107/23 120/3 121/20 124/14 126/16 135/11 135/15 139/17 143/10 146/14 150/20 152/20 154/9 157/2 157/18
alteration [1] 112/4
alterations [1] 121/6
alternative [3] 59/24 111/8 129/14
although [6] 7/18 13/23 63/16 103/10 105/13 119/14
always [9] 19/5 32/25 49/18 66/2 75/9 78/14 101/19 123/1 124/25
am [8] 1/2 1/4 14/19 25/3 39/24 40/1 54/15 151/20
amateurish [1] 151/3
ambulances [2] 18/11 139/15
Amelia [1] 113/13
amended [1] 73/22
Amidst [1] 87/22
among [3] 69/18 107/25 141/16
amongst [2] 57/19 120/9
amount [1] 93/12
amounts [8] 54/1 64/10 115/16 119/4 134/6 150/7 153/17 158/13
ample [1] 64/11
amplifies [1] 82/11
anaesthesia [1] 139/9
analysis [6] 52/14

A

analysis... [5] 130/17 150/6 154/4 155/3 157/21
Andrew [3] 87/23 87/25 104/8
Andy [1] 140/16
anger [2] 59/1 59/3
angry [1] 59/6
another [15] 5/17 22/22 22/23 23/5 23/6 25/22 26/17 47/4 48/15 94/25 97/13 136/10 138/4 139/19 141/24
answer [7] 36/13 36/18 38/8 53/1 68/22 69/2 130/21
answered [2] 38/7 68/24
answers [2] 56/3 70/15
anti [6] 53/10 85/9 149/7 149/10 158/12 162/20
Anti-Corruption [4] 53/10 85/9 149/7 162/20
anti-fraud [1] 158/12
anticipate [1] 64/1
anticipated [1] 40/24
anticipation [1] 10/14
Anwar [1] 36/5
anxiety [1] 139/18
any [37] 8/16 8/25 15/15 16/12 17/4 22/11 25/9 36/1 36/16 43/24 46/16 47/13 47/13 48/18 49/23 52/15 65/14 80/9 83/20 92/4 92/17 93/23 93/24 94/11 97/2 97/11 99/10 108/17 109/7 109/8 111/5 111/7 141/2 152/3 153/10 157/7 157/22
anyone [5] 49/25 130/8 132/2 145/15 150/23
anything [2] 41/22 47/13
Anyway [1] 99/25
anywhere [2] 68/7 79/19
AO [10] 9/5 11/19 14/18 14/20 15/5 15/25 17/6 23/9 27/3 34/19
AOs [1] 23/12
apart [1] 63/11
Apologies [1] 105/19
apparent [5] 11/14 91/21 93/17 116/20 158/6
apparently [3] 39/21 56/25 69/25
appear [9] 36/5 55/4 61/11 63/4 92/4 97/3 100/5 113/12 122/12
appeared [3] 58/22 131/22 155/1
appears [6] 61/14 65/8 93/1 94/10 155/14 155/18
appetite [3] 8/14 44/24 51/16
appetites [1] 128/21
application [1] 7/25
applied [3] 7/21 7/24 8/14
apply [1] 46/7
applying [2] 8/5 48/10
appointed [2] 5/25 47/24
appreciate [3] 63/13 127/18 143/7
appreciated [2] 38/4 38/25
appreciation [1] 98/25
approach [26] 30/13 35/7 44/19 44/25 45/2 46/8 52/16 78/24 79/20 79/23 84/25 85/7 87/9 89/16 103/25 104/7 113/17 119/22 131/12 131/22 132/5 134/17 143/9 147/14 151/12 153/3
approached [1] 2/8
approaches [4] 32/14 59/24 62/8 79/24
appropriate [16] 46/3 54/1 64/13 67/9 74/13 74/13 90/12 96/9 98/5 98/23 118/5 119/9 123/3 137/5 143/25 146/2
appropriately [2] 101/24 105/5
approval [7] 93/3 93/4 93/22 94/7 94/16 94/20 94/23
approvals [5] 6/8 106/15 131/3 131/9 131/16
approve [1] 8/18
approved [3] 7/4 93/18 94/12
April [21] 3/22 11/21 12/19 13/1 14/12 14/14 17/14 23/6 31/20 34/23 70/25 95/22 96/11 102/6 110/6 115/7 115/20 118/10 123/24 133/22 141/6
April 2020 [6] 23/6 102/6 110/6 115/20 118/10 133/22
April/May 2020 [1] 70/25
aprons [1] 18/18
are [87] 1/6 1/12 1/23 3/6 3/10 3/11 5/7 7/20 12/16 13/8 13/12 16/15 16/15 17/4 17/8 17/9 18/25 19/11 20/7 20/13 21/20 23/7 23/21 27/15 28/24 29/23 30/2 30/4 31/13 33/1 34/2 34/11 35/22 39/10 39/20 40/5 48/2 49/21 50/12 53/12 53/19 58/13 58/22 59/23 60/16 62/5 64/5 65/20 65/20 71/4 78/1 78/13 79/17 80/23 81/1 81/18 83/25 83/25 84/7 84/9 84/17 84/17 86/20 88/25 90/23 112/21 113/13 114/7 117/14 122/22 123/3 125/14 127/9 127/12 127/20 132/12 134/14 134/14 135/12 137/9 139/10 152/1 153/21 153/24 155/9 155/20 160/12
area [7] 32/23 34/3 48/6 89/22 110/19 141/22 142/3
areas [9] 10/2 73/8 75/20 83/20 93/20 97/24 98/3 114/12 127/8
aren't [1] 19/11
argue [1] 160/7
argued [1] 85/13
arise [1] 56/8
arisen [1] 92/18
arises [1] 101/21
arising [5] 93/14 98/16 122/17 122/20 124/19
arm [1] 18/23
arm's [2] 98/15 106/4
arm's length [2] 98/15 106/4
armed [1] 55/8
arms [6] 19/3 45/8 45/15 114/6 140/15 151/4
army [1] 55/6
arose [2] 116/10 119/1
around [12] 2/6 17/7 21/3 52/11 70/22 95/25 114/6 125/15 129/20 140/20 151/12 158/7
arrangement [1] 110/23
arrangements [6] 104/14 108/8 111/11 112/14 121/8 123/17
arrive [1] 27/4
arrived [4] 8/17 16/3 27/7 38/24
artificial [1] 69/6
as [231]
Asian [1] 105/6
aside [2] 9/20 12/13
ask [10] 13/3 19/10 30/15 33/15 38/12 40/17 40/21 50/23 83/13 85/13
asked [9] 9/1 39/20 75/12 81/22 100/15 110/6 128/16 132/13 136/21
asking [3] 1/11 28/11 59/14
aspect [1] 47/20
aspects [5] 4/13 60/18 62/14 75/7 87/16
assertions [1] 153/23
assess [1] 97/4
assessed [3] 11/6 37/24 108/12
assessment [10] 6/20 9/10 9/25 19/18 23/17 25/18 29/2 52/5 58/3 110/20
assessments [1] 15/3
assist [5] 40/25 47/6 68/17 72/7 77/6
assistance [7] 9/9 40/6 79/6 108/19 109/23 159/11 160/2
assisted [2] 10/5 107/10
assisting [1] 91/11
associated [4] 53/11 98/10 125/21 130/15
associates [1] 47/14
Association [4] 71/24 103/23 137/16 162/17
assume [1] 154/14
assuming [1] 156/15
assumption [1] 31/7
assurance [10] 8/21 8/22 22/2 22/22 49/25 50/15 50/21 50/24 71/6 118/4
assured [3] 70/24 96/18 101/13
at [155] 1/24 3/1 3/17 3/20 3/23 10/8 10/10 11/25 11/25 12/8 12/15 12/18 12/20 12/22 12/23 13/6 13/11 13/15 13/16 14/13 14/15 14/18 15/15 15/16 16/16 17/2 18/14 18/17 18/20 19/16 19/24 19/25 20/5 20/17 20/17 21/2 22/23 24/13 25/7 25/10 25/16 25/19 26/17 26/18 26/24 27/4 27/7 27/14 28/1 28/5 28/12 28/19 28/22 30/23 31/4 31/7 31/14 31/20 32/17 33/1 34/22 35/4 35/22 38/14 39/11 39/23 41/13 42/15 43/16 44/9 45/3 45/10 46/1 47/3 47/4 49/22 54/7 55/4 55/13 57/10 58/7 58/20 59/3 59/17 59/24 60/11 60/11 63/24 64/5 65/12 65/16 66/20 67/22 69/5 69/15 69/17 69/24 70/11 71/20 79/1 81/10 81/18 83/20 86/2 92/11 92/25 95/5 95/24 96/2 96/24 96/25 99/17 100/18 101/16 103/18 107/22 109/5 109/13 109/14 109/18 110/11 112/13 113/25 114/25 115/12 115/15 116/15 118/9 118/14 118/23 120/16 124/22 125/3 125/10 126/24 129/12 131/3 132/4 133/16 133/23 134/12 136/15 139/10 140/1 141/18 142/23 144/3 144/17 144/23 145/12 149/15 150/24 152/22 154/17 155/6
at 11.25 [1] 39/23
Atamis [1] 34/8
attacked [1] 47/10
attempt [2] 20/6 30/2
attempts [1] 43/11
attend [2] 16/18 120/22
attention [5] 74/22 128/21 130/3 150/8 157/16
attributed [1] 130/13
audit [5] 63/1 98/12 108/24 109/1 124/22
Auditor [2] 108/21 109/6

A

authorisation [2] 16/4 16/10
authorisations [1] 5/21
authorise [1] 93/19
authorised [1] 15/6
authorities [7] 72/16 72/21 103/7 103/25 108/1 110/18 130/14
authority [5] 73/13 102/8 102/14 106/22 131/23
authority's [1] 110/3
automated [1] 33/22
automatically [1] 37/9
automation [1] 59/19
availability [5] 11/25 95/7 102/20 123/23 139/15
available [24] 13/12 14/20 14/23 15/25 16/17 16/19 17/6 26/16 27/24 28/10 31/13 33/19 36/23 63/19 95/20 96/9 97/16 102/7 105/10 110/10 118/15 139/6 148/2 156/3
avalanche [1] 140/14
average [24] 10/25 12/18 13/9 17/14 17/15 20/2 20/7 20/23 21/4 21/5 23/24 24/5 24/7 25/25 26/3 26/24 27/4 27/13 27/15 29/7 29/9 152/21 152/23 155/4
avoid [4] 18/25 60/1 128/7 128/11
avoidable [1] 141/21
avoidably [1] 71/15
avoided [1] 61/11
award [9] 48/9 108/22 109/2 109/3 116/11 154/12 154/17 155/4 155/6
awarded [5] 49/3 51/22 109/8 133/14 133/24
awards [4] 153/3 153/6 153/17 154/6
aware [7] 72/22 73/25 78/10 78/13 95/24 100/22 132/12
awareness [2] 120/9 142/20
away [7] 36/12 36/16 44/21 54/8 66/18 77/11 149/24
awful [1] 24/18

B

back [13] 3/23 10/8 18/20 35/9 37/25 39/11 50/11 51/7 55/7 64/2 92/4 136/22 158/13
backdrop [2] 2/25 87/22
background [4] 3/11 58/1 84/17 91/1
backgrounds [1] 88/7
backlogs [1] 140/23
bad [4] 34/9 79/8 149/19 155/23
bags [1] 149/20
Bailey [3] 56/22 92/19 92/21
Bailey's [1] 94/15
balance [1] 119/8
balanced [1] 85/6
balances [1] 78/8
Bamrah [1] 83/15
Banfield [1] 42/2
Bank [1] 22/15
banking [2] 22/6 22/15
banks [1] 22/18
barely [1] 65/10
Barnett [1] 119/1
Baroness [1] 48/2
Baroness Mone [1] 48/2
based [19] 31/12 33/10 35/11 35/13 44/16 46/8 49/15 58/3 58/8 101/1 118/18 136/18 138/17 143/18 144/20 146/10 151/6 151/12 157/21
basic [3] 70/19 79/24 156/2
basically [2] 151/22 151/25
basis [8] 6/10 6/16 21/22 29/10 57/2 74/21 106/4 110/17
be [195]
bear [2] 8/2 119/16
bearing [5] 8/16 27/10 128/17 136/25 138/13
bears [1] 81/12
Beattie [4] 113/14 114/17 117/20 122/16
beauty [2] 42/14 152/18
became [2] 44/14 116/20
because [29] 6/21 25/6 29/16 31/7 31/24 34/4 35/6 38/15 39/20 44/13 59/11 62/3 63/7 64/6 68/10 73/12 74/6 89/4 103/15 127/17 142/5 143/23 144/15 149/23 150/13 153/12 153/19 154/12 154/16
becomes [1] 94/14
bedrooms [1] 55/7
beds [1] 148/13
been [111] 3/22 6/19 8/19 11/1 11/11 15/9 15/11 15/12 16/24 17/19 17/21 20/15 22/5 22/22 23/20 24/8 25/6 25/15 26/23 27/23 28/1 31/25 33/14 35/8 36/14 36/14 36/15 36/17 36/22 38/13 38/18 38/25 39/4 39/20 43/5 47/1 47/11 48/16 50/2 55/5 55/17 56/4 56/12 57/14 57/23 57/24 58/7 59/14 59/17 60/10 60/19 63/4 63/4 64/11 65/6 65/18 67/8 68/3 70/15 70/18 70/20 71/6 72/3 72/4 74/17 74/22 75/3 75/9 77/2 78/4 78/21 79/9 80/5 80/6 80/10 80/10 82/2 83/5 92/5 93/3 94/18 95/24 102/18 104/20 108/9 108/25 109/1 109/8 109/12 118/3 121/21 123/1 123/7 124/21 127/15 133/20 136/6 138/7 138/22 143/8 144/23 146/4 146/5 146/14 148/17 148/25 149/4 149/5 152/7 159/24 160/5
before [28] 1/11 6/20 16/3 17/25 21/14 23/7 24/17 28/20 38/24 39/1 39/21 40/4 50/11 63/11 63/20 79/7 81/6 105/21 122/1 122/18 125/1 128/21 140/21 144/7 149/14 152/1 160/10 160/11
began [2] 106/16 107/18
begin [5] 3/5 3/11 3/25 114/14 159/15
beginning [6] 14/14 18/14 30/23 35/4 76/19 84/7
begun [1] 114/9
behalf [46] 36/6 41/8 41/11 54/18 66/8 66/11 76/4 81/1 81/8 83/15 91/6 91/9 95/12 100/3 100/6 103/24 105/24 106/1 107/5 107/9 107/12 112/19 113/9 113/11 113/12 122/1 122/10 122/12 127/3 127/6 137/12 137/15 149/7 161/8 161/11 161/15 161/18 161/21 161/24 162/1 162/4 162/7 162/10 162/13 162/16 162/19
behaviour [1] 37/14
behind [2] 9/7 84/6
being [65] 4/16 5/22 8/1 8/10 9/24 11/15 13/8 13/19 15/23 17/8 20/15 21/4 21/24 26/1 26/2 28/9 30/6 30/18 30/21 31/14 31/22 32/12 32/21 34/13 36/12 36/13 37/15 38/25 42/12 46/4 47/16 48/5 51/8 53/20 59/23 60/2 67/15 68/1 72/24 78/13 78/14 78/18 79/13 87/6 95/20 98/9 107/8 108/6 111/24 117/5 117/14 118/12 119/18 125/11 126/20 127/15 130/21 143/4 143/16 144/25 145/1 145/2 148/19 149/22 155/25
Belfast [2] 56/22 57/9
belief [2] 3/9 79/3
believe [2] 67/7 71/14
believing [1] 53/20
Bell [3] 119/25 120/20 132/24
bells [1] 22/13
below [10] 5/24 6/5 6/13 7/3 9/19 20/7 20/13 21/6 26/3 30/3
benchmark [9] 15/13 26/9 26/10 26/11 27/16 30/19 43/9 43/12 51/13
benchmarking [19] 10/3 10/5 10/22 11/16 12/4 13/13 17/7 20/11 20/17 21/17 21/22 24/13 24/15 24/22 27/20 30/16 32/17 32/22 33/8
benchmarks [1] 12/10
beneficial [1] 133/3
benefit [11] 48/9 48/18 49/13 51/8 104/25 107/2 120/9 122/14 126/1 133/9 136/5
benefited [3] 97/19 110/22 112/12
benefits [4] 50/22 103/2 121/3 130/3
bereaved [33] 36/6 41/8 41/11 54/14 54/19 55/22 56/1 58/19 65/23 66/8 66/12 68/23 74/16 75/8 76/5 76/6 76/13 76/15 77/2 77/4 77/7 78/13 79/2 79/8 80/12 80/17 81/2 92/20 158/21 161/8 161/12 161/15 161/19
bereavement [1] 113/1
best [17] 3/8 28/9 36/23 43/11 47/7 59/8 65/24 70/17 71/20 76/17 78/9 97/10 105/16 126/5 135/24 152/6 152/15
Bethell [2] 44/21 53/22
better [23] 10/20 22/17 28/16 30/12 32/24 37/7 37/8 53/8 53/9 59/14 60/24 61/8 70/2 77/9 77/9 77/14 89/22 128/13 129/14 132/9 134/22 150/18 156/14
between [21] 5/20 6/6 12/18 18/16 19/11 20/22 24/10 33/6 68/7 78/3 80/14 92/23 102/13 111/21 119/15 120/4 121/12 123/24 130/25 136/7 145/16
beyond [4] 76/22 107/10 119/10 139/2
bias [2] 83/8 141/24
bids [1] 32/11
big [1] 118/16
billion [7] 42/5 42/7 43/15 53/4 152/16 154/8 155/20
billions [1] 52/20
bin [1] 151/20
birth [1] 156/11
bit [1] 7/11
black [1] 105/6
blend [2] 20/21 32/13
blind [1] 88/23
blinkered [1] 138/3
blocked [1] 43/14
blue [1] 13/10
blueprints [2] 131/8 131/10
BMA [9] 42/2 137/18 141/22 145/13 146/1 147/11 148/23 148/24 149/4
board [9] 21/21

B

board... [8] 21/23 60/13 80/6 99/10 106/18 106/22 111/10 139/21
boards [19] 66/24 70/16 101/5 101/12 101/13 101/18 101/22 103/12 110/12 114/20 116/22 116/24 116/24 118/7 118/12 121/13 125/9 131/16 131/18
bodies [4] 98/15 106/25 115/6 149/24
body [6] 18/20 96/21 106/4 111/15 121/4 149/20
boil [1] 34/18
boldly [2] 61/16 64/1
bordering [2] 37/13 37/14
borders [2] 107/10 125/20
Boris [1] 151/23
borne [3] 59/1 62/21 86/18
both [18] 4/7 6/3 18/20 25/11 34/10 35/9 49/9 53/22 63/14 72/8 78/22 97/8 105/10 121/17 127/23 141/16 152/11 157/25
bottom [8] 17/18 19/25 20/5 20/7 26/18 28/22 155/13 155/24
bought [2] 20/15 31/25
box [3] 12/16 20/7 26/18
boxes [1] 134/4
boys [1] 79/17
Brace [10] 70/4 72/8 100/19 100/22 101/10 102/5 102/8 103/1 107/4 108/4
Brace's [2] 103/9 112/10
branded [1] 47/15
breach [1] 145/3
breaches [2] 84/1 84/1
break [3] 39/20 39/25 99/16
bred [1] 80/4
brief [2] 18/15 114/14
briefly [5] 7/12 36/19 40/5 63/24 97/23
bring [3] 7/14 7/19 38/20
bringing [1] 34/4
brings [4] 6/1 69/20 85/19 132/15
Britain [1] 47/18
British [2] 137/15 162/16
broad [1] 147/16
broader [2] 5/2 86/23
broadly [4] 16/4 16/5 21/4 30/22
brought [8] 8/2 9/17 38/12 38/14 40/7 40/21 87/24 114/19
BSO [12] 56/22 57/9 63/16 63/22 92/23 94/1 94/16 94/19 94/23 95/10 96/22 96/25
BSO PaLS [10] 56/22 63/16 63/22 92/23 94/1 94/16 94/19 94/23 95/10 96/22
BSO PaLS's [1] 96/25
buccaneering [1] 44/25
build [4] 46/10 135/2 140/17 156/8
built [2] 12/5 35/8
bumped [1] 38/19
burdens [1] 44/4
burned [1] 59/5
business [10] 44/3 49/12 50/11 93/3 93/18 94/17 107/19 118/19 120/6 143/16
business-as-usual [4] 107/19 118/19 120/6 143/16
busy [1] 159/17
but [140] 1/7 2/1 2/14 5/7 5/11 6/15 6/24 7/8 9/7 10/19 13/4 14/12 15/17 15/21 16/11 16/19 16/23 16/25 18/7 18/14 19/2 19/4 19/6 21/9 21/20 22/8 22/14 25/3 25/15 26/4 26/15 27/3 27/8 27/21 28/7 29/24 30/11 30/17 32/14 34/9 35/9 37/14 38/25 39/7 42/5 43/2 43/3 44/12 44/20 47/22 52/5 52/11 53/25 55/23 56/14 57/1 57/13 57/22 58/9 58/11 59/3 59/10 59/12 59/16 60/11 60/14 60/17 61/3 62/5 62/9 62/23 63/4 65/19 69/5 69/11 69/13 70/9 70/12 72/7 72/20 74/12 75/8 77/25 80/8 80/10 81/15 81/20 82/13 82/16 82/18 83/11 84/8 84/10 84/14 84/17 85/11 86/1 86/16 88/13 88/23 89/7 89/9 92/6 96/16 97/23 99/23 106/18 107/20 107/23 108/15 109/5 109/6 110/14 119/6 120/16 129/8 129/12 129/24 131/5 132/4 132/21 134/1 135/2 135/16 136/9 136/18 144/14 146/9 149/6 150/19 151/1 152/6 153/20 153/23 155/22 159/9 159/17 159/25 160/9 160/10
buy [16] 12/10 15/14 16/15 16/18 21/21 32/7 35/5 37/15 42/16 45/4 46/2 46/5 46/21 57/18 124/7 125/17
Buy Cell [3] 46/2 46/5 57/18
buyers [4] 154/19 154/22 154/25 155/9
buying [7] 9/16 18/18 18/20 19/6 21/6 21/7 154/5
Byrne [4] 99/22 100/4 105/18 162/2

C

Cabinet [6] 51/4 130/5 131/19 140/16 155/17 155/18
cable [1] 149/21
Cackette [2] 114/23 116/3
Cairnduff [1] 87/10
calculation [1] 57/21
calculus [2] 11/5 12/7
call [7] 11/19 45/8 45/14 76/22 102/5 140/15 151/3
called [6] 10/3 46/5 56/15 93/5 106/9 160/6
calls [2] 41/20 123/1
Callum [1] 113/14
came [9] 6/19 6/20 6/21 6/22 21/20 21/23 25/10 48/13 76/6
Campbell [4] 54/17 54/19 66/5 161/13
can [43] 7/11 8/25 12/21 14/11 17/16 17/18 17/22 19/2 19/17 19/24 20/4 28/16 29/1 29/6 29/7 29/25 34/2 34/18 35/23 38/12 39/6 53/8 59/25 71/5 77/9 80/16 80/17 81/5 82/7 89/3 89/22 90/13 99/23 101/24 102/1 129/16 131/25 134/15 134/18 136/11 137/8 156/8 159/16
can't [3] 8/24 52/11 152/11
candidly [1] 142/25
candour [1] 47/5
cannot [7] 8/8 54/8 60/14 65/24 68/5 127/18 132/7
capability [4] 19/9 77/17 138/24 147/25
capable [2] 127/12 135/19
capacity [9] 4/25 4/25 46/10 93/11 118/8 118/20 125/23 134/6 148/14
care [74] 1/19 4/5 5/14 28/15 35/19 42/1 42/10 42/13 42/19 42/25 43/6 54/2 57/6 57/12 64/15 64/25 67/11 67/25 68/11 71/8 71/9 71/12 71/15 71/19 71/20 72/1 72/4 72/7 72/10 72/11 72/15 72/24 73/13 73/23 75/15 76/10 77/25 95/8 95/11 96/15 96/19 96/23 102/4 102/6 102/15 102/18 102/22 103/17 103/20 107/24 107/24 108/5 110/2 110/5 111/1 114/6 115/14 115/14 115/18 115/21 121/5 123/15 126/9 138/12 139/14 139/17 139/23 140/3 144/10 145/17 145/18 146/9 147/20 152/11
career [3] 3/12 3/14 146/12
carefully [1] 159/10
carers [3] 41/25 123/16 126/8
Cargo [1] 43/8
Caroline [1] 113/14
carried [1] 78/7
carry [3] 55/24 59/9 68/19
case [19] 19/22 25/2 26/20 29/16 43/22 60/13 60/15 71/1 93/3 93/18 94/17 108/23 110/18 111/7 111/14 154/12 154/14 154/16 159/12
cases [3] 21/19 37/1 46/25
caseworker [1] 151/17
CATA [1] 143/11
catalyse [1] 84/10
categories [9] 13/25 19/12 32/20 123/23 132/13 153/23 154/3 154/7 154/8
categorisation [1] 17/7
category [2] 14/6 57/16
cater [1] 88/5
Catherine [1] 74/4
caught [4] 66/17 88/22 105/19 105/22
cause [1] 43/18
caused [6] 45/9 70/4 83/8 139/17 141/19 145/3
Cautious [1] 44/22
caveats [2] 13/23 15/22
cell [8] 12/10 45/4 46/2 46/5 46/21 57/18 109/18 144/3
centered [1] 158/7
central [6] 84/18 103/3 110/1 111/15 112/20 113/23
centralise [1] 102/17
centralised [6] 43/23 77/22 103/8 103/15 108/2 156/21
centrally [1] 118/11
Centre [1] 135/8
centres [1] 118/1
certain [1] 139/16
certainly [5] 21/19 55/4 61/7 112/11 120/8
certified [1] 151/10
Chadlington [4] 48/1 48/15 48/18 49/10
chain [18] 32/15 44/2 92/22 93/14 93/17 94/14 95/11 98/4 99/7 105/1 110/7 112/1 123/13 125/19 133/1 138/2 139/24 140/9
chains [7] 54/22 60/6 74/11 117/11 117/18 117/25 138/19
chair [5] 38/9 77/6 93/16 94/20 161/5
chairing [1] 122/7
chairman [1] 48/14
challenge [10] 27/19 52/15 80/13 87/6 103/12 112/3 132/6 135/6 136/9 156/9
challenges [9] 11/23 32/9 65/21 80/25 97/7 99/4 112/9 134/11 145/19
challenging [5] 68/1 98/8 110/21 135/2

C

challenging... [1] 160/7
change [11] 12/7 18/3 70/8 84/10 90/21 97/14 97/15 114/13 118/21 145/6 147/21
changed [4] 6/22 35/3 35/3 42/23
changes [5] 12/19 90/15 90/17 90/24 144/2
changing [1] 128/21
channelled [1] 52/24
channels [1] 157/18
chap [1] 48/22
characterised [1] 44/23
characteristics [1] 128/1
charge [2] 82/6 152/25
Charlies [1] 44/23
chart [2] 12/13 13/7
charts [2] 153/18 153/21
chase [1] 47/21
cheaper [1] 14/3
checked [1] 73/1
checking [1] 48/5
checks [3] 49/24 50/4 78/8
child [1] 60/4
children [1] 55/23
children's [1] 55/17
Chile [1] 157/1
choice [7] 44/15 44/15 46/18 47/4 47/17 119/6 136/18
choices [1] 42/20
chorus [1] 47/11
Chris [9] 4/8 6/1 23/2 38/22 43/8 51/24 57/5 83/1 91/14
circumstance [2] 8/9 62/22
circumstances [5] 2/8 8/11 32/4 39/8 92/15
civil [12] 3/12 44/22 46/20 48/6 51/25 60/25 61/18 116/12 131/14 135/21 136/12 142/1
claim [2] 41/21 69/6
claims [1] 75/1
Clare [1] 155/16
Clare Gibbs [1] 155/16
clarification [1] 9/1
clarify [2] 92/17 93/13
clarity [2] 96/5 110/10
cleansed [1] 14/1
clear [33] 14/19 17/9 25/5 36/15 41/24 44/9 50/5 54/5 54/10 58/7 62/16 71/5 84/3 86/25 88/22 89/6 90/1 90/9 90/22 94/14 95/9 103/11 107/4 116/8 116/21 125/2 131/10 132/9 142/11 149/21 151/5 151/8 156/22
clearance [3] 21/21 21/23 22/17
clearly [7] 1/20 2/5 7/19 8/11 14/25 32/24 96/6
climate [2] 6/25 60/9
clinical [6] 83/20 89/24 115/3 115/22 117/1 148/6
clinically [1] 35/15
clinicians [4] 41/25 42/10 42/19 42/24
close [7] 5/3 105/14 121/11 125/20 136/6 144/10 156/17
closed [1] 80/19
closely [5] 6/16 6/25 96/8 100/7 126/19
closer [1] 18/23
closes [1] 113/23
closing [43] 39/22 40/4 41/5 41/8 49/24 54/18 66/8 66/11 76/4 81/8 91/6 91/9 100/3 100/9 105/24 113/9 113/11 114/10 122/10 127/3 128/24 131/5 134/9 137/11 137/15 148/23 149/7 149/10 159/4 159/10 161/8 161/11 161/15 161/18 161/21 161/24 162/1 162/4 162/7 162/10 162/13 162/16 162/19
clue [1] 153/13
cluster [1] 67/10
CMO [9] 57/1 92/24 93/15 93/16 93/22 94/6 94/12 94/16 94/20
CMO's [3] 93/2 94/2 94/23
coalition [6] 53/10 85/9 85/13 149/8 149/10 162/20
cogent [1] 57/23
coincidence [2] 27/8 38/15
collaborated [1] 121/19
collaboration [3] 113/19 120/15 124/15
collaborative [5] 103/25 114/18 119/14 120/18 126/3
collapse [2] 123/12 125/19
collapsed [1] 139/1
colleagues [8] 39/12 39/14 61/6 106/14 108/19 109/23 143/24 145/13
collection [1] 104/1
collectively [3] 2/13 6/7 49/4
College [2] 58/18 149/16
Collins [1] 135/11
Collins' [1] 135/8
Colombia [1] 156/7
column [1] 12/15
combative [1] 56/4
combined [1] 114/16
come [14] 8/24 9/6 14/17 20/13 25/18 35/9 37/24 55/14 57/2 61/25 66/2 89/5 89/10 152/6
comes [4] 55/20 55/22 56/10 80/21
comfort [2] 69/14 71/11
coming [5] 11/6 16/7 16/14 103/7 124/25
Command [2] 93/17 94/21
commander [1] 151/1
commendation [1] 93/5
commended [2] 57/1 94/6
commends [1] 99/4
commercial [27] 8/20 9/18 23/1 104/10 104/15 127/13 127/18 127/21 129/5 129/10 129/25 132/12 132/15 132/22 133/20 135/18 135/19 135/22 136/4 136/7 136/13 136/14 136/16 136/17 136/17 136/22 137/4
commercially [3] 25/8 25/9 40/8
commissioned [1] 98/1
commissioner's [1] 158/12
commitment [2] 99/5 112/24
committed [2] 99/9 135/23
Committee [1] 106/19
common [2] 7/25 8/5
communication [5] 96/14 102/13 120/4 120/13 138/14
community [5] 66/16 86/24 139/22 140/2 145/18
companies [7] 46/14 52/23 94/25 151/9 152/17 152/24 156/10
company [3] 36/6 48/25 93/8
comparable [1] 57/11
comparative [2] 57/8 153/21
compared [4] 20/2 51/22 64/22 139/4
comparing [1] 24/19
compels [2] 87/1 89/8
competent [1] 6/11
competitive [3] 26/25 134/18 153/7
Complacency [1] 64/4
complain [1] 152/1
complemented [1] 88/9
complete [4] 1/7 120/2 159/24 160/11
completely [3] 73/5 89/24 138/15
completes [3] 38/11 39/19 159/3
Complex [1] 136/12
compliance [1] 89/11
compliant [2] 4/16 109/21
complicate [1] 121/8
complying [1] 89/12
component [1] 106/11
compounded [2] 137/22 156/9
comprehensive [6] 35/21 91/17 116/16 156/18 157/13 158/22
compromise [2] 82/13 85/7
compromised [1] 90/6
conceded [1] 88/13
concentrated [1] 60/2
concept [2] 61/13 61/14
concern [4] 47/1 65/13 75/9 141/21
concerned [3] 25/11 25/12 52/16
concerning [1] 129/20
concerns [16] 6/17 11/24 64/5 64/7 65/12 67/12 74/16 76/7 76/14 95/18 95/19 109/9 109/15 116/10 144/4 150/6
conclude [4] 49/9 89/6 98/24 112/23
concluded [5] 52/8 110/8 133/4 147/6 160/19
concludes [1] 137/11
concluding [2] 122/19 126/6
conclusion [5] 30/20 49/20 53/6 75/5 121/16
conclusions [2] 77/7 89/5
conditioning [1] 44/22
conditions [2] 11/17 23/21
conduct [4] 53/16 75/21 116/10 157/13
conducting [1] 49/24
confectionery [1] 152/18
Confederation [1] 143/6
conferred [1] 50/22
confidence [8] 2/6 12/2 21/11 21/12 71/5 138/15 145/4 158/18
confident [2] 70/24 108/4
confined [1] 74/17
confirm [2] 3/8 159/8
confirmation [3] 9/2 9/2 9/15
confirmed [6] 50/16 83/2 102/11 109/12 118/13 124/21
conflated [1] 93/3
conflating [1] 26/14
conflation [2] 24/10 27/10
conflict [2] 65/1 158/2
conflicts [6] 61/11 65/3 65/5 77/21 116/12 155/16
confronted [1] 135/6
confronting [1] 135/25
confused [2] 93/22 108/16
confusion [4] 70/4 92/17 95/25 100/2
congratulation [1] 64/4
congratulatory [2] 92/5 97/3
connect [2] 154/19 154/23
connected [1]

C

connected... [1] 133/14
connecting [1] 155/10
connections [2] 58/5 58/8
consensus [1] 90/9
consequence [4] 127/25 130/4 141/24 144/8
consequences [8] 2/19 58/12 61/23 84/6 85/21 89/3 126/17 144/19
Conservative [2] 48/14 48/15
consider [11] 57/24 59/18 79/5 79/8 83/5 89/2 105/15 128/9 133/4 147/7 157/2
considerably [3] 27/12 116/5 119/20
consideration [5] 51/14 64/8 94/13 98/22 137/2
considered [11] 11/11 15/5 17/4 46/4 74/1 78/1 84/17 108/12 117/14 119/18 150/23
considering [8] 14/21 27/1 40/25 60/9 94/9 122/14 133/3 159/9
considers [1] 94/14
consistent [4] 44/18 46/8 74/23 83/16
consistently [1] 153/25
conspiracy [1] 53/21
constant [1] 145/11
constantly [1] 18/13
constraint [1] 25/13
constraints [1] 45/1
constructive [2] 77/8 119/14
consultancy [1] 136/14
consultant [1] 146/1
consulting [1] 152/19
consumable [1] 116/25
contact [6] 36/20 50/20 101/11 114/18 144/10 151/23
contacted [3] 51/2 102/9 123/22
contacts [4] 7/2 36/24 123/21 141/17
contained [1] 40/8
containing [2] 107/1 141/8
contend [3] 92/6 93/7 94/1
content [3] 9/5 23/8 98/20
contentious [1] 87/16
contents [1] 147/18
context [13] 1/20 1/21 2/4 2/5 2/12 5/7 10/17 11/9 13/4 37/13 74/2 133/17 142/20
contextual [2] 34/21 40/24
contingency [2] 44/3 138/17
continue [8] 51/9 58/13 105/14 112/18 112/22 126/3 126/18 145/23
continued [1] 122/6
continues [3] 132/7 145/7 146/11
continuing [2] 43/17 118/4
contract [16] 40/20 43/9 87/7 93/24 94/8 105/1 106/15 107/14 109/2 109/8 132/1 154/12 154/17 155/4 155/6 158/14
contracted [1] 146/1
contracting [7] 107/11 130/12 130/14 131/23 150/16 156/5 156/13
contracts [32] 7/6 8/17 10/1 22/24 43/4 48/10 48/19 49/3 49/6 49/11 49/19 50/10 51/11 51/22 107/9 108/22 108/23 109/4 116/11 117/12 130/15 134/9 138/25 140/8 147/22 152/14 152/16 152/22 155/14 155/19 156/16 157/19
contrast [5] 7/5 57/5 103/17 108/1 111/21
contribute [1] 158/17
contributed [1] 83/15
contributing [1] 45/19
contribution [1] 141/25
contributor [1] 107/16
control [3] 2/11 73/17 120/1
controversies [1] 61/12
controversy [1] 59/13
conversation [1] 22/14
conversations [1] 22/5
Conversely [1] 63/10
conversion [1] 51/20
cooperation [1] 62/7
coordinate [1] 156/1
coordinated [1] 97/6
coordination [5] 55/1 70/11 156/20 157/8 158/7
cope [1] 140/10
core [5] 49/8 123/6 123/23 148/24 160/3
cornerstone [1] 84/4
corporate [2] 91/15 98/19
correct [8] 3/15 3/18 3/21 3/24 5/15 5/25 11/21 70/21
correctly [1] 130/13
correspondence [1] 142/10
corresponding [1] 112/5
correspondingly [1] 112/1
corruption [10] 53/10 77/21 79/12 79/16 80/5 85/9 85/11 149/7 149/10 162/20
cost [13] 10/13 19/23 29/12 43/2 43/17 55/13 60/11 86/22 125/21 128/16 134/19 137/1 160/13
cost-effective [2] 128/16 137/1
costing [1] 117/1
costs [2] 33/4 86/13
could [57] 3/5 3/7 4/2 9/8 10/4 11/23 12/8 12/11 13/6 13/20 15/16 17/17 19/5 19/16 23/15 23/23 25/22 26/17 27/22 28/21 28/23 30/15 32/22 33/15 33/22 35/7 40/21 41/18 42/8 43/5 46/9 48/5 48/18 49/9 50/23 51/6 53/5 57/14 57/24 58/2 58/10 61/5 62/20 68/17 72/6 72/25 72/25 76/18 102/18 113/5 115/25 118/13 138/21 139/15 151/9 152/15 160/7
couldn't [2] 113/6 156/8
council [1] 113/13
counsel [5] 1/10 92/19 129/1 133/12 161/3
counsel's [1] 150/12
count [1] 125/6
counter [1] 73/15
countermeasures [1] 137/8
counterparties [1] 22/19
countries [9] 22/10 125/20 139/4 147/24 150/17 151/11 153/20 154/25 156/23
country [9] 1/17 22/9 62/20 62/24 76/20 112/11 117/22 129/4 142/25
country's [1] 125/25
couple [2] 140/25 154/13
courage [1] 142/24
course [35] 13/18 15/1 15/17 18/3 21/5 22/13 28/13 31/5 31/7 31/19 32/5 46/12 57/12 57/21 62/7 66/2 73/12 74/24 75/24 76/13 77/5 78/10 80/11 92/21 95/1 99/3 105/11 109/14 117/1 122/4 122/6 128/15 129/10 159/22 160/4
court [3] 133/4 154/12 154/15
coverage [1] 18/24
coverall [8] 18/7 18/8 18/16 19/9 21/3 26/13 28/23 29/5
coveralls [25] 12/23 17/10 17/15 17/22 18/1 18/11 18/25 19/6 19/14 20/2 20/10 20/21 23/18 24/11 24/14 26/11 26/14 27/10 29/9 29/21 29/24 30/7 30/10 30/18 31/11
coveralls/gowns [1] 23/18
covered [2] 7/10 120/3
covers [2] 14/6 18/19
Covid [47] 2/22 4/13 4/17 36/6 38/15 38/24 41/8 41/11 42/11 43/7 54/19 56/1 65/23 66/8 66/12 66/14 66/17 69/18 71/15 76/4 76/6 77/2 79/2 81/2 92/20 93/21 98/1 112/3 128/7 134/12 140/6 144/8 144/10 145/8 145/22 145/23 146/2 146/3 146/9 146/11 154/18 158/12 160/14 161/8 161/12 161/15 161/18
Covid-19 [18] 2/22 41/8 42/11 54/19 66/8 66/12 98/1 128/7 134/12 140/6 144/8 145/8 145/22 146/2 160/14 161/8 161/12 161/15
Covid-related [1] 4/13
CPAPs [1] 75/11
CR [2] 62/16 63/12
CR Pharmaceutical [1] 63/12
create [4] 46/18 123/19 134/18 136/11
created [4] 47/6 79/15 117/23 141/16
creating [4] 85/4 128/8 134/20 136/6
creation [4] 80/3 80/7 114/23 131/7
credentialised [1] 48/24
credentials [1] 151/10
credible [1] 150/9
crime [1] 55/19
crises [2] 59/22 82/21
crisis [11] 32/25 60/9 78/16 79/17 81/14 82/9 85/8 90/15 121/1 148/3 158/19
criteria [6] 8/1 11/20 25/19 30/1 37/24 46/8
criteria-based [1] 46/8
criterion [1] 133/10
critical [13] 8/10 9/25 29/23 30/11 42/24 67/21 67/21 86/2 87/20 108/14 114/17 152/16 156/25
critically [2] 87/1 132/23
criticism [4] 60/21 61/3 77/12 80/2
criticisms [3] 52/11 54/9 79/3
critique [2] 84/10 84/24
CRM [1] 37/8
CRM-type [1] 37/8
cronyism [4] 47/3 54/4 58/9 59/5
crooks [1] 47/18
cross [4] 74/3 130/2 131/7 156/20
cross-cutting [1] 74/3
cross-government [1] 156/20
crowd [1] 42/16

C

crucial [4] 81/11 86/15 88/18 126/23
crude [1] 57/21
cultural [2] 90/15 90/17
culture [2] 52/17 52/21
Cummings [1] 133/16
curb [1] 67/6
currency [1] 22/9
current [6] 23/20 29/3 39/4 116/25 121/9 121/14
currently [2] 16/16 117/14
cusp [1] 143/16
cut [1] 127/17
cutting [1] 74/3
Cymru [5] 66/9 66/12 68/23 75/9 161/16
Cymru's [1] 74/16

D

da [1] 100/5
daft [1] 157/6
daily [4] 2/17 16/18 29/4 101/11
damage [1] 141/20
damaged [1] 148/18
Dame [2] 9/8 88/18
Dame Emily [1] 9/8
damning [1] 84/24
Daniel [1] 42/12
DAs [1] 120/5
dashboards [2] 156/6 156/8
data [45] 12/11 14/1 15/20 16/17 16/19 24/15 28/4 28/5 28/5 28/9 30/6 31/13 32/24 33/24 35/18 35/23 43/23 44/17 54/12 62/8 63/20 77/17 90/1 103/14 103/18 104/2 116/15 116/17 116/18 116/25 117/1 130/7 130/11 130/12 130/12 141/5 141/8 150/6 153/12 153/15 153/20 155/4 156/5 156/8 156/13
data-driven [1] 150/6
date [12] 20/8 21/10 24/6 27/1 29/8 29/9 54/25 67/18 67/23 138/9 138/11 138/13
dates [1] 38/23
daughter [1] 66/19
DAVID [3] 1/9 48/21 161/2
David Sumner [1] 48/21
Dawn [1] 151/17
day [11] 4/17 5/15 6/10 6/10 6/16 6/16 10/11 66/13 73/21 86/9 145/6
days [15] 11/2 12/6 58/14 58/15 68/4 97/8 102/21 114/1 140/20 142/1 144/7 151/20 155/5 155/6 158/14
dead [1] 150/2
deadly [2] 86/10 141/1
deal [29] 4/12 6/22 7/11 8/21 10/20 10/21 10/25 14/1 14/2 14/3 15/8 15/15 16/10 16/14 16/23 20/19 20/25 23/6 25/10 27/23 33/4 37/23 59/21 62/25 63/12 78/9 118/16 131/4 151/16
dealing [7] 2/16 2/19 22/20 32/10 32/16 46/22 151/22
deals [31] 2/15 6/13 6/14 6/19 8/19 8/25 9/1 9/10 9/25 10/6 13/17 13/20 15/11 15/13 16/2 16/6 16/20 16/25 21/11 21/21 22/7 22/9 24/22 25/12 28/9 31/21 31/23 32/12 34/14 34/22 152/9
dealt [1] 6/9
deaths [4] 66/14 66/25 67/8 146/15
debt [2] 55/16 55/23
decade [1] 70/17
December [2] 98/11 140/7
December 2019 [1] 140/7
December 2020 [1] 98/11
decent [2] 25/17 34/12
decision [23] 11/3 11/11 14/16 16/8 21/16 27/21 29/24 31/10 33/11 33/18 58/9 82/11 89/21 90/2 135/5 137/10 142/3 142/12 142/24 144/13 145/2 148/2 158/6
decision makers [1] 142/12
decision-making [2] 89/21 158/6
decisions [18] 1/21 3/1 6/8 8/5 10/17 28/5 28/7 33/13 41/19 62/5 108/25 128/18 133/8 137/9 137/23 141/13 143/13 150/13
decisive [3] 21/19 56/21 97/5
decisively [1] 82/17
declaring [2] 65/5 158/2
declassified [1] 144/7
decline [1] 53/14
dedicated [3] 75/7 84/2 107/1
dedication [2] 76/16 99/4
deemed [1] 23/22
deep [6] 1/16 10/12 44/1 58/25 81/13 132/24
deep-seated [1] 58/25
deeply [2] 56/11 84/20
defective [2] 43/5 150/10
defence [5] 3/13 3/23 38/18 61/17 61/22
defences [1] 56/6
defending [1] 151/1
defensiveness [1] 56/10
deficiencies [1] 73/19
deficient [1] 138/5
definitely [1] 34/2
degree [3] 6/2 7/1 134/21
Deighton [1] 50/15
delay [2] 64/14 71/17
delayed [1] 1/3
delaying [1] 154/23
delays [2] 109/2 109/4
delegated [1] 6/4
deliberate [2] 81/24 109/5
deliver [5] 9/17 17/23 32/13 110/1 156/24
deliverability [1] 7/15
delivered [6] 20/1 23/13 23/20 23/21 24/8 102/2
deliveries [1] 110/5
delivering [3] 2/7 101/18 114/25
delivers [1] 152/13
delivery [7] 11/16 14/4 21/12 23/19 27/25 70/18 118/3
Deloitte [1] 110/22
delve [1] 86/13
delved [2] 81/13 84/20
demand [22] 18/2 18/3 29/19 30/6 30/17 35/12 69/10 101/25 104/4 110/18 110/20 118/18 120/12 140/10 142/8 142/8 143/16 143/18 144/14 144/17 144/21 158/21
demanding [3] 2/21 30/12 160/7
demands [1] 60/7
democratic [7] 47/20 61/14 61/16 61/21 62/2 62/11 121/14
democratically [1] 47/23
demonstrate [1] 142/20
demonstrated [4] 87/11 92/7 112/25 117/12
demonstrates [1] 94/22
demonstrating [1] 63/12
Denbigh [2] 66/16 69/17
denial [1] 47/12
denied [1] 146/9
department [47] 1/22 2/15 4/5 4/9 4/11 4/15 4/19 5/13 34/8 38/17 39/2 57/6 57/11 63/24 64/2 67/24 91/6 91/10 91/11 91/16 92/3 92/7 92/11 92/16 93/13 95/2 95/4 95/13 95/17 95/21 95/24 96/13 96/18 97/5 97/19 98/15 98/24 99/4 99/8 125/4 151/18 153/10 155/16 155/21 157/6 158/8 161/24
Department's [1] 96/3
departmental [1] 64/2
departments [5] 34/5 131/1 131/13 136/21 156/15
depending [1] 21/9
deprioritises [1] 82/11
depth [2] 1/25 134/2
deputy [2] 23/1 91/14
describe [3] 6/25 13/5 19/13
described [12] 8/10 11/10 42/12 44/8 69/11 112/10 114/4 117/20 139/12 140/21 145/11 160/8
describes [1] 154/11
describing [2] 13/11 62/15
description [3] 16/1 28/22 33/6
deserve [1] 64/9
deserved [2] 60/24 77/11
deserves [1] 63/17
design [3] 62/22 73/11 89/15
designated [1] 50/20
designed [4] 44/2 88/14 139/10 139/25
desirability [1] 120/1
desk [3] 8/17 10/1 16/3
desperate [1] 140/11
desperately [3] 51/18 72/24 76/18
despite [6] 42/4 67/14 68/13 125/2 140/6 143/16
detail [4] 32/19 88/13 98/18 100/10
detailed [6] 26/15 77/4 91/12 97/22 150/6 153/22
details [1] 127/14
detecting [1] 65/6
detection [1] 22/12
determination [1] 10/6
determine [1] 124/2
determining [1] 69/8
detracted [1] 141/25
detrimental [1] 124/17
devastating [1] 146/5
develop [7] 44/17 46/7 103/6 103/25 117/18 126/5 128/24
developed [4] 96/4 104/18 145/23 146/11
developing [3] 90/13 135/12 135/15
development [4] 13/2 16/21 132/14 135/7
deviations [1] 85/10
device [1] 88/5
devices [1] 133/24
devolved [19] 54/21 55/2 56/17 61/6 61/10 62/4 62/5 62/11 62/12 64/20 65/9 78/3 111/12 111/21 112/2 112/7 119/12 121/5 123/2
DHSC [10] 3/17 3/20 10/2 38/14 43/10 44/7 45/3 51/25 83/2 120/16
DHSC's [2] 142/7 144/16
diagnostics [5]

D

diagnostics... [5] 128/13 135/9 135/13 136/3 137/7
diatribes [1] 52/13
did [47] 2/13 6/9 16/7 16/8 16/11 16/17 18/3 35/18 50/5 53/22 54/24 55/15 57/22 58/10 59/8 68/9 68/10 68/14 69/13 70/23 71/21 72/4 72/5 79/14 81/24 83/22 88/5 93/11 101/18 109/13 109/22 110/3 118/14 120/15 123/19 124/17 124/22 125/4 129/8 139/8 141/8 143/1 143/23 144/20 146/13 147/7 151/11
didn't [11] 8/17 18/6 45/13 70/13 75/11 145/15 149/3 150/19 150/22 153/12 155/2
died [5] 1/18 2/2 59/9 71/14 146/14
difference [2] 18/16 141/3
differences [3] 5/20 19/11 146/24
different [19] 14/5 19/3 20/25 24/14 29/16 33/20 34/4 34/6 35/7 58/20 58/21 61/15 61/15 101/3 127/11 128/4 133/21 133/23 153/19
differentiation [1] 33/5
differently [3] 41/23 47/13 101/8
differing [2] 45/24 52/4
difficult [15] 2/7 2/8 35/12 35/13 39/8 39/11 41/20 42/20 44/1 57/22 62/3 92/14 128/17 135/4 137/9
difficulties [6] 65/5 82/3 100/23 102/22 111/2 146/18
difficulty [1] 109/16
digital [4] 130/6 156/3 156/4 157/4
digitisation [1] 157/6
diligence [5] 34/1 45/5 49/24 51/12 85/1
dilute [1] 129/12
diminish [1] 82/9
diminished [1] 85/12
dire [1] 89/3
direct [9] 4/7 45/11 85/21 93/23 131/13 138/24 153/3 153/6 153/16
direction [1] 4/19
directly [6] 2/22 48/9 51/3 115/25 150/16 151/24
director [3] 3/16 23/2 38/19
directorate [5] 104/10 104/15 106/25 113/15 114/24
directors [1] 6/3
disagreed [1] 61/24
disaster [2] 151/2 156/19
discharge [1] 106/9
discharges [1] 106/20
disciplinaries [1] 83/23
disclosed [3] 49/8 142/10 151/19
discovery [1] 134/10
discrete [1] 93/2
discretion [1] 83/22
discrimination [1] 83/17
discuss [1] 103/22
discussed [2] 15/19 116/20
discussions [2] 86/3 88/25
disease [2] 2/17 144/8
dismissed [3] 64/23 150/11 153/15
dismissive [3] 56/4 78/23 78/25
disparities [1] 89/10
dispensable [1] 129/7
displacement [1] 2/23
disposal [1] 158/10
disposed [1] 43/16
disproportionate [1] 146/18
disproportionately [2] 81/17 87/5
disregarded [1] 85/4
disregarding [1] 85/1
disrupted [2] 138/20 154/20
disruption [1] 138/21
disruptions [1] 138/3
disseminated [1] 109/18
disservice [2] 59/7 59/10
distancing [1] 4/15
distilled [1] 56/24
distinct [4] 6/24 20/23 94/21 122/22
distracted [2] 150/8 157/16
distribute [5] 99/2 112/19 140/2 140/13 147/19
distributed [5] 92/1 99/6 110/16 124/13 125/11
distributing [2] 69/7 100/21
distribution [26] 11/23 69/3 69/20 69/22 70/18 71/4 72/13 72/15 73/16 90/1 93/5 93/9 94/9 97/7 100/24 102/13 102/22 110/2 110/4 110/9 110/15 111/12 115/20 118/6 137/19 140/12
distributions [1] 74/11
distributor [1] 109/25
distributors [1] 139/1
diverse [9] 54/2 88/6 89/2 89/16 105/10 111/1 138/23 147/9 147/23
diversification [1] 117/11
diversified [1] 117/24
diversify [1] 59/25
diversity [3] 88/15 111/3 147/18
diverted [1] 137/6
divided [1] 27/6
do [26] 8/16 27/23 33/20 33/21 36/12 40/14 41/22 59/20 60/4 60/6 60/25 63/6 67/19 79/2 79/4 83/10 89/22 126/1 126/1 126/11 133/7 135/4 136/9 152/15 156/14 159/16
docks [1] 43/15
doctor [2] 145/13 149/15
document [11] 12/8 14/20 14/25 20/9 20/14 24/10 33/3 40/7 40/12 40/12 63/23
documentary [1] 134/1
documents [7] 9/6 19/19 23/7 23/8 40/21 41/3 133/18
does [17] 26/10 59/7 59/10 63/4 66/2 82/9 85/7 92/3 97/21 106/17 109/14 113/24 125/18 130/23 132/8 132/11 157/1
Doherty [4] 122/9 122/11 127/1 162/11
doing [7] 22/8 24/23 24/25 28/17 36/17 74/8 117/21
dollar [1] 22/8
dollars [1] 28/25
domestic [7] 77/16 104/19 104/22 138/23 139/6 147/24 156/24
domestically [1] 59/25
Dominic [1] 133/16
don't [11] 7/13 20/24 23/8 26/12 27/7 28/11 35/25 39/6 52/20 99/25 155/23
done [21] 13/14 18/14 24/23 25/12 28/9 34/14 39/15 39/21 47/12 48/5 48/6 50/4 80/8 80/9 83/5 104/20 115/18 127/15 127/15 129/19 143/4
donors [1] 53/18
door [2] 132/10 151/8
double [2] 118/8 152/4
doubt [4] 51/19 75/1 83/6 133/19
doubtlessly [1] 76/7
Douglas [1] 66/15
down [12] 12/14 13/10 13/20 16/7 27/24 34/18 52/24 68/1 122/1 143/23 145/1 152/4
Dr [9] 9/13 9/17 36/4 50/14 76/5 142/19 143/11 161/4 161/19
Dr Hall [1] 50/14
Dr Lawson [2] 9/13 9/17
Dr Lisa Ritchie [1] 142/19
Dr Parry-Jones [1] 143/11
drafted [1] 96/15
draw [1] 105/14
drawn [3] 55/5 128/20 156/19
draws [1] 121/9
drew [3] 101/6 130/3 156/23
drinking [1] 152/17
drive [1] 134/19
driven [1] 150/6
dual [1] 87/6
duck [1] 66/21
due [16] 34/1 45/4 49/24 51/12 63/17 67/8 77/5 82/5 85/1 86/19 87/8 94/11 109/5 116/25 123/12 146/2
due-diligence [1] 49/24
duff [1] 57/14
duly [1] 102/10
Dunkirk [1] 151/1
duplication [1] 56/24
duration [1] 124/8
during [43] 1/22 4/3 4/5 13/25 18/3 78/24 80/19 81/14 81/23 82/21 86/3 88/2 90/14 91/20 99/6 101/17 101/24 103/21 104/6 104/9 104/22 105/2 108/11 113/2 113/18 117/16 124/12 124/21 124/22 126/7 126/13 128/15 129/7 135/14 137/19 142/18 148/2 150/1 150/22 152/7 153/2 157/25 158/20
dust [1] 61/3
duty [5] 76/22 82/12 84/4 89/11 89/13
dying [2] 10/11 76/10
dynamic [2] 32/1 97/16
dysfunctional [1] 52/21

E

e-procurement [2] 156/4 157/4
each [15] 11/20 19/12 32/20 50/1 82/23 95/15 106/21 110/1 110/2 111/8 111/12 111/14 120/21 136/10 139/21
earlier [6] 24/16 24/21 27/14 92/5 102/19 149/16
early [27] 11/21 14/4 14/12 18/4 21/25 34/22 37/18 95/22 96/2 96/4 96/20 97/1 97/8 100/23 102/21 102/23 103/12 103/21 113/25 116/20 119/2 123/7 137/21 140/5 140/7 141/2 145/20
earnest [1] 159/15
earthquakes [1] 157/1
easily [1] 57/14
East [1] 43/9
easy [2] 57/22 159/24
economic [2] 2/25 10/12
economy [1] 160/14
Ecuador [1] 156/7
Education [1] 151/18
effect [4] 50/1 89/25

E

effect... [2] 97/15 124/17
effective [8] 54/23 104/13 117/13 120/21 124/12 128/16 137/1 152/25
effectively [8] 12/18 24/25 92/1 99/6 115/5 120/25 126/11 141/10
effectiveness [4] 86/6 90/7 104/21 122/21
effects [1] 145/24
efficient [1] 120/21
efficiently [1] 102/2
efforts [5] 59/23 77/3 88/12 99/1 104/21
eight [2] 16/2 125/15
eight-stage [1] 16/2
either [5] 2/18 15/9 17/9 85/24 138/8
elected [2] 47/23 137/10
element [6] 7/19 9/18 11/5 21/4 33/10 62/19
else [6] 31/25 50/3 60/12 126/16 155/11 159/5
elsewhere [1] 124/18
elusive [1] 69/2
email [15] 67/25 92/22 92/24 93/2 93/14 93/17 94/10 94/13 94/15 94/22 133/7 133/15 142/10 151/18 156/2
emails [3] 48/17 98/21 142/18
embarked [1] 132/10
emerged [2] 95/4 100/13
emergencies [1] 120/7
emergency [26] 44/12 47/8 50/8 50/10 53/9 53/12 90/11 99/12 101/1 101/7 105/2 107/20 117/13 118/25 119/19 119/20 131/8 137/5 150/3 150/18 150/23 156/18 156/25 157/8 157/12 158/1
Emily [4] 9/8 35/11 87/24 88/9
Emily Lawson [2] 35/11 87/24
Emily Lawson's [1] 88/9
Emily's [1] 88/18
eminent [2] 52/12 84/23
emotion [1] 1/25
emotional [2] 55/24 86/18
emphasis [1] 52/2
emphasise [2] 39/7 131/1
emphasising [1] 85/14
enable [4] 46/13 54/23 58/2 66/1
enabled [2] 49/14 59/4
enabling [3] 45/20 62/21 62/24
encompass [1] 87/2
encouraged [1] 45/14
end [23] 2/25 14/12 14/14 16/11 16/12 18/17 21/2 23/3 25/20 27/21 30/20 34/6 34/18 34/20 36/7 64/13 65/16 70/11 98/11 109/11 118/17 129/12 148/7
endangered [1] 86/1
endeavoured [1] 92/11
endeavours [1] 97/10
endorse [3] 52/18 61/25 104/7
endured [1] 113/1
enduring [2] 1/16 55/22
energy [1] 129/21
enforceable [1] 87/2
engage [1] 16/20
engaged [2] 95/21 120/14
engagement [6] 16/13 35/10 37/18 85/23 89/18 120/11
engaging [1] 6/15
England [7] 5/3 43/24 60/13 61/12 111/23 112/5 140/3
enhance [1] 105/16
enhances [1] 130/19
enlisted [1] 110/21
enormous [2] 26/6 126/15
enough [7] 3/7 31/2 37/20 72/19 84/8 118/16 158/3
enquiries [1] 20/16
enrich [1] 58/24
ensure [28] 20/6 30/2 32/2 36/23 42/13 64/12 76/8 76/17 77/23 77/25 79/12 80/21 82/17 87/2 90/23 92/1 92/12 96/8 96/15 97/10 101/22 101/25 109/19 115/10 117/2 124/16 125/9 148/8
ensured [1] 50/3
ensuring [12] 4/10 4/15 4/20 64/14 64/16 67/18 86/23 90/12 99/5 119/8 148/11 148/12
entailed [1] 4/3
enter [1] 107/9
entered [2] 108/8 140/21
Enterprise [2] 114/20 117/17
entertain [1] 61/2
entire [3] 85/17 94/13 107/12
entirely [4] 39/7 138/19 140/11 141/21
entirety [1] 68/5
entities [1] 54/21
entitled [1] 115/23
entity [2] 21/23 65/10
entrants [1] 45/16
entry [2] 46/10 132/11
environment [2] 28/8 60/12
environmental [1] 60/8
environmentally [1] 65/20
equal [2] 120/22 126/4
equalities [1] 146/17
Equality [3] 82/12 84/4 89/13
equally [2] 21/20 78/25
equipment [55] 11/15 39/15 42/16 42/23 57/17 64/12 67/10 72/14 72/19 72/20 73/2 73/9 74/15 74/19 75/10 75/13 75/21 77/24 79/14 80/24 83/9 86/9 88/8 91/19 95/11 96/9 102/11 102/14 105/5 110/3 110/11 117/3 117/5 117/6 117/9 117/19 118/7 120/2 121/25 123/1 123/20 124/24 128/6 138/6 139/20 140/4 142/5 142/21 143/2 143/2 144/15 147/14 147/20 148/10 153/24
equipped [1] 77/9
equitable [1] 84/15
equity [1] 82/10
equivalent [2] 64/20 79/19
eroded [1] 90/6
erroneous [1] 94/6
errors [1] 65/14
escalate [1] 42/24
escalated [1] 37/16
escalating [1] 10/23
escalation [1] 24/18
escaped [2] 55/25 56/2
especially [6] 38/14 145/20 153/11 155/11 157/6 158/18
essential [8] 42/22 64/16 78/6 85/7 121/25 144/15 157/15 157/18
essentially [2] 32/9 32/15
establish [3] 22/16 123/22 157/18
established [13] 21/25 56/11 70/19 103/4 106/16 115/21 118/4 123/6 123/9 123/21 132/6 137/3 157/17
establishing [1] 58/7
establishment [5] 59/4 120/3 120/17 131/15 135/9
estate [1] 70/22
estates [1] 148/12
esteem [1] 120/23
estimate [1] 7/5
estimated [2] 43/15 68/6
ethical [1] 54/12
ethnic [9] 81/8 81/18 83/4 84/17 87/4 88/7 105/6 146/17 161/22
ethnicity [1] 147/1
Europe [3] 153/25 154/3 154/7
European [3] 153/18 153/20 154/1
euros [1] 154/8
evaluating [1] 32/11
evaluation [4] 8/20 8/21 133/10 135/8
evasive [2] 56/5 68/20
even [20] 32/2 33/12 43/21 47/17 47/19 50/25 56/4 56/9 58/12 68/15 69/13 70/19 80/5 83/22 87/11 100/17 132/4 136/12 150/9 151/3
event [4] 125/24 131/6 137/4 138/20
events [1] 158/22
eventually [1] 134/19
ever [4] 5/15 44/2 50/10 55/2
every [11] 8/8 8/9 10/11 43/4 49/22 77/10 82/11 84/16 86/9 90/25 92/11
everybody [3] 127/17 159/8 160/2
everyone [3] 122/4 126/16 159/23
everything [5] 39/15 60/12 134/17 143/4 155/11
evidence [104] 2/4 5/17 5/19 9/4 36/8 36/11 37/4 39/19 40/7 40/18 40/20 40/25 41/24 49/23 50/19 51/21 52/11 52/12 54/7 55/16 56/21 57/5 57/14 58/17 59/6 60/23 62/1 62/14 62/15 62/23 64/6 64/11 64/19 65/1 65/16 74/20 75/6 75/6 78/22 78/25 79/7 80/18 83/2 83/6 83/11 83/13 83/14 84/3 84/19 85/19 88/18 89/8 91/13 91/16 95/3 100/8 100/13 100/17 101/17 103/9 104/5 104/11 105/15 107/4 108/21 109/7 111/15 112/10 113/24 114/13 114/15 115/24 116/15 117/15 119/23 119/25 120/3 121/16 122/14 122/18 122/20 124/10 124/11 124/14 124/19 124/20 125/13 126/10 127/14 129/8 131/3 132/18 132/22 135/9 142/11 143/11 143/21 152/5 152/6 152/8 155/15 155/18 155/21 159/3
evidencing [1] 108/24
evident [2] 90/21 93/8
evidential [1] 160/16
evidently [1] 71/1
evolved [1] 35/17
evolving [1] 90/14
ex [6] 29/10 29/11 48/23 48/23 56/14 152/4
ex post facto [1] 56/14
ex-military [1] 48/23
ex-politicians [1] 152/4
ex-SAS [1] 48/23
ex-works [2] 29/10 29/11

E

exacerbated [2] 102/23 138/14
examination [2] 65/13 87/17
examine [2] 1/23 158/5
examined [1] 80/5
examining [1] 128/6
example [20] 11/17 21/15 23/5 25/22 26/6 26/17 28/19 29/16 33/24 64/10 68/12 114/4 125/20 131/11 138/10 139/19 139/24 142/18 147/9 149/25
examples [5] 12/23 17/2 21/20 47/18 48/3
exasperated [1] 47/18
exceed [1] 20/8
Excel [3] 55/8 141/7 156/1
except [1] 55/20
exception [1] 87/22
exchange [3] 62/7 62/8 92/24
exchanged [1] 92/23
excluding [2] 29/13 115/8
exclusively [1] 65/4
excuse [1] 82/7
Executive [2] 62/19 146/22
executives [1] 131/14
exercise [4] 41/21 50/9 134/1 136/24
exercises [1] 97/20
Exhibited [1] 133/17
exhibits [1] 69/2
exigent [1] 92/15
exist [2] 54/24 132/8
existence [1] 51/1
existing [6] 11/13 45/1 121/7 123/16 132/21 139/6
exists [2] 114/3 121/12
expand [3] 36/19 71/18 107/23
expanded [4] 96/10 101/24 104/14 115/13
expanding [1] 49/11
expect [4] 3/2 26/15 47/12 54/14
expectation [2] 10/13 53/23
expectations [1] 35/12
expected [5] 9/17 50/3 53/25 83/19 125/17
expecting [2] 16/14 99/23
expects [1] 112/18
expedite [1] 17/22
expenditure [1] 92/12
expense [3] 54/8 60/11 141/18
expensive [2] 32/3 135/3
experience [9] 24/24 48/25 59/21 97/13 107/6 112/17 123/8 145/24 146/11
experienced [11] 43/1 59/2 69/14 74/18 75/2 102/23 103/4 103/20 107/1 111/17 146/18
experiences [1] 100/16
experiencing [2] 116/2 136/1
expert [7] 52/12 84/23 103/3 114/25 119/23 124/10 150/21
expertise [7] 48/8 59/21 79/18 108/2 115/1 121/9 131/19
experts [3] 85/19 104/25 136/8
expired [1] 138/9
expiry [2] 138/9 138/13
explain [3] 4/2 142/25 144/18
explained [6] 50/7 74/5 115/1 119/8 134/1 139/14
explanation [2] 70/21 73/15
explanations [1] 70/14
exploration [1] 135/21
explore [2] 3/2 94/24
explored [2] 20/22 129/5
expose [1] 46/20
exposed [4] 42/11 46/19 48/7 80/4
exposing [1] 86/10
exposure [1] 88/16
expressed [3] 28/24 109/11 143/10
expression [1] 55/19
extend [1] 122/2
extended [1] 126/14
extensive [3] 127/14 132/20 132/22
extent [3] 18/6 67/20 92/14
external [1] 136/19
extracts [1] 20/20
extras [1] 82/18
extreme [2] 17/21 109/5
extremely [4] 30/25 54/16 159/17 159/23
eye [1] 25/14
eyebrows [1] 132/4

F

face [6] 68/9 76/12 77/10 80/24 135/4 135/4
faced [10] 42/19 56/18 65/21 81/19 82/3 87/6 97/7 99/3 126/20 145/18
facilitate [1] 120/11
facilitates [1] 130/17
facing [1] 141/1
fact [11] 14/21 32/6 32/13 33/10 49/23 52/19 93/8 95/15 102/12 103/19 143/22
facto [1] 56/14
factor [6] 11/4 12/3 16/8 26/21 103/19 128/20
factories [1] 58/2
factors [12] 11/12 14/15 14/17 15/18 21/10 30/24 33/20 34/19 34/21 34/23 35/3 57/25
factory [1] 29/13
fade [1] 160/11
fail [3] 79/14 86/10 140/9
failed [7] 67/19 72/17 76/8 89/2 89/16 123/12 133/22
failings [12] 54/6 59/1 64/22 82/7 82/16 83/25 84/9 86/14 89/7 137/19 139/2 148/18
failure [18] 41/14 43/18 43/19 45/10 59/3 63/19 64/14 67/20 67/21 68/14 80/6 88/3 112/14 128/9 144/18 147/10 152/9 157/19
failures [9] 47/5 64/12 71/4 73/16 74/18 81/20 86/13 109/7 150/1
fair [3] 33/15 80/10 97/18
fairly [3] 35/2 37/24 125/11
fairness [2] 77/19 87/21
fallen [1] 31/24
false [2] 58/23 144/21
familiar [1] 77/13
families [23] 1/18 2/2 2/9 41/8 41/12 42/25 54/14 54/19 55/22 58/19 66/8 66/12 68/23 74/16 75/9 76/10 86/17 86/18 92/20 158/21 161/9 161/12 161/16
family [3] 2/10 2/18 145/15
far [14] 18/8 36/24 43/9 47/19 60/7 61/7 71/5 135/1 135/6 137/25 138/1 139/4 152/2 154/16
Far East [1] 43/9
fashion [2] 31/2 152/18
fast [1] 107/7
fast-moving [1] 107/7
faster [2] 53/9 133/9
father [1] 66/20
faults [1] 61/9
favourable [2] 24/9 107/14
favoured [1] 119/8
fear [3] 74/10 86/12 145/11
feasibility [1] 7/15
feature [2] 22/7 27/2
features [1] 23/11
February [4] 67/23 120/17 142/12 143/14
February 2020 [2] 142/12 143/14
February 2021 [1] 120/17
Federation [2] 81/8 161/21
feed [1] 51/7
feedback [2] 36/16 90/14
feel [3] 20/24 151/20 151/22
feeling [1] 149/23
Feldman [4] 48/14 48/16 48/20 87/19
Felixstowe [1] 43/15
fell [1] 63/11
felt [6] 55/14 58/13 58/13 70/24 83/21 145/14
female [1] 146/17
FEMHO [5] 83/15 84/9 84/11 84/12 89/20
fertile [1] 85/4
few [7] 7/8 7/8 138/1 139/10 140/24 149/12 154/12
fewer [1] 139/4
FFP3 [21] 57/3 67/22 67/22 68/2 68/11 69/16 73/18 73/20 73/22 75/16 111/7 138/10 142/13 142/20 143/13 144/4 144/12 144/22 144/24 145/8 146/9
Fifth [1] 148/8
figure [2] 30/22 149/25
figures [1] 87/19
filibustering [1] 60/23
fill [1] 36/21
final [4] 19/24 28/19 132/4 139/24
finally [11] 33/15 47/5 90/16 98/18 99/8 105/3 119/23 126/6 134/8 148/16 155/25
finance [4] 3/16 23/1 63/25 119/13
financial [9] 5/2 8/22 11/2 11/5 49/12 55/13 55/23 64/23 119/17
financially [1] 48/18
find [6] 28/16 51/6 133/2 134/14 134/15 152/24
findings [3] 52/15 54/6 158/17
finished [1] 159/19
firm [1] 93/5
firmly [1] 106/3
first [30] 3/12 12/16 14/11 22/15 35/15 39/2 40/6 41/7 50/12 50/22 57/2 57/2 66/14 66/25 67/14 86/3 86/25 93/14 95/5 122/20 125/14 134/4 136/20 137/20 139/7 141/15 143/13 144/20 147/12 156/18
firsthand [2] 75/3 96/24
firstly [4] 16/10 116/15 128/25 131/2
fit [9] 52/25 68/9 68/10 83/18 88/8 110/9 111/9 137/25 146/24
fits [4] 18/19 87/9 89/15 111/1
fitting [5] 18/24 90/13 105/5 146/19 147/4
five [5] 2/1 65/18 66/13 146/4 155/23
five years [4] 2/1 65/18 66/13 155/23
flaw [4] 133/6 133/8 138/4 138/7
flawed [5] 52/14 56/11 137/22 141/13

F

flawed... [1] 142/3
flaws [3] 85/20 85/20 132/20
flexibility [3] 6/14 19/8 134/5
flexible [3] 104/3 107/22 119/21
flimsy [1] 144/11
floating [1] 70/22
flow [3] 22/17 34/25 133/24
flows [2] 70/2 70/10
fluctuating [1] 10/23
fluctuation [1] 14/10
fluctuations [1] 13/4
fluid [3] 32/1 107/12 142/16
fluid-resistant [2] 107/12 142/16
flying [1] 140/17
focus [12] 5/8 9/21 12/1 33/23 60/10 69/21 80/2 100/12 122/17 138/3 141/14 145/17
focused [3] 48/12 55/10 80/11
focusing [3] 6/6 18/8 84/22
follow [3] 14/22 44/15 44/18
followed [2] 56/16 125/7
following [9] 56/23 112/17 119/1 125/13 128/23 131/2 143/13 146/4 147/11
Fong [1] 149/15
foot [2] 92/18 149/21
forced [1] 60/4
forefront [1] 87/24
foreign [2] 22/9 22/9
forged [1] 121/19
forget [1] 39/10
forgive [5] 19/24 21/23 23/15 25/5 31/6
forgotten [1] 105/20
formal [4] 38/21 108/7 119/19 120/4
formally [2] 5/25 104/21
former [2] 48/14 150/11
fortuitously [1] 63/7
fortune [1] 62/19
Forum [1] 72/1
forward [13] 12/21 17/1 47/7 80/20 82/15 90/22 110/11 112/22 124/6 125/14 127/15 131/5 158/17
forward-looking [1] 47/7
found [3] 61/13 109/1 109/6
foundation [2] 44/17 54/12
foundational [1] 85/2
four [16] 54/7 68/1 68/7 75/5 105/4 105/15 119/23 120/9 120/10 120/18 120/22 121/3 126/4 144/3 152/22 159/18
four-nation [1] 144/3
Fourth [1] 148/5
Fourthly [1] 73/17
fragmented [2] 102/24 111/24
framework [7] 44/11 84/5 135/12 135/13 135/14 135/16 156/23
frameworks [1] 151/8
frantic [1] 84/5
fraud [3] 22/12 54/3 158/12
fraudsters [1] 55/12
fraudulent [1] 116/10
fraught [1] 82/24
freedom [2] 6/14 19/8
Freeman [9] 61/21 62/1 114/4 115/1 115/21 115/24 116/17 118/13 121/13
freestanding [1] 133/10
friends [1] 47/14
front [14] 2/3 10/21 10/25 13/21 18/19 46/16 46/19 47/15 52/5 80/22 81/20 115/25 132/9 151/8
frontispiece [1] 9/6
frontline [13] 1/18 2/7 11/24 28/14 58/16 86/8 109/15 119/7 123/15 126/8 126/19 142/2 148/6
fruition [1] 66/3
frustration [1] 55/3
fulfilling [1] 73/7
full [6] 4/9 18/12 66/22 86/22 102/12 158/11
fully [13] 3/2 14/1 38/4 63/2 63/13 73/10 77/21 84/7 96/21 97/11 98/10 126/20 150/2
function [3] 4/16 103/3 103/8
functionality [1] 141/9
functions [1] 106/20
fundamental [3] 65/14 147/5 147/21
fundamentally [1] 147/12
funded [1] 110/23
funding [9] 42/16 106/8 118/23 118/25 119/11 119/17 119/20 128/17 135/5
Fundrey [8] 5/19 5/23 6/3 6/7 7/4 11/6 14/24 16/9
funds [2] 54/8 92/12
further [9] 9/1 36/1 45/19 54/7 96/18 111/9 118/7 138/7 144/22
Furthermore [1] 121/13
future [44] 25/13 25/16 28/17 32/18 34/15 34/17 35/24 54/11 56/8 59/10 59/20 59/22 59/22 60/7 60/15 60/24 63/6 63/8 65/15 65/21 71/7 72/9 76/1 82/21 84/12 85/17 90/8 90/11 99/11 104/12 118/2 119/19 121/1 127/10 127/21 127/22 128/6 131/6 137/2 141/22 148/9 156/15 157/22 160/14

G

Gallagher [2] 89/23 143/21
gaps [6] 36/22 63/19 73/8 75/20 75/23 89/13
Gareth [3] 140/22 151/24 155/17
gave [4] 107/16 115/3 119/25 156/11
gazumping [1] 45/18
GDP [1] 154/1
gender [1] 146/25
general [9] 3/16 13/23 18/21 38/19 74/23 91/21 108/21 109/6 144/24
generally [4] 32/23 35/12 72/21 95/1
generated [3] 37/9 103/18 119/1
generating [2] 73/23 144/5
generation [1] 55/17
generations [4] 55/14 59/11 60/24 160/14
generous [1] 55/11
genuine [1] 109/9
genuinely [1] 35/13
geographical [1] 99/3
geographically [1] 65/19
get [19] 8/4 16/14 19/2 28/14 39/13 39/15 47/15 52/11 56/12 80/23 81/5 114/24 131/25 136/9 151/10 151/16 151/25 155/24 158/13
get-out [1] 56/12
gets [2] 50/12 115/11
getting [5] 12/2 34/11 34/14 103/11 119/5
Gibbs [1] 155/16
girls [1] 79/18
give [1] 34/12
given [21] 16/22 16/24 36/13 51/15 52/6 57/3 57/23 60/17 70/7 73/3 74/22 75/6 94/7 96/20 98/9 104/5 124/7 125/12 136/10 143/20 148/25
giving [2] 55/11 149/5
glaring [4] 58/6 58/11 64/14 147/9
global [10] 10/23 45/19 46/15 62/25 65/17 81/14 82/1 99/7 138/20 143/17
globe [1] 78/12
gloves [1] 115/8
go [11] 14/19 17/3 17/15 19/19 25/15 50/11 66/7 70/23 83/19 99/25 122/4
goes [1] 131/23
going [23] 1/23 5/7 12/22 13/3 13/10 14/17 19/10 19/19 25/9 26/9 31/11 32/17 32/25 37/23 37/24 50/10 76/22 89/4 124/6 125/14 131/13 152/5 159/20
Gold [2] 93/16 94/20
gone [1] 122/3
good [24] 1/5 1/6 2/12 35/18 44/11 45/1 48/22 52/9 53/6 53/14 54/12 54/12 62/19 69/15 75/1 92/9 99/21 100/5 106/6 106/12 116/6 135/17 154/14 156/12
Goodbye [1] 160/17
goods [3] 28/22 46/16 57/16
Gordon [2] 114/17 122/16
Gordon Beattie [1] 122/16
got [13] 8/19 22/17 33/4 37/17 37/23 50/14 52/5 57/7 149/19 151/12 153/13 154/11 155/13
Gove [8] 44/23 47/19 52/9 53/22 61/16 78/22 87/19 151/24
Gove's [1] 79/2
governance [6] 53/6 53/14 54/12 112/11 113/20 116/6
government [104] 22/6 22/15 34/5 41/14 42/4 44/10 45/5 45/17 45/18 47/25 48/19 49/10 50/18 51/16 52/18 53/23 53/25 60/25 67/3 67/16 67/19 68/6 68/15 68/18 68/19 68/21 68/24 69/4 70/24 71/18 71/24 72/6 75/25 78/2 79/3 79/20 79/23 100/3 100/6 100/7 100/15 101/17 102/16 102/24 103/22 103/23 104/9 105/8 105/14 106/4 106/7 106/13 106/14 107/5 109/19 110/6 110/15 110/24 112/13 112/18 112/21 113/12 113/15 113/18 113/24 114/11 114/16 114/20 115/5 115/13 116/1 116/7 116/16 116/18 117/16 118/2 119/3 119/4 119/6 119/16 120/4 120/8 120/14 120/19 120/24 121/2 121/12 121/18 121/22 122/2 124/2 128/18 130/2 130/25 131/7 136/16 137/4 154/11 156/15 156/20 157/23 158/18 158/24 162/2
government's [16] 42/5 45/8 53/3 74/23 75/21 78/24 79/11 84/25 87/16 100/9 100/20 104/15 123/11 136/13 150/3 155/3
governments [6] 53/8 76/8 78/4 80/15 119/15 156/3
gown [3] 17/14 18/16 69/16
gowns [39] 12/15 12/22 13/7 13/8 14/6 14/7 14/8 17/9 17/22 17/25 18/6 18/13

G

gowns... [27] 18/20 19/12 19/21 20/9 20/21 23/13 23/18 23/20 24/7 24/11 24/13 25/25 26/10 26/14 27/10 29/18 29/22 30/7 30/17 30/19 30/21 30/25 31/1 31/11 31/13 31/14 68/12
Graells [8] 44/9 46/1 46/22 50/7 52/8 84/23 131/21 150/20
Graells' [1] 52/18
grant [1] 40/10
granted [1] 157/16
granular [2] 32/19 33/12
graphic [1] 149/25
grapple [1] 132/18
grappling [1] 22/14
grateful [11] 40/6 40/10 54/16 66/6 81/4 91/4 126/23 148/25 149/4 159/2 159/23
gratitude [1] 112/24
great [5] 52/1 52/7 76/16 111/19 114/1
greater [7] 12/5 18/24 64/21 89/19 111/25 112/8 117/22
grew [1] 57/18
grief [2] 59/9 86/18
grip [1] 70/25
ground [4] 85/4 85/21 133/2 133/3
group [20] 3/17 22/23 53/19 67/2 68/23 70/7 71/2 71/14 73/25 74/1 74/10 75/1 75/12 91/15 107/1 114/19 114/19 118/3 120/10 135/23
groups [4] 18/9 19/7 30/10 89/20
guard [1] 77/20
guidance [22] 6/17 8/4 37/21 70/5 70/8 73/17 73/21 73/25 74/9 75/16 96/4 96/6 96/11 96/15 104/17 120/11 144/2 145/6 146/10 146/21 148/19 157/23
guide [1] 23/17
guided [1] 90/20

H

habile [1] 114/13
had [137] 1/17 2/18 4/21 5/12 6/12 6/13 6/16 6/24 7/24 8/15 8/19 10/9 10/21 12/5 13/16 13/17 13/20 15/11 15/11 16/1 16/6 20/14 21/13 22/5 23/20 24/23 25/12 25/14 25/14 27/23 28/1 28/6 28/10 28/13 32/2 32/7 34/3 35/8 36/14 36/22 36/23 37/7 37/7 38/13 38/18 39/3 39/3 41/20 43/16 44/10 47/4 48/22 49/10 50/6 50/16 50/20 51/2 51/4 51/7 51/11 61/24 62/19 64/21 66/24 70/1 70/15 70/19 70/25 71/20 71/21 72/2 72/4 72/25 73/1 76/8 76/23 79/9 80/5 80/6 83/2 83/4 85/20 89/25 93/23 94/6 94/18 94/19 95/13 96/23 102/6 103/8 103/18 106/6 108/9 108/25 109/1 109/8 109/15 111/4 112/13 116/4 119/6 119/9 119/16 122/14 123/6 123/7 123/8 123/9 124/25 129/6 131/3 132/2 133/19 133/21 133/24 134/6 135/14 138/7 138/8 139/3 139/6 140/17 142/24 144/19 144/23 147/8 149/23 150/14 151/14 152/9 153/13 153/13 153/19 154/18 157/19 160/1
half [2] 49/2 68/13
Hall [1] 50/14
Hancock [7] 44/24 47/16 52/9 150/11 151/23 153/15 154/10
Hancock's [2] 78/25 79/5
hand [4] 12/14 111/22 132/19 132/21
handful [1] 15/11
handholding [1] 50/17
handle [1] 88/14
hands [1] 12/2
happened [4] 27/5 38/16 74/22 142/23
happens [2] 61/5 65/24
hard [6] 62/23 72/23 73/3 76/15 112/24 126/14
hardly [1] 152/25
harm [1] 83/8
has [89] 5/17 5/18 24/6 26/21 26/23 27/5 33/4 38/7 41/24 47/1 47/11 48/17 50/2 50/2 52/25 55/17 55/25 56/4 59/17 60/10 60/19 67/7 71/8 73/13 74/4 74/22 74/24 75/3 75/9 77/2 79/7 89/6 89/13 89/19 90/6 91/12 91/16 92/5 92/7 93/3 93/10 95/2 95/24 97/14 97/19 100/7 100/10 106/25 109/12 114/9 114/13 117/15 118/3 118/17 119/11 121/17 121/20 122/3 122/23 122/24 123/1 124/21 127/15 128/15 128/20 129/2 129/19 130/5 132/2 132/10 132/19 132/20 132/22 135/6 135/7 135/20 136/6 140/18 141/19 141/25 145/3 146/5 148/17 152/2 152/7 157/9 159/23 160/1 160/10
hasn't [2] 49/23 159/24
hasty [1] 85/23
haunted [1] 61/12
have [195]
having [23] 11/11 11/24 18/13 22/5 32/24 34/9 35/20 42/14 42/16 46/25 56/11 70/2 74/12 77/19 93/23 103/2 110/17 110/25 120/1 122/14 125/2 132/9 147/15
Hayman [4] 149/6 149/8 159/1 162/20
hazmat [1] 66/22
he [38] 7/16 46/5 48/21 48/21 48/22 50/19 52/3 52/12 55/16 55/16 66/16 68/20 69/11 70/9 70/10 72/5 84/25 88/4 93/19 94/2 100/22 100/25 100/25 101/6 101/11 102/9 103/10 104/12 104/20 107/5 149/18 150/25 153/11 153/18 153/20 154/10 154/11 154/14
headlights [2] 44/8 150/25
headlines [1] 58/23
health [62] 1/22 2/24 4/5 5/13 34/8 38/17 42/1 42/10 43/6 54/2 57/6 57/12 64/3 65/9 66/24 67/24 68/10 70/16 81/14 91/6 91/10 92/24 95/10 98/2 101/5 101/12 101/13 101/18 101/22 103/12 106/22 106/22 110/12 111/1 111/10 114/6 114/20 115/21 116/22 116/24 118/12 121/5 121/13 123/1 125/8 126/9 127/3 127/6 128/10 138/12 145/14 145/15 146/12 146/22 147/20 153/11 155/16 155/21 157/7 158/8 161/25 162/14
healthcare [51] 2/23 64/24 66/23 70/13 71/1 71/9 75/17 78/12 81/9 81/19 82/21 84/15 84/16 85/17 86/1 86/4 86/14 87/4 88/6 88/17 88/20 89/16 90/7 90/18 90/25 91/19 95/15 95/19 95/21 96/1 98/14 105/7 107/20 108/1 111/20 122/25 124/24 139/22 141/1 141/17 142/2 142/17 142/25 143/7 143/12 144/9 144/25 145/11 145/16 148/9 161/22
healthcare-related [2] 91/19 122/25
hear [6] 17/5 64/2 113/5 113/6 129/21 150/23
heard [57] 5/17 36/11 41/1 41/24 49/23 50/2 52/25 56/5 57/15 58/14 58/17 59/7 60/23 62/15 63/20 65/16 69/4 71/9 73/13 74/5 74/20 76/13 80/19 82/8 82/22 83/7 83/13 84/19 87/18 87/23 91/13 100/8 100/19 101/17 104/5 104/8 107/25 110/17 119/11 122/23 129/18 131/2 132/19 132/20 132/22 134/25 135/3 135/7 135/11 136/20 140/18 146/7 151/3 151/15 152/4 152/20 155/25
hearing [4] 49/17 49/20 95/2 160/17
hearings [5] 105/13 149/13 152/7 159/18 159/19
heart [4] 41/13 45/10 47/3 81/13
heave [2] 107/25 134/25
heavily [2] 34/21 111/3
height [1] 144/3
heightened [1] 101/25
heightening [1] 65/13
heinous [1] 58/24
held [10] 43/24 43/25 67/22 69/24 70/12 103/11 110/14 111/13 118/11 139/21
help [12] 9/8 10/4 80/21 96/15 99/11 99/14 116/7 126/21 149/4 152/24 154/19 154/22
helped [2] 125/9 159/23
helpful [1] 32/24
helping [1] 150/17
helpline [1] 115/20
her [3] 48/2 77/6 146/12
here [19] 16/15 16/25 18/18 20/24 21/8 21/12 23/12 23/17 26/6 26/14 27/3 27/9 27/11 29/24 30/5 31/8 71/8 84/9 94/8
herring [1] 70/7
high [15] 7/1 43/7 47/1 75/15 83/20 87/18 108/13 123/19 131/9 133/4 133/5 141/15 144/8 148/21 154/15
high-risk [1] 83/20
higher [7] 14/8 19/5 27/11 51/21 152/9 157/19 157/19
highest [4] 50/23 67/8 92/8 143/3
highest-risk [1] 143/3
highlight [3] 62/14 95/4 130/4
highlighted [8] 85/6 89/19 103/1 104/11 113/16 130/24 136/23 146/23
highlighting [2] 77/18 105/4
highlights [2] 82/10 147/11
highly [1] 6/11
hijacked [1] 55/12
him [4] 48/17 94/18 101/13 102/6
hims [1] 52/13
himself [2] 72/8 73/6
hindered [1] 155/1
his [23] 42/12 48/1

H

his... [21] 50/19 52/10 52/12 52/15 62/17 66/19 78/22 85/6 93/16 93/19 94/20 101/10 104/11 114/21 120/2 128/25 143/11 150/12 150/21 153/5 153/23
hit [1] 44/7
hold [2] 118/7 139/25
holding [1] 118/18
holdings [1] 35/21
Holiday [1] 22/16
Holl [3] 105/22 105/25 162/5
Holl-Allen [2] 105/25 162/5
Holywell [1] 66/15
home [7] 39/11 64/15 73/13 96/19 96/23 102/6 102/15
homes [16] 42/19 67/11 71/8 71/12 71/15 71/20 72/4 72/7 72/11 72/24 75/15 76/9 76/10 77/25 95/15 110/5
honest [1] 145/2
honestly [1] 144/18
honesty [1] 148/17
hoof [1] 55/2
hoops [1] 151/25
hope [4] 7/11 65/24 104/6 159/15
hoped [1] 91/16
Hopefully [2] 135/20 155/24
hoping [1] 66/2
hospital [10] 66/14 66/16 66/17 66/21 69/17 70/11 101/20 102/2 110/5 148/12
hospital's [1] 110/1
hospitals [5] 42/18 70/1 70/16 125/6 139/16
hosted [1] 106/18
hostile [2] 47/16 79/1
hour [2] 58/14 142/1
hours [3] 94/11 126/14 139/10
House [1] 53/17
Housekeeping [2] 40/3 161/6
how [48] 2/1 2/8 2/12 4/13 4/14 6/9 7/20 8/13 10/5 10/24 15/3 16/8 24/25 35/14 35/16 39/10 42/20 42/24 47/7 59/24 60/4 60/6 69/25 73/8 77/9 80/15 85/10 91/18 96/1 101/3 105/15 128/1 128/2 129/2 129/15 129/16 130/21 131/8 131/11 135/6 136/9 150/7 150/8 150/9 151/3 153/16 155/9 156/21
however [17] 39/2 41/24 63/5 76/15 79/8 82/5 94/13 95/20 101/15 104/20 106/6 107/21 111/2 117/5 125/24 131/14 146/21
HR [1] 152/19
Hub [1] 108/20
hubs [1] 115/19
huge [10] 39/12 45/9 55/13 55/16 55/24 107/11 150/7 158/10 158/13 160/13
hugely [1] 152/13
human [9] 55/13 60/5 78/14 83/7 86/12 86/22 87/24 135/25 149/25
hundred [2] 22/8 140/24
hundreds [2] 10/11 69/1

I

I am [3] 14/19 25/3 54/15
I appear [3] 100/5 113/12 122/12
I ask [2] 30/15 38/12
I assume [1] 154/14
I be [1] 35/2
I begin [1] 3/5
I can [4] 7/11 8/25 19/2 99/23
I can't [1] 8/24
I caught [1] 105/19
I come [1] 35/9
I contracted [1] 146/1
I could [2] 33/15 40/21
I delegated [1] 6/4
I did [1] 16/17
I didn't [2] 149/3 150/22
I do [2] 40/14 83/10
I don't [3] 20/24 26/12 35/25
I expect [1] 3/2
I feel [1] 151/20
I felt [1] 145/14
I had [1] 6/12
I have [5] 1/24 63/17 73/19 146/3 149/4
I hope [2] 7/11 159/15
I imagine [1] 36/18
I just [2] 12/20 39/6
I know [5] 39/6 89/4 159/8 159/25 160/6
I make [2] 66/11 106/1
I may [4] 31/18 82/2 87/13 97/23
I mean [20] 2/3 13/14 13/22 15/7 16/11 16/17 18/5 22/7 24/15 27/12 27/19 28/2 32/8 32/13 32/23 32/24 33/2 36/20 37/7 37/13
I mention [1] 122/21
I might [1] 10/7
I move [1] 25/22
I note [1] 153/15
I observe [1] 60/22
I ought [1] 18/14
I perhaps [1] 64/1
I personally [1] 37/25
I quote [2] 72/18 87/12
I recall [1] 18/9
I repeat [2] 155/5 160/9
I represent [1] 53/19
I said [3] 24/21 30/9 35/2
I say [2] 18/19 73/12
I shall [3] 39/22 99/16 159/9
I share [1] 149/14
I should [1] 95/9
I sit [1] 122/1
I start [1] 1/11
I stated [1] 94/19
I suggested [1] 33/2
I take [1] 20/20
I thank [1] 39/14
I think [45] 2/4 13/23 18/19 21/2 25/2 25/3 25/10 26/13 27/16 27/19 29/13 31/20 31/20 32/23 33/2 33/9 34/6 34/19 36/3 37/1 37/6 37/10 37/12 37/13 37/18 39/2 39/7 39/10 39/19 41/5 41/7 54/17 66/7 76/3 81/5 99/22 105/20 105/22 122/9 149/6 157/11 158/5 159/5 159/6 159/25
I thought [1] 38/24
I turn [2] 67/12 116/14
I understand [3] 1/12 3/11 37/13
I want [1] 89/5
I was [6] 4/4 5/25 26/4 34/25 38/19 151/21
I will [1] 127/7
I would [12] 1/15 15/20 16/20 16/22 16/23 27/16 28/6 30/24 95/6 97/23 122/1 158/2
I'd [6] 2/14 7/8 17/4 38/18 40/5 122/16
I'm [21] 13/3 17/3 18/17 18/25 19/10 19/19 24/2 28/11 28/12 38/6 66/5 68/20 83/1 89/4 151/25 155/22 159/5 159/23 160/1 160/6 160/10
I've [7] 7/7 9/1 34/20 38/4 39/20 84/11 160/10
ICU [5] 117/3 118/7 118/8 144/5 144/24
idea [1] 61/18
ideally [1] 32/3
Idelbi [4] 127/2 127/4 137/13 162/14
identification [1] 46/13
identified [10] 53/23 61/10 88/1 97/14 98/2 100/25 113/19 116/13 128/8 143/22
identify [3] 44/17 84/8 114/12
identifying [1] 98/19
ie [2] 9/5 110/11
if [84] 6/16 7/9 8/22 10/7 10/21 12/11 12/13 12/21 12/23 14/3 14/5 14/12 17/18 17/22 18/6 19/4 19/17 19/24 20/4 20/14 22/11 23/15 23/23 24/5 24/13 25/2 25/20 25/23 26/9 26/18 28/7 28/16 28/21 28/23 29/1 29/6 29/7 29/25 30/18 31/18 32/1 32/3 32/17 33/1 33/7 33/15 35/2 37/7 40/10 40/21 63/8 69/13 70/21 71/10 73/1 73/7 73/9 73/12 74/9 75/23 75/24 80/5 82/2 83/20 83/23 86/9 86/10 96/6 97/23 100/17 105/19 111/5 126/1 129/12 129/15 132/4 151/16 152/11 154/21 155/11 156/7 159/16 160/10 160/12
ignorance [1] 87/11
ignored [1] 130/19
ill [5] 1/18 2/18 2/19 76/10 137/22
ill-judged [1] 137/22
illogical [1] 143/20
illustrated [2] 15/23 103/9
illustrative [2] 14/8 14/10
imagine [3] 14/7 30/24 36/18
imagined [1] 78/18
immediately [2] 8/24 72/10
impact [19] 1/16 1/24 1/25 2/5 2/9 2/22 2/22 2/23 2/25 10/12 11/23 38/24 83/7 86/4 86/16 87/25 103/9 135/25 149/25
impacted [2] 80/15 139/13
impacting [1] 139/16
impacts [2] 74/10 145/10
imperative [1] 82/15
imperfect [1] 28/5
implementation [2] 97/23 114/8
implemented [4] 98/7 98/11 118/21 137/8
implications [2] 74/7 89/1
implicit [1] 73/15
importance [11] 77/16 77/17 77/19 77/22 105/4 109/3 110/25 114/5 116/16 130/18 130/24
important [26] 2/4 2/12 5/12 9/11 11/2 12/3 21/17 33/7 33/23 36/20 40/23 47/22 51/2 62/3 62/9 75/23 100/10 101/21 104/5 118/9 125/14 126/24 127/9 134/23 147/2 151/23
importantly [3] 51/24 124/5 150/9
imposed [1] 65/3
improve [3] 51/8 97/25 120/25
improved [3] 102/20 116/5 116/19
improvement [2] 90/8 148/1
improvements [1] 80/17
improving [1] 117/9
inability [1] 31/1
inadequacy [1] 65/2
inadequate [11] 42/3 42/6 43/2 53/3 75/14 83/8 83/18 86/19 87/8 137/20 138/16
inadequately [1] 75/17

I

inappropriately [1] 145/7
inbox [2] 16/11 16/12
inboxes [2] 133/7 133/15
inclined [1] 39/10
include [3] 131/10 131/15 139/3
included [6] 14/2 97/10 104/10 104/13 133/10 134/12
includes [6] 26/20 40/19 90/11 147/15 147/23 148/11
including [12] 4/24 19/21 44/12 91/22 94/4 98/3 105/1 105/6 122/15 124/10 131/18 156/20
inclusive [1] 88/3
inclusivity [3] 82/24 88/21 89/15
inconsequential [1] 154/24
incorporate [1] 148/6
increase [2] 12/25 45/20
increased [8] 44/4 45/8 85/11 104/4 106/9 111/14 115/16 118/17
increases [1] 13/24
increasing [2] 29/4 49/12
incredible [1] 51/17
incredibly [1] 144/21
incumbent [1] 90/22
indeed [21] 8/3 14/24 22/17 27/13 35/20 38/10 54/15 72/25 73/10 80/5 81/3 93/23 94/6 96/18 127/1 135/1 137/13 152/7 154/2 159/1 159/14
independent [8] 95/7 95/15 95/18 96/1 96/7 96/14 96/19 96/23
independently [1] 108/20
indeterminate [1] 124/6
indicate [1] 94/10
indicated [1] 104/24
indicates [2] 64/19 106/23
indication [1] 15/8
indispensable [1] 82/18
individual [5] 5/1 62/24 110/5 111/24 136/18
individuals [4] 9/20 55/6 126/16 135/24
industry [1] 63/16
ineffective [1] 85/25
inefficiencies [1] 81/15
inefficient [2] 42/6 53/4
inequalities [1] 147/7
inevitable [2] 136/11 138/2
inevitably [4] 89/25 103/19 125/21 152/5
inexplicably [1] 143/15
infected [1] 145/22
infection [5] 2/11 66/15 67/1 73/17 75/14
infections [2] 42/11 146/16
infectious [2] 128/2 144/8
infer [1] 28/11
inference [1] 27/17
inflow [2] 21/11 25/11
influence [3] 47/25 57/25 111/5
influenced [2] 45/3 75/16
influenza [3] 43/25 67/15 138/3
inform [1] 47/8
information [42] 14/23 15/9 15/18 15/25 17/6 21/8 21/9 22/18 25/8 25/10 26/15 27/14 33/13 33/19 33/22 34/13 34/13 36/22 36/23 37/9 37/25 40/9 40/11 40/24 69/23 70/2 70/10 90/3 106/15 120/16 129/17 129/19 129/22 129/25 130/9 130/15 131/12 148/2 154/17 154/18 154/22 155/2
informed [2] 17/19 17/21
informing [1] 102/6
inherited [1] 56/12
initial [4] 84/20 140/22 153/4 153/7
initially [3] 26/3 88/14 116/3
initiated [2] 36/25 110/23
initiative [1] 130/2
injury [1] 139/18
injustices [2] 81/16 81/17
innovated [1] 121/19
innovation [1] 113/20
innovations [2] 121/6 136/5
innovative [1] 126/5
input [7] 11/2 21/18 27/21 33/11 96/19 110/22 148/7
inputs [1] 9/11
INQ000339131 [1] 144/17
INQ000475014 [1] 3/7
INQ000475015 [1] 3/7
INQ000496719 [1] 12/9
INQ000503883 [1] 92/25
INQ000512396 [1] 28/21
INQ000521799 [1] 19/16
INQ000521800 [2] 17/17 40/13
INQ000560854 [1] 23/5
INQ000569902 [1] 25/23
INQ000569906 [1] 26/18
INQUIRY [83] 1/10 1/20 3/6 4/2 5/17 10/4 11/10 28/20 36/11 41/17 41/24 43/8 43/20 45/7 47/4 47/6 47/10 47/16 48/17 49/8 49/9 49/18 49/23 50/2 51/10 52/14 52/16 52/25 54/5 62/10 65/25 71/8 73/12 74/2 74/4 77/4 78/23 79/6 79/7 80/6 81/12 82/16 82/22 89/6 90/19 91/11 91/13 99/11 100/19 100/22 101/10 102/9 103/10 104/6 104/8 114/11 119/11 122/3 122/7 122/23 129/1 133/12 133/18 140/18 143/7 146/7 149/17 150/5 150/21 151/19 152/8 153/22 155/15 156/17 157/13 157/21 158/4 158/5 158/11 158/23 160/4 160/11 161/3
Inquiry's [3] 40/18 77/14 147/6
ins [1] 2/17
insight [1] 103/14
insights [3] 88/21 90/1 90/21
insist [1] 54/11
instance [4] 11/4 18/10 85/21 102/5
instances [2] 85/24 95/18
instead [5] 46/18 47/10 123/20 143/12 149/21
institutions [1] 2/10
instructed [2] 36/5 113/14
instruction [1] 110/15
insufficient [5] 43/22 55/1 59/17 60/19 63/23
insurance [4] 22/4 125/25 125/25 126/2
integrate [1] 90/10
integrated [2] 77/22 106/17
integrity [2] 85/17 92/9
intelligence [2] 70/3 103/14
intend [1] 83/10
intended [2] 106/23 129/12
intensive [1] 73/23
intention [1] 49/10
inter [1] 92/23
interchangeable [2] 18/2 18/5
interest [7] 60/17 60/18 61/12 65/1 77/21 116/12 158/3
interesting [1] 21/18
interim [1] 96/3
intermediaries [2] 45/15 45/21
internal [2] 63/21 110/4
internally [1] 64/8
international [2] 111/4 123/13
internationally [1] 60/1
interpretation [1] 55/11
interrupt [2] 5/5 24/1
intertwined [1] 127/20
intervention [2] 37/10 37/22
into [43] 11/3 11/13 14/15 16/8 21/24 22/10 23/23 25/9 26/21 27/21 28/23 32/11 33/11 35/20 37/4 40/17 45/14 45/16 51/14 53/20 55/5 56/24 57/16 62/4 63/7 69/20 71/3 76/6 81/13 83/21 84/20 86/13 90/10 97/15 103/7 106/17 107/9 108/8 121/21 122/3 127/8 130/6 154/11
introduced [3] 34/7 72/3 125/6
introduction [1] 125/7
invention [1] 58/2
inventory [10] 54/24 73/4 116/19 117/9 120/2 125/8 139/19 148/3 153/10 158/7
investigate [2] 49/19 157/15
investigation [2] 41/1 94/12
investigations [1] 47/2
investment [2] 131/16 152/19
invidious [1] 62/3
invite [1] 137/2
inviting [1] 44/19
involved [9] 7/5 49/20 52/19 96/22 99/1 99/5 122/4 150/16 154/17
involvement [5] 48/2 87/19 89/20 93/23 94/3
involving [1] 131/9
IPC [10] 70/5 73/21 73/25 74/9 109/18 144/2 144/3 145/6 146/10 148/18
IPC guidance [1] 70/5
Ireland [25] 54/18 56/1 60/14 61/10 62/13 63/1 63/11 63/13 63/18 64/9 64/19 65/23 91/7 91/10 91/18 91/24 92/20 93/10 95/9 97/7 98/12 99/2 99/3 161/11 161/25
Ireland's [1] 95/10
Irish [1] 62/18
irrational [1] 143/13
irrespective [3] 29/3 84/16 90/25
Irvine [5] 68/3 68/17 69/10 72/18 73/6
is [261]
is INQ000521800 [1] 40/13
islands [1] 63/14
isn't [2] 5/21 7/17
isolation [1] 94/10
issue [16] 62/5 64/16 65/10 71/17 71/17 72/13 74/2 74/3 87/11 94/8 95/6 102/13 109/2 119/1 119/11

I

issue... [1] 119/16
issued [2] 12/11 149/21
issues [26] 6/12 8/22 22/13 59/15 59/16 60/16 60/16 62/12 63/18 70/11 74/9 86/24 88/8 89/12 93/2 95/3 95/23 99/9 100/10 114/3 116/1 116/14 118/23 135/21 146/17 158/9
it [270]
it cannot [1] 54/8
it's [43] 1/19 1/20 5/21 7/16 7/18 7/22 13/25 22/7 22/22 24/19 25/2 25/5 25/6 28/19 28/21 29/22 32/3 33/12 36/7 37/3 37/20 37/23 38/2 47/22 52/23 63/8 65/18 81/11 82/15 84/3 84/8 85/15 85/16 86/15 86/21 89/6 90/22 91/16 155/22 157/15 157/18 158/14 159/11
item [5] 26/9 26/10 29/3 30/17 30/17
items [17] 15/5 17/8 20/23 24/6 29/8 32/21 40/19 60/11 91/22 96/7 108/14 124/7 138/8 140/2 147/16 150/10 156/25
its [53] 2/16 10/10 21/18 33/9 43/8 47/11 49/14 53/25 54/5 61/1 63/13 64/12 66/14 74/17 88/23 90/19 92/8 95/5 96/5 97/10 98/15 98/25 102/16 103/5 103/15 106/20 106/21 106/23 106/24 107/23 110/8 110/14 112/24 112/25 112/25 114/12 115/2 119/6 119/7 121/2 121/23 122/24 123/7 123/16 124/23 125/1 126/17 129/20 131/5 147/17 153/17 154/5 156/13
itself [9] 4/12 4/16 8/3 11/5 68/6 80/6 87/12 92/4 109/14

J

Jackson [1] 151/17
James [1] 50/19
January [2] 78/3 142/12
January 2020 [1] 78/3
job [7] 2/9 2/12 36/12 36/16 89/22 146/6 158/15
joined [2] 3/12 34/9
joined-up [1] 34/9
joining [1] 93/1
joint [11] 63/10 72/14 72/19 72/20 73/2 73/9 102/10 102/14 110/3 110/11 119/12
jointly [1] 9/14
Jon [1] 23/2
Jonathan [3] 35/10 89/21 142/19
Jones [1] 143/11
JS [1] 83/15
judged [1] 137/22
judgement [8] 7/20 8/10 9/12 11/7 11/19 31/12 32/4 34/20
judgements [1] 8/14
July [1] 133/16
July 2020 [1] 133/16
jump [1] 46/19
jumping [1] 151/25
juncture [2] 81/10 92/11
June [4] 34/24 78/4 123/24 144/22
June 2022 [1] 78/4
junior [1] 113/13
jurisdiction [1] 65/2
jurisdictions [2] 61/15 64/22
just [82] 1/15 2/14 3/25 5/7 5/20 6/6 9/20 10/8 11/8 11/10 12/20 12/22 13/4 13/15 13/22 14/19 14/22 14/22 16/11 16/12 17/5 17/8 17/12 17/15 17/19 17/21 17/25 18/15 19/8 19/19 20/9 25/5 27/2 27/2 27/8 28/19 29/15 30/5 33/9 35/5 36/19 37/23 38/24 39/6 40/7 43/2 48/2 49/4 53/12 55/20 55/23 61/2 62/18 63/11 65/18 65/24 66/21 68/2 68/11 70/7 70/13 75/5 81/15 84/10 84/17 85/15 88/23 89/7 91/13 117/12 123/11 124/7 125/15 138/1 138/18 140/8 140/20 141/14 147/22 149/24 159/8 159/12
justice [13] 41/9 41/12 54/19 66/9 66/12 68/23 74/16 75/9 80/8 92/20 161/9 161/12 161/16
Justice Cymru [3] 66/12 68/23 75/9
Justice Cymru's [1] 74/16
Justice UK [1] 41/12
justifiably [1] 60/14
justification [1] 56/14

K

Karen [2] 56/21 92/19
KC [18] 36/4 41/9 54/19 76/5 81/9 91/7 105/25 113/10 122/11 161/4 161/9 161/13 161/19 161/23 161/25 162/5 162/8 162/11
keen [1] 51/4
keep [2] 121/24 134/23
keeping [1] 145/19
kept [1] 67/18
key [22] 71/17 72/13 74/19 75/21 83/9 91/19 97/24 98/3 98/20 104/19 106/11 118/6 118/21 123/10 123/20 123/21 124/24 129/16 138/22 141/22 147/19 150/6
keys [1] 149/11
keystones [1] 113/17
kind [5] 3/7 14/9 34/16 37/5 151/10
kindness [1] 82/5
Kingdom [5] 107/13 109/10 127/3 127/6 162/13
kits [1] 5/1
knew [4] 142/12 144/25 151/13 151/14
knitted [1] 57/16
knock [1] 89/25
know [30] 10/20 14/13 16/13 18/23 19/2 26/12 27/8 28/1 28/6 31/22 33/21 33/24 35/16 38/3 39/6 45/13 57/18 68/8 70/13 72/13 72/16 89/4 129/2 129/15 131/11 134/23 155/23 159/8 159/25 160/6
knowing [4] 20/19 69/25 127/25 140/6
knowledge [3] 3/8 13/16 121/10
known [5] 47/18 52/23 139/21 143/20 146/20

L

lab [1] 4/25
Laboratory [1] 109/24
labour [2] 60/4 60/5
lack [28] 42/22 43/23 44/6 44/13 45/10 51/15 63/21 64/5 65/1 65/12 67/9 85/22 90/4 95/19 110/10 118/24 137/21 138/14 139/19 140/5 140/22 141/12 142/5 145/21 146/2 147/8 153/10 158/6
lacked [2] 58/16 90/2
lacking [2] 71/13 142/13
lady [97] 1/6 24/4 24/6 38/7 40/4 40/15 40/25 41/4 41/10 41/11 43/2 43/18 44/5 45/23 46/12 50/5 50/22 51/3 53/6 53/19 54/5 54/20 55/25 57/23 58/6 59/10 60/22 63/5 63/20 65/7 65/16 66/10 69/5 69/21 70/14 73/9 73/12 74/15 75/5 75/19 75/25 76/6 81/10 82/2 83/1 88/25 89/4 90/9 90/19 91/2 91/8 91/9 91/11 92/3 92/17 92/21 93/7 94/1 94/5 94/19 95/1 97/2 97/13 98/12 98/24 99/8 99/23 100/1 100/5 104/6 105/13 106/1 113/4 113/7 113/11 121/16 122/1 122/6 122/12 124/10 126/6 126/25 127/20 129/21 130/18 132/17 134/8 135/7 137/11 137/17 137/18 147/11 148/23 149/9 155/24 158/25 159/6
Lady's [1] 80/20
Ladyship [12] 127/5 127/23 128/8 128/15 129/18 131/2 132/19 132/19 132/22 135/11 135/20 136/20
Ladyship's [2] 128/20 136/25
Lamb [4] 117/3 118/15 118/21 119/8
landed [1] 10/1
lane [43] 46/18 46/24 48/11 49/3 49/14 49/21 50/5 50/14 50/16 50/21 50/23 50/25 51/11 51/20 51/22 52/8 52/24 54/9 56/6 58/6 58/12 59/13 60/19 61/17 61/23 79/19 80/3 80/12 87/18 87/20 108/13 123/19 133/5 141/15 148/21 151/16 152/8 152/20 155/15 156/11 157/14 157/16 157/23
language [2] 21/2 47/17
lapses [1] 82/24
laptops [1] 55/7
large [9] 32/11 46/15 57/12 58/3 125/22 131/9 138/8 145/21 153/3
large-scale [1] 58/3
largely [1] 68/9
larger [4] 45/12 138/22 147/15 153/17
largest [1] 133/13
last [8] 15/11 65/17 135/18 138/21 143/7 148/24 149/6 149/12
lasting [1] 90/24
lastly [2] 74/15 158/11
late [9] 10/10 14/11 24/17 34/24 63/13 63/15 102/5 140/7 154/13
later [11] 1/7 12/5 35/7 52/19 72/1 73/21 96/10 155/5 155/6 155/11 155/23
lateral [2] 34/25 133/24
latter [1] 37/3
law [2] 84/24 154/14
laws [1] 85/15
Lawson [5] 9/8 9/13 9/17 35/11 87/24
Lawson's [1] 88/9
lay [1] 73/16
layman [1] 18/17
layman's [1] 18/15
lead [3] 23/1 52/3 58/4
leadership [4] 4/4 4/18 46/2 156/22
leading [4] 61/17 70/5 135/18 140/10
leads [3] 52/6 56/24 101/11
learn [2] 61/2 61/4
learned [12] 63/22 63/23 74/10 90/10 97/20 98/20 100/13 105/8 114/7 118/22 121/20 149/12
learning [13] 35/15 52/17 52/22 59/15 63/21 90/8 97/14

L

learning... [6] 97/22 98/2 98/16 99/9 141/23 160/12
learns [1] 84/13
learnt [3] 71/6 76/1 80/16
least [6] 34/3 38/20 57/10 59/18 120/17 149/6
leaving [2] 84/6 136/18
led [10] 44/17 79/7 85/24 100/20 102/17 114/15 124/2 140/23 144/21 158/8
left [5] 12/14 38/18 55/17 73/5 140/24
legacy [1] 55/17
legal [7] 44/11 46/25 52/15 82/12 84/4 113/15 122/5
legitimate [6] 37/6 46/6 46/14 58/25 76/14 93/18
legs [1] 19/3
length [2] 98/15 106/4
less [8] 18/2 52/6 54/14 93/11 112/1 117/2 152/24 158/21
lesson [4] 52/22 101/21 105/7 118/21
lesson learning [1] 52/22
lessons [20] 34/2 59/15 63/22 63/23 71/6 74/10 76/1 90/10 90/23 97/20 98/20 100/13 101/6 104/11 114/7 114/8 121/20 127/16 127/17 160/12
let [11] 10/8 36/19 47/14 84/19 85/1 89/6 90/20 139/21 145/1 154/9 156/17
Let's [1] 17/2
letter [1] 119/12
level [27] 10/9 11/3 11/25 12/1 19/8 21/10 21/14 22/2 22/4 22/17 22/22 23/2 35/22 55/4 69/5 69/15 69/24 71/25 74/13 100/18 108/7 109/14 109/18 115/1 116/21 118/18 124/20
levels [11] 11/14 11/22 30/25 46/25 83/3 110/17 110/20 116/25 125/1 125/3 125/5
Liam [2] 94/15 94/22
Liam McIvor's [1] 94/22
life [6] 2/20 42/22 64/25 108/19 140/4 145/14
life-saving [2] 42/22 140/4
light [3] 85/20 87/15 89/10
like [34] 1/15 2/14 13/15 16/8 17/5 17/24 18/25 20/14 21/10 24/19 24/19 26/11 27/4 27/7 32/1 42/23 61/10 70/9 71/9 89/20 91/5 92/16 93/13 95/4 95/6 98/24 122/1 122/16 125/25 126/16 149/14 149/24 151/20 156/25
liked [2] 32/3 69/10
likely [5] 48/9 49/7 87/7 87/7 151/15
limit [1] 20/13
limitations [1] 33/1
limited [8] 50/9 50/10 97/4 111/5 119/4 139/5 143/15 144/4
line [7] 2/3 13/10 21/4 78/18 80/22 115/25 130/11
lines [4] 81/20 124/6 131/10 146/25
lingerie [1] 152/17
linked [1] 130/16
links [3] 128/19 138/24 147/23
Lisa [1] 142/19
list [5] 40/21 59/16 60/16 97/22 108/13
listen [1] 61/3
listened [1] 100/7
Listening [1] 150/22
lists [1] 154/25
Lithuania [1] 156/7
little [7] 1/6 7/11 69/14 71/11 74/21 83/4 120/16
lived [2] 41/18 41/25
lives [17] 39/13 41/15 78/21 82/13 84/2 126/22 145/12 145/12 145/25 147/4 148/10 150/10 152/12 153/1 154/21 155/12 160/13
living [2] 145/11 150/2
local [36] 35/22 42/14 62/2 66/23 69/15 69/17 69/24 71/23 72/16 72/21 73/2 73/13 90/2 98/13 100/16 101/5 101/12 101/13 101/18 101/22 101/23 102/4 102/7 102/14 102/24 103/7 103/12 103/20 103/23 103/24 107/25 110/2 110/18 110/19 115/19 125/4
localised [2] 115/19 139/9
locate [1] 45/17
located [1] 92/24
locations [2] 110/11 117/5
lockdown [5] 2/19 2/24 10/12 10/15 140/21
logistical [1] 99/3
logistics [4] 29/12 33/4 69/3 69/20
London [3] 56/18 57/6 149/16
long [6] 69/16 126/14 145/23 146/3 146/11 153/6
Long Covid [2] 145/23 146/3
longer [3] 24/16 27/15 153/17
longstanding [1] 115/2
look [31] 4/4 6/11 8/11 10/10 11/21 12/8 12/13 12/20 12/22 13/6 13/15 13/16 14/15 14/18 16/7 17/2 19/16 19/24 20/19 21/8 22/25 26/11 26/17 27/19 32/17 32/23 37/4 59/23 61/5 80/20 158/17
looked [4] 1/24 9/13 28/19 63/24
looking [18] 12/14 12/18 12/23 13/11 16/16 22/23 24/13 27/14 31/7 33/1 34/22 47/7 84/12 116/15 118/9 118/23 128/5 131/5
looks [2] 27/3 27/7
looney [1] 151/20
lord [22] 43/14 44/7 44/21 47/17 48/1 48/14 48/15 48/16 48/18 48/20 49/10 50/15 51/3 53/21 53/22 55/15 58/22 87/19 139/14 150/24 153/5 153/9
Lord Agnew [9] 43/14 44/7 47/17 53/21 58/22 139/14 150/24 153/5 153/9
Lord Agnew's [1] 55/15
Lord Bethell [2] 44/21 53/22
Lord Chadlington [3] 48/1 48/18 49/10
Lord Deighton [1] 50/15
Lord Feldman [1] 48/14
Lords [1] 53/17
lose [1] 146/5
loss [4] 59/2 64/23 64/25 64/25
losses [1] 78/20
lost [2] 46/25 86/19
Losty [2] 62/15 62/21
lot [6] 6/12 14/11 24/18 83/10 103/13 152/25
love [1] 146/6
loved [4] 42/18 86/19 136/2 145/13
low [3] 30/25 118/10 138/1
lower [2] 19/4 83/3
lowest [1] 60/11
luck [2] 62/18 73/11
ludicrous [3] 138/18 154/12 154/16
lunch [4] 81/6 91/5 99/16 105/21

M

M2 [1] 159/21
M3 [1] 159/21
M4 [1] 159/22
M5 [2] 159/15 159/22
machines [1] 139/9
macro [2] 10/8 10/16
made [23] 3/19 8/14 14/22 20/16 23/3 28/7 32/16 33/13 36/14 46/15 46/16 49/5 52/2 59/23 80/17 88/11 95/20 96/9 99/1 105/9 128/18 141/4 151/16
magnification [1] 82/20
magnitude [1] 153/12
Mah [1] 113/13
mailbox [1] 98/21
maintain [2] 132/25 134/23
maintained [6] 46/9 49/18 125/16 138/8 138/17 147/17
maintaining [3] 2/11 125/22 125/22
maintenance [1] 125/24
majority [4] 3/14 7/3 28/6 111/19
make [33] 6/8 7/22 7/24 8/7 11/8 14/19 15/3 20/6 20/16 30/2 31/6 31/10 31/12 33/7 34/2 41/20 43/11 45/21 47/4 54/10 58/15 66/11 76/23 91/9 94/5 106/1 128/23 129/11 129/17 129/19 149/10 157/3 157/22
makers [6] 90/2 137/10 142/12 142/24 145/2 148/2
makes [2] 62/10 130/6
making [27] 1/22 3/1 8/6 8/21 10/18 11/3 11/19 16/2 16/8 27/21 28/4 33/11 33/18 46/3 49/15 54/9 58/9 62/16 64/12 77/11 89/21 122/18 127/9 129/22 132/17 142/3 158/6
malpractice [1] 85/5
manage [4] 34/10 36/9 123/25 141/10
managed [3] 108/19 118/13 142/22
management [24] 37/6 54/24 69/11 70/20 72/2 73/4 91/15 98/3 98/4 101/23 104/1 105/1 105/1 116/19 117/7 125/8 135/16 135/17 141/5 144/15 148/3 152/19 153/10 158/7
managing [11] 4/14 7/10 7/13 7/24 8/3 8/7 9/24 15/15 44/19 69/8 141/6
mandates [1] 82/13
mandatory [1] 137/5
manner [2] 79/1 98/8
Manners [3] 119/25 120/20 132/24
Manners-Bell [1] 132/24
manual [1] 37/10
manufactured [1] 115/8
manufacturers [5] 45/11 45/17 115/7 138/25 147/23
manufacturing [7] 49/1 60/2 117/18 125/23 138/24 139/6 147/24
many [34] 15/22 42/25 47/23 55/24 56/3 57/13 65/21 66/25 67/2 67/2 67/4 71/14 74/9 76/7 76/16 76/20 77/13 81/23

M

many... [16] 82/4 83/21 89/16 113/2 114/3 114/8 121/20 123/6 123/8 142/1 142/15 146/13 150/12 150/18 151/11 153/6
March [24] 1/1 3/19 10/10 13/9 14/12 24/17 38/12 66/18 67/24 68/4 71/18 73/20 73/21 96/11 98/14 100/20 102/19 115/12 116/23 133/21 140/7 140/20 144/3 144/9
March 2020 [6] 3/19 38/12 73/20 102/19 115/12 133/21
March 2022 [1] 98/14
margins [1] 81/18
market [16] 10/23 14/9 15/16 19/17 23/17 25/15 29/2 32/1 45/16 107/8 111/4 120/6 131/23 134/18 134/20 134/23
marketplace [1] 154/20
markets [1] 136/5
Marron [5] 9/7 9/14 16/1 35/10 89/21
Marron's [1] 51/21
mask [6] 69/16 70/8 87/13 87/14 144/11 147/3
masks [13] 57/3 67/22 67/22 68/2 68/11 73/18 73/22 75/16 107/12 107/13 111/7 142/16 145/8
mass [1] 67/10
massive [2] 45/21 158/8
master [1] 62/17
matched [1] 121/10
material [8] 23/11 25/13 40/17 40/19 40/23 47/2 49/7 160/2
materially [2] 10/24 120/25
materials [2] 92/1 109/23
mates [1] 58/25
Matt [4] 150/11 151/23 153/15 154/10
Matt Hancock [4] 150/11 151/23 153/15 154/10
matter [9] 17/24 36/7 40/16 53/7 68/21 93/25 94/11 123/2 145/15
mattered [2] 27/22 151/13
matters [7] 40/5 50/12 53/7 53/7 74/12 103/15 125/14
Matthews [1] 91/14
Matthias [2] 50/25 151/17
Matthias-Jackson [1] 151/17
Max [1] 87/10
maximum [4] 26/1 26/24 92/14 131/24
may [49] 12/11 12/11 12/19 13/1 13/9 13/14 14/12 14/14 16/7 17/14 20/15 21/24 21/25 22/21 25/20 27/2 31/18 34/24 39/14 41/3 42/23 56/12 61/9 63/7 64/1 64/11 65/6 68/3 69/10 70/24 70/25 71/21 78/19 79/8 82/2 87/13 92/17 97/23 102/19 105/20 119/13 128/3 128/14 131/16 132/3 132/13 141/4 160/9 160/17
May 2020 [1] 71/21
maybe [2] 113/6 157/1
McCue [1] 113/14
McIvor [1] 94/15
McIvor's [1] 94/22
me [29] 2/12 6/4 6/15 6/17 6/19 6/20 6/21 8/19 8/23 8/24 10/8 19/25 21/20 21/23 23/15 31/6 34/22 36/19 37/17 37/17 39/4 39/6 84/19 89/6 97/21 113/5 132/15 154/9 156/17
mean [23] 2/3 13/14 13/22 15/7 16/11 16/17 18/5 18/7 22/7 24/15 27/12 27/19 28/2 32/8 32/13 32/23 32/24 33/2 36/20 37/7 37/13 60/21 101/19
meaningful [1] 153/21
meaningless [1] 153/18
meanings [1] 61/15
means [7] 53/8 94/4 115/24 128/11 130/12 142/14 159/20
meant [12] 6/22 42/9 42/17 44/6 45/12 79/20 81/21 139/9 139/20 143/24 144/9 145/17
meantime [1] 136/25
measure [4] 78/20 104/21 142/8 143/25
measured [3] 64/25 65/18 78/21
measures [2] 86/19 128/7
mechanism [4] 114/22 118/24 119/19 153/1
mechanisms [2] 98/5 104/18
medical [9] 78/5 80/24 117/6 117/8 137/8 137/15 153/19 153/24 162/16
Medpro [1] 48/2
meet [8] 60/7 76/24 91/24 109/15 120/5 123/15 131/25 134/15
meeting [2] 31/23 142/10
meetings [1] 101/12
Meller [1] 40/20
member [1] 4/4
members [18] 2/10 2/18 37/15 42/12 42/14 53/16 53/17 71/2 74/17 74/25 75/2 75/8 83/16 83/19 83/21 86/16 87/10 123/7
membership [2] 106/21 131/17
memories [1] 160/11
memory [1] 158/20
mental [1] 2/24
mention [4] 19/23 122/21 124/20 128/22
mentioned [2] 73/19 118/24
mere [1] 83/25
merely [4] 64/6 84/8 85/3 88/25
message [1] 96/10
messaging [2] 96/1 96/5
met [5] 71/22 76/23 92/8 117/22 132/9
Michael [1] 87/19
microbiology [2] 135/12 135/14
microphone [2] 113/3 149/2
mid [2] 31/20 95/22
mid-April [1] 31/20
mid-April 2020 [1] 95/22
middle [2] 133/2 133/3
midst [1] 129/4
might [14] 7/8 10/7 10/14 11/1 11/9 14/7 25/15 59/22 61/13 63/3 73/14 128/1 128/2 160/8
Miles [1] 66/15
military [4] 48/23 110/6 110/22 151/2
million [11] 5/23 5/24 6/5 6/13 7/3 22/8 49/2 49/4 49/5 68/13 141/8
mind [10] 8/16 17/13 19/2 27/11 30/22 55/20 83/12 128/17 136/25 154/16
mindful [1] 82/3
minimum [2] 26/1 26/23
Minister [4] 44/24 92/23 98/2 151/24
ministerial [3] 61/19 131/13 141/17
ministers [12] 37/5 48/4 48/7 53/16 61/24 113/9 116/12 118/4 119/13 131/11 157/24 162/7
Ministry [3] 3/13 3/23 38/18
minority [8] 81/9 81/19 83/4 87/4 88/7 105/6 146/18 161/22
minutes [2] 142/11 155/8
misapprehension [1] 93/7
mismanagement [1] 85/4
mission [1] 152/16
mission-critical [1] 152/16
missteps [1] 53/13
mistake [2] 55/20 55/21
mistakes [3] 55/21 61/1 84/14
misunderstand [1] 159/12
misunderstood [1] 38/23
Mitchell [14] 36/3 36/4 38/10 76/3 76/5 81/3 87/23 88/1 113/6 113/10 122/8 161/4 161/19 162/8
mitigate [2] 60/4 158/3
mitigated [1] 138/2
mitigations [1] 138/22
mobile [1] 55/8
MoD [1] 38/13
modelled [1] 43/25
modelling [6] 35/13 65/7 98/4 120/12 124/2 143/18
modern [2] 60/5 157/4
module [61] 1/25 9/21 41/13 49/18 56/3 58/17 58/18 59/7 59/12 59/16 60/17 60/24 62/10 64/7 65/11 65/25 67/13 74/1 74/17 76/7 76/14 77/18 80/11 81/23 82/2 83/2 83/7 94/2 99/10 100/10 101/16 101/17 104/6 105/13 113/22 121/17 122/3 122/15 125/13 127/18 128/9 128/15 129/18 129/20 129/24 135/1 135/1 135/3 135/8 135/21 143/11 146/7 147/6 148/24 149/17 150/12 150/22 159/4 159/24 160/1 160/19
Module 1 [3] 83/2 128/9 147/6
Module 3 [4] 83/7 101/17 143/11 146/7
Module 4 [3] 129/18 135/1 135/8
Module 5 [4] 80/11 100/10 129/24 160/19
Module 7 [1] 129/20
modules [5] 56/5 56/13 77/14 127/17 159/25
Moldova [1] 156/7
moment [7] 9/20 17/13 25/16 28/16 30/5 32/5 62/24
moments [1] 78/15
Mone [1] 48/2
money [27] 7/10 7/13 7/15 7/24 8/3 8/8 9/22 9/25 10/2 10/13 10/15 10/17 15/4 33/16 42/5 53/2 53/9 79/13 80/22 92/13 129/2 129/16 130/21 150/8 152/25 153/17 158/14
monitor [2] 34/11 120/6
monitoring [1] 69/6
month [4] 15/2 83/13 100/8 116/4
months [8] 103/21 137/21 138/21 140/5 141/3 142/15 143/15 146/5
Moonesinghe [3] 42/21 43/20 139/12
moral [1] 139/18
more [83] 3/2 7/8 7/8 7/9 10/21 12/3 15/15 18/2 18/11 18/23 18/25 21/8 26/11 26/15 27/17 30/12

M

more... [67] 32/3 32/19 32/22 33/12 34/21 36/16 37/19 37/25 38/1 44/22 44/25 47/17 50/24 53/12 55/9 56/4 56/4 56/4 57/10 62/21 63/2 64/20 70/14 72/7 72/19 72/21 73/1 80/13 85/14 87/7 87/7 95/1 98/8 98/18 103/14 103/25 104/2 104/20 104/25 107/17 108/3 111/23 119/20 119/21 129/17 129/23 130/10 135/1 136/14 138/1 138/23 143/8 144/24 146/25 150/8 150/9 151/13 151/15 152/21 152/22 152/25 153/14 153/16 157/16 159/18 160/1 160/8
Moreover [2] 86/3 96/13
morning [7] 1/5 1/6 5/8 55/7 92/6 93/4 97/20
Morris [4] 41/7 41/9 54/15 161/9
Mortimer [2] 42/12 143/6
most [22] 15/23 22/25 24/24 33/7 33/23 51/24 55/11 58/11 64/14 64/17 67/25 70/19 76/17 79/13 81/14 82/20 87/16 88/16 126/18 148/3 159/25 160/1
mostly [1] 123/21
motivated [3] 45/25 53/21 79/4
motives [2] 45/24 135/24
move [7] 25/22 41/5 63/7 82/15 89/4 102/17 102/19
moved [1] 45/16
movement [2] 18/11 19/8
moves [2] 90/19 136/18
moving [3] 107/7 140/5 149/15
MP [1] 51/3
MPs [1] 154/15
Mr [101] 1/5 1/7 1/9 1/11 1/14 3/4 5/18 5/19 5/23 5/23 6/3 6/3 6/7 6/7 7/4 7/4 7/11 7/16 9/7 9/14 11/6 11/6 14/24 14/25 16/1 16/9 16/9 23/7 23/25 35/25 36/2 38/11 39/18 39/19 40/2 44/23 44/24 45/7 47/16 47/19 49/9 50/19 51/10 51/21 52/9 52/9 53/22 61/16 62/21 68/3 68/17 69/10 69/21 70/4 70/9 72/4 72/8 72/18 73/6 78/22 78/25 79/2 79/5 81/5 81/7 91/3 94/15 99/22 100/4 100/22 101/10 102/5 102/8 103/1 103/9 104/24 105/17 105/18 105/22 105/25 112/10 113/6 113/10 114/23 116/3 117/20 122/8 137/14 137/16 143/6 149/5 149/6 149/8 159/1 159/5 161/2 162/2 162/5 162/8 162/17 162/20
Mr Beattie [1] 117/20
Mr Brace [7] 70/4 72/8 100/22 101/10 102/5 102/8 103/1
Mr Brace's [2] 103/9 112/10
Mr Byrne [2] 99/22 105/18
Mr Cackette [2] 114/23 116/3
Mr Fundrey [8] 5/19 5/23 6/3 6/7 7/4 11/6 14/24 16/9
Mr Gove [6] 44/23 47/19 52/9 53/22 61/16 78/22
Mr Gove's [1] 79/2
Mr Hancock [3] 44/24 47/16 52/9
Mr Hancock's [2] 78/25 79/5
Mr Hayman [2] 149/6 159/1
Mr Holl-Allen [1] 105/22
Mr Irvine [5] 68/3 68/17 69/10 72/18 73/6
Mr James [1] 50/19
Mr Liam McIvor [1] 94/15
Mr Losty [1] 62/21
Mr Marron [3] 9/7 9/14 16/1
Mr Marron's [1] 51/21
Mr Mitchell [2] 113/6 122/8
Mr Mortimer [1] 143/6
Mr Rhys [1] 45/7
Mr Sharma [5] 1/5 1/14 23/25 36/2 39/19
Mr Slade [4] 69/21 70/9 72/4 104/24
Mr Stanton [2] 137/14 149/5
Mr Sumner [1] 49/9
Mr Thomas [3] 81/5 81/7 91/3
Mr Wald [2] 40/2 159/5
Mr Wales [1] 105/17
Mr Williams [5] 1/11 3/4 35/25 38/11 39/18
Mr Williams's [1] 1/7
Mr Young [12] 5/18 5/23 6/3 6/7 7/4 7/11 7/16 11/6 14/25 16/9 23/7 51/10
Ms [50] 36/3 38/10 41/7 41/9 50/25 54/15 54/17 54/19 61/21 62/1 66/5 66/7 66/9 76/2 76/3 81/3 81/6 91/5 91/7 92/19 92/21 94/15 99/15 105/20 114/4 115/1 115/21 115/24 116/17 117/3 118/13 118/15 118/21 119/8 121/13 122/9 122/11 127/1 127/2 127/4 135/8 135/11 137/13 146/10 161/9 161/13 161/16 161/25 162/11 162/14
Ms Bailey [1] 92/21
Ms Bailey's [1] 94/15
Ms Campbell [1] 66/5
Ms Collins [1] 135/11
Ms Collins' [1] 135/8
Ms Doherty [2] 122/9 127/1
MS DOHERTY KC [2] 122/11 162/11
Ms Freeman [9] 61/21 62/1 114/4 115/1 115/21 115/24 116/17 118/13 121/13
Ms Idelbi [2] 127/2 137/13
Ms Karen [1] 92/19
Ms Lamb [4] 117/3 118/15 118/21 119/8
Ms Matthias [1] 50/25
Ms Mitchell [4] 36/3 38/10 76/3 81/3
Ms Morris [4] 41/7 41/9 54/15 161/9
Ms Murnaghan [4] 81/6 91/5 99/15 105/20
Ms Parsons [2] 66/7 76/2
Ms Ritchie [1] 146/10
much [36] 3/4 5/5 22/11 35/5 35/25 37/17 38/10 51/12 54/15 66/5 69/25 73/8 74/20 75/6 81/3 89/22 91/3 93/11 98/18 99/14 105/18 111/23 111/25 127/1 137/13 143/8 147/15 149/9 151/13 155/10 156/14 158/16 158/25 159/1 159/14 160/16
multi [1] 22/8
multi-hundred-million [1] 22/8
multimillion [1] 62/25
multimillion-pound [1] 62/25
multiphased [1] 134/2
multiple [1] 138/13
Murnaghan [6] 81/6 91/5 91/7 99/15 105/20 161/25
must [18] 46/12 48/16 65/2 66/1 67/8 70/18 72/9 80/8 86/20 105/8 105/9 121/4 128/7 130/1 133/2 134/16 148/8 160/11
muted [3] 113/3 113/7 149/2
mutual [6] 62/8 104/13 107/16 120/15 124/16 160/12
my [123] 1/6 1/21 4/6 4/10 7/7 16/10 16/11 16/12 19/2 24/4 24/6 24/21 34/16 35/10 36/13 37/12 38/5 38/7 40/4 40/15 40/25 41/4 41/10 41/11 41/11 43/2 43/18 44/5 45/23 46/12 50/5 50/22 53/6 53/19 54/5 54/20 55/25 57/23 58/6 59/10 60/22 63/5 63/20 65/7 65/16 66/10 66/20 69/5 69/21 70/14 73/9 73/12 74/15 75/5 75/19 75/25 76/6 81/10 82/2 83/1 88/25 89/4 89/5 90/9 90/19 91/2 91/8 91/9 91/11 92/3 92/17 92/21 93/7 94/1 94/5 94/19 95/1 97/2 97/13 98/12 98/24 99/8 99/23 100/1 100/5 104/6 105/13 106/1 113/4 113/7 113/11 121/16 122/1 122/6 122/12 124/10 126/6 126/9 126/25 127/20 129/21 130/18 132/17 134/8 135/7 137/11 137/17 137/18 145/14 145/14 145/15 146/2 146/5 147/11 148/23 149/9 150/15 154/16 155/24 157/9 158/25 159/6 160/4
my Lady [33] 40/25 46/12 50/22 57/23 60/22 63/20 69/5 69/21 70/14 75/5 75/25 82/2 90/9 90/19 92/3 94/1 94/5 94/19 95/1 97/2 97/13 98/12 98/24 99/8 104/6 105/13 113/4 122/1 122/6 124/10 126/6 135/7 137/18
myself [1] 149/3

N

naive [3] 47/15 56/7 150/13
name [1] 106/23
named [1] 133/15
names [1] 133/7
narrative [1] 74/24
narratives [1] 58/23
narrow [1] 147/8
nation [1] 144/3
national [27] 12/1 35/22 69/5 78/16 100/18 109/14 110/8 117/6 117/8 122/10 122/13 122/21 122/24 123/2 123/5 123/13 124/3 124/5 124/11 124/23 124/24 125/2 125/3 125/7 126/6 126/10 162/10
nationally [2] 43/24 110/8
nations [14] 56/17 64/21 68/1 105/4 105/15 119/24 120/9 120/10 120/18 120/22 121/3 122/23 124/15 126/4
nature [11] 28/8 50/8 52/3 67/20 78/14 88/10 98/9 102/24 109/17 118/16 144/19
navigate [1] 50/17
nearly [1] 141/8
necessarily [4] 24/19 72/21 101/19 130/1

N

necessary [12] 22/7 50/4 56/7 56/16 56/20 58/16 67/5 78/8 80/23 121/14 124/12 134/18
necessity [2] 89/9 90/17
need [45] 7/14 14/14 37/11 37/25 39/6 39/21 51/15 56/8 57/4 59/22 76/17 77/14 77/15 77/21 77/23 81/24 82/10 85/6 85/15 86/24 89/19 90/9 93/11 101/22 103/6 108/14 115/11 117/22 119/2 127/21 127/24 128/11 128/18 130/23 131/17 132/24 136/11 142/22 147/18 148/6 148/10 148/16 148/21 151/6 152/12
needed [29] 19/7 30/11 31/4 36/12 37/22 44/18 69/17 69/23 72/24 75/10 76/11 76/19 88/19 92/2 101/5 108/15 115/22 116/18 119/5 124/3 126/21 128/14 136/15 138/1 139/8 140/19 141/9 145/8 148/14
needing [1] 18/11
needs [23] 34/19 49/18 71/22 84/16 88/6 88/11 88/15 89/2 90/2 90/14 91/24 111/19 123/3 123/15 128/3 133/17 135/17 136/4 147/13 147/17 147/19 147/21 148/1
negotiate [3] 13/20 27/23 132/2
negotiated [4] 19/22 23/18 23/21 107/15
negotiations [1] 51/9
neither [3] 57/22 62/18 150/2
nervousness [1] 22/6
NERVTAG [1] 144/7
net [1] 107/16
network [1] 79/18
networks [1] 123/9
never [8] 41/18 65/7 69/4 71/10 74/25 76/23 76/24 100/17
nevertheless [2] 103/13 108/4
new [15] 21/13 34/8 44/23 45/16 72/2 85/23 103/6 111/7 117/18 130/23 135/12 140/11 140/19 156/12 157/23
news [1] 156/12
next [15] 37/11 47/9 54/17 66/7 77/15 80/21 99/22 122/9 128/1 128/3 132/16 134/22 158/5 159/16 160/16
NHS [52] 1/19 5/1 5/3 28/14 35/19 35/21 41/15 42/8 44/2 46/15 53/5 70/22 72/5 76/9 77/24 80/16 101/3 101/3 101/22 102/1 102/9 102/17 103/2 103/3 103/15 105/24 106/2 106/3 106/17 106/19 107/3 112/1 117/8 118/7 119/10 122/10 122/13 123/4 123/8 123/9 124/23 126/19 136/19 136/22 139/21 140/9 143/6 143/14 149/16 153/23 162/4 162/10
NHS Trust [3] 106/19 139/21 149/16
NHS-led [1] 102/17
Nicola [1] 146/8
Nicola Ritchie [1] 146/8
nightmares [1] 149/23
ninth [1] 22/2
Nixonian [1] 79/3
no [49] 5/15 8/23 15/22 20/8 25/7 25/7 26/19 28/4 31/13 38/17 44/3 44/22 46/24 48/7 48/25 50/12 51/19 54/14 57/23 60/21 61/24 61/25 63/22 65/21 66/20 69/25 71/5 75/3 79/19 83/6 94/3 95/13 103/8 108/13 108/21 109/6 109/13 116/10 116/11 118/14 119/6 124/22 133/18 139/6 140/1 141/5 142/14 144/13 152/6
Noakes [1] 74/4
noise [2] 45/23 51/17
non [7] 14/6 18/21 19/13 28/23 50/21 51/23 131/13
non-ministerial [1] 131/13
non-sterile [4] 14/6 18/21 19/13 28/23
non-VIP [1] 51/23
non-VIP Lane [1] 50/21
none [1] 102/7
nor [7] 35/18 56/1 56/17 72/5 79/4 110/5 150/2
normal [5] 79/24 110/17 111/18 111/23 157/25
normalcy [1] 85/16
normally [3] 8/22 16/22 51/11
north [1] 63/17
Northern [25] 54/18 56/1 60/14 61/10 62/13 63/1 63/13 63/18 64/9 64/19 65/23 91/7 91/10 91/18 91/24 92/19 93/10 95/9 95/10 97/7 98/12 99/2 99/2 161/11 161/25
Northern Ireland [2] 60/14 64/9
nosocomial [4] 67/1 67/8 75/14 146/15
not [209]
note [6] 16/24 56/21 97/13 118/10 125/14 153/15
noted [7] 73/20 79/1 88/4 101/15 114/23 117/3 121/13
nothing [5] 8/4 66/24 129/13 158/21 159/5
notice [6] 16/12 55/25 56/2 107/22 112/14 155/5
noticed [1] 89/23
notices [5] 109/2 130/7 154/13 155/6 155/8
notwithstanding [2] 68/25 69/1
nous [1] 9/18
November [1] 72/1
November 2020 [1] 72/1
now [36] 17/1 19/1 19/4 32/18 36/18 37/20 39/20 40/7 40/22 52/23 57/20 77/13 84/7 84/19 91/21 92/3 95/1 95/9 98/24 99/16 105/13 105/22 113/22 114/3 116/14 117/11 118/7 118/9 118/17 118/23 119/23 125/12 150/5 151/24 159/14 159/22
NSS [15] 80/16 114/16 114/17 114/19 114/24 115/2 115/13 117/17 117/24 118/19 121/9 122/13 122/16 126/12 126/23
number [17] 5/12 31/22 31/23 35/23 50/10 57/11 57/13 91/12 94/25 97/19 98/3 104/11 115/6 133/16 139/5 141/13 146/15
Number 10 [1] 133/16
numbers [6] 7/2 27/13 138/8 142/15 145/21 145/23
numerous [2] 45/15 85/24
nurses [2] 83/23 149/22
nursing [4] 58/18 76/9 77/25 95/15
nutritional [1] 57/15
NWSSP [17] 106/2 106/3 106/6 106/16 107/8 107/18 108/7 109/2 109/9 110/13 110/16 110/21 110/25 112/13 112/17 112/21 112/23
NWSSP's [3] 106/11 109/19 109/25
NWT [5] 93/5 93/9 94/9 94/21 94/24
NWT Distribution [2] 93/9 94/9

O

oath [1] 154/10
objective [2] 129/15 154/21
objectively [2] 92/6 124/10
objectives [2] 134/16 134/19
obligation [1] 89/9
obligations [1] 60/8
obliged [1] 38/6
observation [1] 8/7
observations [4] 122/18 125/12 128/23 129/11
observe [1] 60/22
observed [4] 24/7 55/7 66/22 129/1
observes [1] 68/24
obtain [2] 17/16 78/9
obtained [2] 64/11 91/22
obtaining [1] 109/16
obvious [6] 15/23 48/16 65/5 77/2 107/7 132/18
obviously [7] 15/7 35/15 38/25 39/13 79/15 148/3 159/9
occupied [1] 62/21
off [10] 6/14 13/17 16/23 18/13 30/25 35/18 55/18 61/3 64/21 124/7
offer [10] 2/10 11/14 11/20 49/16 49/19 50/14 94/24 132/4 132/11 134/4
offered [7] 13/19 17/8 19/9 31/14 84/24 93/9 134/5
offering [3] 15/4 45/24 82/4
offeror [1] 58/5
offers [51] 27/24 32/16 32/20 34/11 36/10 44/19 45/3 46/3 46/4 46/9 46/11 46/13 46/14 47/21 48/11 49/15 49/21 50/6 50/16 50/20 50/23 50/25 51/22 51/23 56/23 57/7 57/10 57/11 57/13 57/15 57/16 57/19 57/20 71/11 78/17 79/22 80/3 108/11 108/18 116/7 116/8 123/19 124/1 140/14 140/24 141/4 141/6 141/10 152/6 156/5 156/10
offguard [1] 88/22
office [11] 51/3 51/4 62/20 63/2 98/12 130/5 131/20 140/16 155/17 155/18 158/13
officer [14] 4/2 4/22 5/9 5/12 5/18 5/19 5/22 6/1 7/19 9/12 11/7 14/24 38/21 52/1
officer's [1] 8/6
officers [2] 23/1 43/10
officials [6] 6/12 37/5 37/17 65/4 68/19 129/5
offing [1] 15/14
often [5] 16/22 84/5 87/6 88/5 135/24
Oh [2] 24/2 99/24
Okay [1] 17/11
old [1] 79/17
on [291]
onboard [1] 4/20
once [4] 35/8 63/17 121/22 153/7
one [70] 5/8 5/15 8/1 8/1 9/11 9/24 10/2 10/8 10/21 11/3 11/5 12/10 12/14 15/15 15/15 18/2 18/19 19/6 24/15 25/2 25/3 25/14 26/22 28/19 28/19 30/5 30/19 30/25 31/5

O

one... [41] 32/9 33/10 39/20 48/13 55/20 55/24 56/12 57/16 60/2 61/13 62/20 66/13 66/25 70/7 71/17 73/21 75/23 81/23 83/17 84/14 86/8 87/9 89/15 93/2 94/14 100/15 101/6 111/22 112/6 120/20 124/7 132/5 132/19 133/15 133/25 134/16 136/3 145/13 146/23 152/2 154/9
one-size-fits-all [2] 87/9 89/15
ones [7] 17/4 24/23 42/18 69/8 86/19 136/2 145/13
onesie [1] 19/1
ongoing [5] 59/23 105/11 110/20 136/6 145/4
online [1] 123/25
only [44] 2/1 7/5 9/5 11/3 11/5 19/1 25/14 30/7 33/10 33/23 38/2 41/17 43/10 44/2 45/8 50/9 59/11 71/21 73/1 73/22 77/24 79/14 80/8 80/9 81/19 82/12 82/16 82/18 84/7 84/13 85/11 85/25 86/15 94/17 96/16 107/23 125/23 134/14 139/10 139/25 144/6 144/11 145/7 152/2
onward [1] 72/15
open [7] 47/2 130/12 134/17 145/2 150/16 151/8 156/13
Open Contracting [1] 150/16
opened [1] 62/19
opening [10] 48/12 75/12 101/15 102/16 113/16 116/9 118/23 127/5 128/25 136/23
openly [2] 144/18 154/25
operated [4] 91/18 101/4 123/25 126/11
operating [5] 4/18 14/9 28/8 55/6 55/13
operation [3] 66/16 87/18 133/5
operational [4] 46/6 74/7 88/23 117/7
operations [2] 3/17 107/24
opinion [1] 158/15
opinions [1] 79/5
opportunity [8] 44/20 56/8 62/22 92/17 96/24 122/17 126/12 149/1
opposed [2] 52/2 156/2
opposition [1] 154/15
option [1] 10/21
optional [1] 82/18
or [115] 2/18 6/8 6/17 6/21 8/1 8/9 9/1 9/2 9/9 10/13 10/14 11/1 11/5 11/6 12/6 14/1 14/24 15/10 15/10 16/10 17/9 21/13 23/12 24/25 26/10 27/8 29/12 31/11 33/4 33/21 33/25 34/24 35/1 37/19 37/21 37/21 38/14 38/15 38/15 39/21 43/4 43/16 43/24 45/11 46/15 48/8 49/25 52/15 53/1 54/24 54/25 56/8 56/9 57/10 57/20 58/5 58/9 58/10 58/10 58/23 58/24 62/3 64/4 65/18 67/9 70/23 71/6 72/20 73/23 76/20 77/21 78/18 82/21 83/10 83/11 83/17 85/25 86/10 92/4 93/4 93/23 93/24 94/6 94/12 101/20 102/13 106/2 106/4 107/20 110/2 111/7 116/11 116/12 116/22 118/25 121/6 122/13 124/23 124/24 125/5 125/22 127/7 129/4 131/14 131/16 131/16 132/2 132/13 136/10 138/9 139/21 139/22 146/14 154/23 160/7
oral [6] 91/13 100/8 121/17 136/23 143/21 159/12
order [12] 17/23 27/4 31/5 31/10 36/21 40/11 124/16 126/21 127/11 144/22 152/15 153/12
ordering [5] 143/13 153/9 153/11 153/14 158/9
orderly [1] 151/6
orders [2] 23/19 143/15
organisation [5] 136/16 137/4 150/15 157/7 157/9
organisations [3] 81/9 91/25 161/22
organised [1] 4/12
orientated [1] 84/12
other [65] 2/23 4/23 5/3 5/12 14/15 15/13 15/18 16/6 18/3 20/2 21/11 23/12 27/24 30/13 31/13 31/21 34/13 47/2 47/14 47/14 50/25 52/10 53/18 56/17 57/17 59/15 60/5 61/9 61/10 64/20 64/22 74/19 77/14 77/24 103/1 105/5 105/9 111/22 116/14 118/11 122/22 123/20 124/15 124/24 131/13 132/21 136/21 139/2 139/4 139/21 141/18 147/14 150/17 151/11 151/24 152/9 152/21 153/19 154/9 154/25 155/6 155/18 156/3 156/23 157/20
others [8] 11/12 58/19 61/2 63/16 71/21 84/2 98/8 114/21
otherwise [4] 56/7 106/5 119/16 120/23
ought [4] 18/14 30/6 36/15 80/9
our [62] 2/6 11/7 12/2 12/2 21/11 21/12 22/25 24/23 25/7 31/23 35/11 38/11 47/8 48/12 54/1 55/17 59/25 60/6 60/8 64/5 65/12 78/20 81/15 81/18 82/20 83/16 83/19 83/21 84/4 84/20 85/17 86/9 86/14 86/16 86/22 86/23 87/10 88/16 88/19 89/13 89/16 90/17 101/15 113/16 114/5 116/9 118/23 120/25 122/2 128/24 130/21 134/8 136/23 150/6 153/15 153/18 154/4 155/3 156/17 157/10 158/15 160/12
ourselves [1] 22/14
out [44] 4/6 6/5 10/9 11/8 12/16 18/10 18/11 28/16 29/1 29/25 39/13 39/16 49/17 51/6 54/25 56/12 59/1 62/22 67/23 68/19 69/5 69/13 71/10 78/7 84/25 88/10 89/9 89/9 100/18 101/2 102/6 107/17 109/13 116/23 118/12 118/14 124/23 131/23 138/11 144/16 149/20 150/20 151/5 151/8
outbreaks [2] 67/10 71/15
outcomes [3] 113/22 117/10 157/14
outlined [1] 85/10
outs [1] 2/17
outset [5] 44/10 101/16 114/5 134/13 148/7
over [32] 11/1 15/1 15/10 20/4 22/15 23/15 23/23 24/5 24/24 29/2 29/6 32/2 40/11 56/22 61/23 67/23 68/13 76/13 83/13 85/1 93/9 106/14 118/25 126/14 149/12 150/6 151/15 152/16 153/11 154/6 155/5 158/9
over-ordering [2] 153/11 158/9
over-specced [1] 32/2
overall [2] 53/3 110/7
overarching [1] 33/2
overboard [1] 45/2
overflowing [1] 73/10
overlooked [2] 72/5 75/15
overnight [1] 31/24
overpaid [1] 43/4
overseas [2] 138/18 138/25
oversight [4] 109/5 117/8 125/2 125/4
oversights [1] 88/12
overspeaking [1] 25/8
overview [1] 120/1
overwhelm [1] 45/8
overwhelmed [3] 44/14 44/14 151/4
overwhelming [1] 86/7
own [15] 21/18 61/1 78/19 88/23 95/16 111/25 112/16 112/25 119/7 122/24 133/13 136/1 142/7 145/12 155/3
oximeters [1] 83/9
oxygen [2] 71/13 148/11

P

pace [4] 28/5 28/12 32/6 103/19
pack [3] 23/9 26/16 27/3
packs [7] 9/5 14/18 14/20 15/5 15/7 21/9 101/2
page [14] 7/23 12/12 12/21 13/6 20/4 23/13 23/15 23/16 23/23 24/5 25/23 28/21 29/2 29/6
page 1 [2] 23/13 28/21
page 2 [2] 20/4 23/16
page 3 [4] 12/21 23/23 24/5 29/6
page 31 [1] 13/6
page 6 [1] 7/23
pages [1] 69/1
paid [13] 13/8 19/12 20/8 24/6 24/7 26/1 26/2 26/3 29/8 30/21 43/7 64/20 152/21
painful [1] 141/3
paint [1] 88/21
painting [1] 82/23
palpable [2] 2/3 86/12
PaLS [10] 56/22 63/16 63/22 92/23 94/1 94/16 94/19 94/23 95/10 96/22
PaLS's [1] 96/25
pandemic [140] 1/17 4/3 4/11 4/23 8/12 10/14 12/17 12/25 18/4 32/18 34/15 35/5 35/14 35/16 44/1 44/4 44/7 44/10 45/22 47/9 49/1 53/15 54/6 54/23 58/20 59/23 63/6 63/8 65/15 65/18 65/19 67/14 67/14 67/17 70/17 72/9 76/12 76/19 76/25 77/10 77/15 78/6 78/11 78/25 80/21 80/25 81/20 82/1 84/21 87/17 88/2 88/12 90/10 90/23 91/20 95/13 96/3 96/5 96/20 97/1 97/8 97/14 100/24 100/24 101/6 102/21 102/23 103/7 103/13 103/21 104/9 104/12 104/23 105/8 106/6 106/12 106/16 107/18 107/20 107/23 108/12 111/14 112/3 112/9 112/15 113/2 113/18 114/1 116/20 117/12 117/15 117/16 117/24 118/2 118/16 119/2 121/18 123/5 124/9 124/12 124/21 124/22 125/3 125/16

P

pandemic... [36] 125/18 125/24 126/7 126/13 126/17 127/16 127/22 128/3 129/4 129/7 131/6 131/23 132/5 134/13 134/22 135/15 135/23 136/9 136/21 137/19 138/4 138/20 139/7 143/17 145/20 146/21 147/7 147/13 148/9 148/15 150/1 150/17 153/2 153/4 158/20 160/15
pandemics [1] 82/21
panic [2] 55/5 153/7
paragraph [2] 7/23 21/2
paragraph 18 [1] 7/23
parallel [1] 32/15
paramedics [1] 18/10
parity [1] 120/23
Parliament [2] 6/3 53/17
parlours [1] 42/15
Parry [2] 66/19 143/11
Parsons [4] 66/7 66/9 76/2 161/16
part [16] 4/18 5/8 22/4 23/7 34/15 37/7 60/2 61/22 62/17 67/9 70/17 74/6 93/18 94/9 103/13 106/3
Participant [1] 148/25
participants [3] 49/8 87/3 160/3
participate [1] 149/1
particular [14] 11/17 13/22 14/10 19/7 25/2 25/4 27/3 27/3 32/15 37/16 83/14 111/3 111/5 145/18
particularly [12] 11/22 17/6 35/19 84/22 87/4 87/17 88/6 88/18 94/14 113/25 131/9 141/2
parties [1] 130/13
partner [1] 126/4
partners [4] 112/25 114/12 120/22 121/23
partnership [9] 102/1 102/10 103/3 105/25 106/2 106/24 135/15 150/16 162/5
partnerships [2] 127/12 132/15
parts [2] 5/3 137/19
partway [1] 136/20
party [3] 47/24 48/14 48/15
pass [1] 68/9
passed [2] 66/18 133/25
past [5] 47/19 83/13 84/13 150/3 153/4
pat [2] 64/2 92/3
patchy [1] 71/20
path [1] 90/22
pathogen [4] 127/24 128/1 128/14 134/20
pathogen X [1] 128/14
pathogens [1] 147/17
paths [1] 70/18
pathway [1] 89/7
patient [4] 117/9 139/13 139/17 144/10
patients [13] 42/10 42/20 42/25 67/4 69/19 86/16 126/8 139/7 144/14 145/10 145/12 145/19 145/22
pause [1] 30/5
paves [1] 84/14
pay [7] 28/1 45/6 55/18 55/23 59/11 121/22 126/1
paying [3] 11/1 15/9 25/15
payment [1] 21/15
payments [1] 23/3
peacetime [1] 128/12
peak [2] 10/11 118/18
peer [1] 48/15
peers [3] 47/24 131/12 153/18
pence [1] 78/20
people [30] 1/17 10/11 18/10 22/23 36/11 36/13 36/16 39/8 39/10 39/14 42/17 43/3 45/24 46/19 48/7 51/2 53/20 55/10 57/19 58/22 60/12 76/23 78/12 79/21 80/4 91/24 115/11 116/9 121/24 159/12
per [6] 15/4 26/4 26/19 26/25 57/20 152/21
perceived [1] 141/24
percentage [1] 69/9
perception [2] 95/25 141/16
perceptions [1] 148/20
perfect [3] 15/21 28/4 61/7
perfectly [1] 44/11
perform [3] 18/12 47/7 106/10
perhaps [8] 35/4 55/11 56/10 58/11 61/25 63/12 64/1 113/7
period [11] 1/22 4/6 8/15 13/25 31/20 32/14 37/18 92/7 99/7 124/6 142/18
periods [1] 126/15
permanent [7] 3/19 3/22 4/1 4/7 4/8 38/13 39/3
permission [1] 40/17
permit [1] 97/21
persistent [2] 37/19 89/12
person [2] 14/21 57/20
personal [9] 6/2 7/20 37/12 49/12 52/13 77/1 79/5 145/14 145/24
personally [4] 6/9 8/25 37/25 126/17
personnel [1] 103/4
perspective [2] 18/1 120/24
persuaded [1] 121/3
pertaining [2] 93/20 95/5
pervasive [1] 63/18
Pharmaceutical [2] 62/16 63/12
phase [3] 14/11 34/7 90/20
PHE [1] 134/3
philanthropic [1] 45/25
phone [1] 41/20
phones [1] 55/8
physiotherapist [1] 146/8
picture [6] 13/23 82/23 83/16 88/22 91/17 103/11
piece [1] 67/21
pieces [3] 63/7 74/19 141/8
pillars [1] 82/19
pipeline [2] 16/7 130/1
PIPP [4] 68/16 98/5 110/14 123/12
pivot [1] 153/7
place [17] 5/7 34/9 44/4 50/13 63/8 70/20 74/21 77/20 78/8 98/25 101/24 102/19 108/9 118/6 120/11 125/10 140/20
placed [5] 52/2 62/4 84/1 128/13 143/14
plan [12] 32/18 58/24 62/17 63/6 63/8 63/9 98/10 112/22 115/10 120/7 140/1 147/19
planning [8] 44/3 83/4 101/1 117/15 118/5 136/23 147/7 156/20
plans [3] 55/4 118/18 131/15
plastic [1] 149/21
platform [1] 130/9
platforms [1] 130/6
platoon [1] 151/1
played [2] 104/14 139/15
playing [2] 86/21 97/4
plea [1] 132/2
please [30] 3/5 3/25 4/2 7/10 9/8 10/4 12/8 12/12 12/21 12/22 12/24 13/6 17/3 17/5 17/13 17/17 17/18 18/15 19/16 19/17 23/5 25/22 25/23 26/17 28/11 28/19 28/24 29/1 29/7 30/15
plenty [1] 70/22
plums [1] 57/13
plus [1] 159/18
pm [4] 51/3 99/18 99/20 160/18
pockets [1] 78/19
poignant [1] 87/23
point [20] 14/22 21/5 24/20 27/18 35/10 46/1 46/10 63/5 75/23 93/14 94/5 110/2 114/18 118/14 124/22 129/1 129/12 132/11 133/17 142/23
pointed [1] 84/25
pointing [1] 88/10
points [10] 70/18 93/13 95/5 97/22 98/2 98/16 100/12 131/2 133/23 150/20
policies [1] 90/11
policy [5] 48/6 125/25 125/25 134/10 142/9
politely [1] 61/2
political [9] 53/14 53/18 55/13 58/4 58/5 58/8 59/3 151/12 157/24
politically [6] 46/19 48/7 53/20 65/19 79/4 80/4
politicians [9] 41/17 47/10 47/21 48/8 52/10 56/25 151/4 152/4 158/4
politics [1] 86/21
poor [4] 44/5 146/11 150/3 150/7
poorly [1] 138/17
population [3] 57/8 110/19 121/11
portal [1] 123/25
portfolio [1] 48/5
posed [1] 92/18
position [11] 22/21 29/23 31/5 33/19 63/14 68/1 71/11 71/23 121/2 134/10 159/13
positions [1] 62/4
positive [2] 104/11 121/21
possible [16] 33/12 35/6 36/24 42/21 46/23 60/8 77/8 77/20 78/7 78/9 82/6 92/14 97/12 117/25 143/4 160/5
post [1] 56/14
potential [3] 85/5 124/8 141/19
potentially [3] 27/9 139/13 141/1
pound [3] 43/4 43/5 62/25
pounds [4] 49/2 52/20 78/20 155/20
power [2] 44/20 58/24
powerful [2] 83/6 83/14
PPE [214]
PPE Buy [1] 45/4
practical [8] 7/23 17/2 103/9 111/2 127/25 128/16 130/3 137/1
practice [3] 72/16 105/16 126/5
practices [4] 54/13 85/11 89/14 150/4
praise [1] 82/4
praised [1] 114/17
pre [7] 4/11 12/17 12/25 49/1 52/12 84/23 132/21
pre-existing [1] 132/21
pre-pandemic [4] 4/11 12/17 12/25 49/1
precautionary [1] 147/13
precautions [1] 67/5
preceding [1] 143/15
precious [1] 10/7
precise [1] 117/4
predecessor [1] 94/16
predict [1] 35/13

P

predictable [2] 138/19 141/21
preface [1] 1/15
preferable [1] 32/19
preference [1] 147/3
preferential [4] 108/16 108/22 141/18 148/20
pregnant [1] 83/23
preliminary [1] 49/17
premium [2] 43/7 126/1
preparation [4] 44/6 97/9 137/20 159/18
preparations [2] 105/11 137/24
prepare [3] 45/10 59/4 66/1
prepared [4] 45/5 77/9 77/15 134/22
preparedness [13] 34/15 42/6 43/19 44/6 44/13 51/15 53/3 67/15 90/8 90/11 118/3 139/2 147/13
preparing [1] 38/2
prepayment [3] 11/4 11/18 22/10
present [4] 2/1 141/13 151/9 159/8
presented [5] 32/7 84/3 85/19 122/15 125/13
pressing [1] 108/14
pressure [16] 28/12 32/6 37/2 37/14 38/5 39/12 42/22 46/5 46/21 48/10 51/17 61/20 99/7 109/6 111/9 126/15
pressured [1] 83/21
pressures [3] 41/19 45/20 111/14
presumably [1] 22/22
preventable [2] 42/11 88/15
prevented [1] 42/18
preventing [1] 64/17
prevention [1] 73/17
previous [10] 11/1 11/2 13/17 15/2 15/10 24/24 56/5 56/13 74/1 135/13
previously [5] 28/2 30/9 33/3 60/10 94/19
price [85] 6/21 10/3 10/4 10/22 10/24 10/25 11/8 11/15 11/16 12/3 12/17 12/17 12/18 12/19 12/24 12/25 13/12 13/23 14/5 14/7 15/8 15/9 15/10 17/7 17/14 17/15 19/17 19/22 20/1 20/8 20/18 21/5 21/17 21/17 21/22 21/22 23/13 23/17 23/18 23/19 24/6 24/7 24/9 24/18 25/14 25/17 25/24 25/25 26/1 26/1 26/2 26/3 26/13 26/19 26/23 26/24 26/25 27/4 27/9 27/11 27/20 27/22 27/23 28/1 29/2 29/3 29/7 30/15 30/18 30/21 31/14 32/17 32/21 33/5 33/7 33/25 34/12 43/10 43/13 44/5 45/5 45/20 107/14 131/24 152/23
prices [28] 10/23 12/16 13/5 13/8 13/12 13/18 13/19 13/24 14/10 14/13 15/4 15/16 17/12 19/11 19/21 20/6 20/8 20/23 21/4 23/21 24/24 26/7 27/1 28/24 30/2 30/4 34/12 157/20
pricing [3] 12/10 13/2 15/21
primarily [1] 115/18
primary [6] 42/13 107/24 115/14 139/22 140/2 145/18
Prime [1] 44/24
Prime Minister [1] 44/24
primitive [1] 156/9
principal [2] 51/25 100/12
principled [1] 44/18
principles [10] 7/13 7/16 7/18 7/20 8/1 8/13 9/24 85/2 113/21 116/6
prior [4] 95/13 120/17 141/7 146/21
priorities [1] 135/5
prioritisation [3] 49/15 133/6 157/15
prioritise [1] 141/10
prioritised [3] 72/5 108/15 133/9
prioritising [3] 151/12 153/1 154/22
priority [12] 50/23 52/7 80/3 108/13 123/19 126/7 129/8 133/5 133/15 141/15 148/21 155/11
private [4] 2/20 51/3 64/15 115/16
privately [1] 95/14
privately-run [1] 95/14
prizes [1] 50/13
proactive [3] 88/20 119/21 156/23
probably [8] 18/17 26/14 27/17 36/18 36/19 50/14 81/5 81/22
problem [8] 46/23 52/4 58/6 58/11 70/23 100/25 144/19 146/20
problems [10] 45/9 53/11 56/18 65/7 69/22 70/10 75/2 103/20 159/25 160/1
procedural [2] 75/7 83/25
procedure [1] 105/16
procedures [4] 44/11 73/24 143/3 144/5
Proceedings [1] 1/3
process [34] 8/20 12/5 16/3 22/3 37/7 37/23 44/3 44/16 45/19 51/13 55/9 63/3 69/11 72/17 82/24 83/12 84/22 87/21 89/21 90/6 93/24 94/3 94/12 101/8 101/8 120/14 129/10 129/13 132/12 133/9 134/3 151/7 152/13 158/6
processed [4] 45/4 49/2 50/6 50/24
processes [20] 45/1 51/19 77/20 77/23 86/15 91/17 91/18 92/8 97/25 101/23 103/5 122/24 123/2 123/17 126/11 128/12 130/14 131/16 141/20 148/6
processing [5] 32/10 44/19 48/10 49/21 51/17
procure [12] 96/2 99/1 119/3 119/6 123/14 124/4 128/13 129/9 136/15 142/2 143/4 144/1
procured [7] 11/15 30/18 85/13 95/16 109/20 124/13 144/23
procurement [150] 2/16 4/23 4/24 4/25 35/1 41/21 42/6 43/19 44/12 44/12 45/1 47/8 48/8 50/8 50/9 52/9 53/4 53/8 53/12 54/7 54/22 59/20 60/10 62/2 62/13 62/16 63/10 74/20 75/8 77/23 78/24 79/9 79/24 80/15 81/13 82/7 82/19 82/24 84/13 84/18 84/22 84/24 85/2 85/10 85/14 85/15 86/13 86/14 87/1 87/9 87/21 87/25 88/22 89/14 89/24 90/5 90/18 91/17 92/8 93/16 93/24 93/25 94/3 94/4 95/11 97/5 98/13 102/18 102/24 103/3 103/8 103/16 104/1 104/10 104/15 104/16 104/17 104/25 105/12 105/16 106/25 107/2 107/19 107/21 107/23 107/25 108/2 109/22 110/13 111/11 111/16 111/17 111/18 111/25 112/15 112/16 113/17 116/11 119/24 120/10 121/4 121/6 121/7 122/21 122/24 122/25 123/5 123/6 123/13 123/17 124/4 124/5 124/25 125/4 126/10 126/13 127/16 128/3 129/24 130/4 130/7 130/7 130/16 134/11 137/7 137/18 140/12 140/19 140/23 141/20 144/20 147/9 148/5 150/1 150/3 150/13 150/17 150/18 150/24 151/9 155/4 156/1 156/4 156/12 156/19 157/4 157/8 157/11 157/25 158/18
Procurement's [3] 123/2 124/11 126/7
procurements [3] 130/15 130/17 157/5
procuring [2] 67/17 142/15
produce [1] 115/7
produced [2] 98/21 144/2
product [9] 19/3 20/17 21/1 51/8 55/10 88/3 111/6 123/22 148/5
production [6] 58/3 77/16 104/19 104/22 118/1 156/24
products [7] 19/5 30/13 111/8 124/1 132/6 132/13 133/23
professional [5] 6/11 7/1 77/1 145/25 152/12
professionals [10] 86/5 107/2 111/17 132/23 135/18 136/7 136/14 136/17 136/19 136/22
Professor [22] 42/2 42/21 43/20 44/9 46/1 46/22 50/7 52/8 52/18 74/4 81/9 83/15 84/23 119/25 120/20 131/21 132/24 139/12 142/19 149/15 150/20 161/23
Professor Banfield [1] 42/2
Professor Catherine [1] 74/4
Professor Fong [1] 149/15
Professor Jonathan [1] 142/19
Professor JS [1] 83/15
Professor Manners-Bell [2] 119/25 120/20
Professor Moonesinghe [3] 42/21 43/20 139/12
Professor Sanchez-Graells [8] 44/9 46/1 46/22 50/7 52/8 84/23 131/21 150/20
Professor Sanchez-Graells' [1] 52/18
profile [1] 87/18
profit [3] 45/25 49/6 78/15
profited [1] 54/10
profiteer [1] 78/19
profiteering [5] 47/3 49/14 54/4 59/5 79/12
profits [2] 45/21 78/20
profound [4] 81/12 81/16 86/20 144/19
programme [4] 5/2 67/15 67/16 118/3
progress [3] 34/11 35/14 37/2
progressed [1] 88/13
Project [1] 154/15
prolonged [1] 55/21
promise [1] 52/3
promising [1] 52/6
promoted [1] 151/21
prompted [3] 8/23 22/4 97/14
proper [9] 52/15 56/20 60/19 79/18 80/1 85/23 108/24 141/5 158/12
properly [10] 74/5 78/1 78/7 79/13 80/22 138/8 145/1 147/4 147/7 147/17

P

proportion [1] 111/25
proportionate [1] 51/14
proportionately [1] 57/10
proposal [6] 93/6 94/8 94/9 94/13 94/21 137/3
proposals [1] 93/20
propose [1] 17/1
proposed [2] 26/4 63/10
proposition [1] 103/23
propriety [1] 7/14
prospect [1] 10/20
prospective [1] 15/15
protect [19] 39/14 41/15 54/1 54/3 65/3 79/11 79/14 81/21 82/14 84/18 86/10 87/3 90/24 119/7 126/8 126/21 142/16 145/9 148/10
protected [6] 61/19 75/18 76/24 144/13 145/1 150/2
protection [9] 18/21 64/16 74/14 87/8 141/2 145/21 146/10 146/19 146/23
protective [7] 20/1 20/10 21/3 86/19 88/8 138/6 142/4
Protocol [1] 120/18
protocols [1] 37/21
prove [2] 66/25 128/2
proved [3] 98/8 110/21 152/2
provide [18] 13/4 18/24 22/1 70/15 72/9 77/4 77/8 88/3 97/21 115/14 117/1 117/8 118/4 119/9 119/20 132/14 134/6 137/6
provided [16] 3/6 9/9 36/22 52/24 73/14 76/11 76/18 86/6 88/4 91/16 92/13 96/19 106/8 138/13 144/11 150/5
provider [1] 95/16
providers [8] 73/14 95/19 95/21 96/2 96/7 98/14 115/14 160/3
provides [5] 40/23 104/2 116/24 121/14 132/11
providing [5] 4/7 52/14 105/4 144/10
146/9
provision [12] 41/15 54/22 69/23 95/7 95/14 96/25 104/16 104/17 112/22 118/5 121/25 148/18
provisions [2] 83/5 156/13
prynhawn [1] 100/5
psychological [1] 86/4
public [52] 7/10 7/13 7/24 8/3 8/7 9/24 42/5 43/3 43/17 47/1 47/12 53/22 53/25 54/2 54/3 54/8 54/8 54/14 60/17 60/18 60/20 65/9 76/16 78/9 78/10 79/13 79/24 80/21 82/12 84/4 85/2 89/11 89/12 92/8 92/12 104/24 115/6 128/10 129/2 129/15 129/17 129/23 130/7 130/19 130/20 132/23 141/16 141/20 150/8 156/8 157/24 158/18
publicly [1] 59/18
publish [3] 132/7 155/8 156/15
published [14] 40/18 41/3 96/4 96/11 98/14 130/9 130/11 146/22 153/25 154/3 155/3 155/5 155/10 159/16
publishing [2] 154/17 154/22
pull [1] 101/4
pulse [1] 83/9
punishing [1] 160/8
purchase [4] 18/8 20/21 32/1 33/5
purchased [1] 107/13
purchases [2] 20/3 24/8
purchasing [4] 97/16 150/7 150/10 156/21
purpose [7] 22/1 28/15 52/25 73/5 110/9 137/25 139/25
purposes [4] 19/10 33/10 106/24 141/14
purse [3] 43/3 43/17 54/3
pursued [1] 31/22
pursuing [2] 16/24 113/21
pursuit [2] 32/12 84/25
PUS [1] 38/20
push [2] 101/1 110/17
pushed [1] 101/2
put [19] 18/13 37/15 55/5 70/20 73/6 78/8 93/4 94/18 97/15 102/19 105/3 114/1 115/24 120/11 129/21 133/17 133/21 136/10 140/19
putting [2] 111/9 112/23

Q

qualification [1] 151/7
qualified [1] 155/1
qualifying [1] 156/5
quality [12] 8/20 11/14 27/25 30/12 83/5 85/12 91/23 115/11 116/18 134/16 135/17 139/13
quango [1] 130/23
quantities [5] 27/25 31/4 124/3 137/25 143/1
quantity [4] 11/14 32/11 57/17 107/11
quarter [1] 12/17
queries [2] 36/13 37/5
question [10] 30/15 33/16 36/3 36/14 46/24 67/3 68/25 81/22 129/16 130/21
questioned [3] 67/4 78/23 92/22
questioning [5] 1/8 30/23 38/11 132/20 133/12
questions [23] 1/10 1/12 13/3 19/10 28/11 36/1 36/4 38/8 38/9 56/3 59/15 70/14 75/19 75/24 87/20 92/18 100/15 105/3 137/1 150/12 161/3 161/4 161/5
queue [3] 46/20 47/15 52/5
quick [2] 46/13 151/25
quickened [1] 102/20
quicker [2] 45/16 50/15
quickly [7] 19/20 44/14 72/7 90/14 104/18 118/13 139/1
quite [11] 5/15 8/19 19/3 19/20 20/22 24/14 34/20 34/23 34/24 37/1 61/17
quote [2] 72/18 87/12

R

rabbits [2] 44/8 150/25
racial [1] 83/8
raise [4] 6/18 70/14 115/25 132/3
raised [7] 67/12 87/20 95/18 99/10 100/11 116/14 119/12
raises [1] 64/7
ramp [1] 103/5
ran [4] 69/5 71/10 100/18 149/20
range [16] 3/1 4/9 4/22 13/12 15/16 16/20 18/12 20/22 26/6 37/1 93/20 105/10 128/9 147/16 147/16 147/24
ranges [1] 13/8
ranging [1] 130/10
rapid [3] 2/16 4/24 98/1
rapidly [5] 46/8 53/24 57/18 104/3 123/14
Rarely [1] 21/18
rate [3] 67/8 152/9 157/19
rates [2] 51/20 103/11
rather [17] 11/25 32/12 36/25 37/10 56/11 64/1 73/11 79/7 79/22 82/10 112/19 131/12 138/25 142/5 144/11 147/3 151/5
ratio [1] 30/4
ration [1] 148/19
rationale [1] 56/10
rationed [1] 143/2
rationing [1] 144/14
raw [1] 25/13
re [4] 59/24 68/4 68/7 68/8
re-test [2] 68/7 68/8
re-tested [1] 68/4
re-usable [1] 59/24
reached [4] 72/1 101/19 108/25 125/1
reaching [1] 77/6
react [1] 67/3
reactive [2] 88/10 88/20
ready [2] 54/21 67/18
real [13] 2/1 41/18 41/25 42/9 42/17 42/19 50/5 75/25 78/18 89/1 90/23 143/18 143/24
realised [1] 136/5
reality [3] 41/13 56/15 79/9
really [22] 2/4 2/7 2/11 2/20 5/15 9/13 10/22 14/3 18/21 24/25 27/22 33/7 35/20 37/3 39/8 61/3 61/4 82/7 114/21 149/22 152/6 152/15
realtime [1] 156/5
reason [7] 25/5 57/23 61/13 67/7 75/1 75/4 128/5
reasonable [7] 15/20 20/6 23/22 30/2 32/4 43/22 97/3
reasons [7] 51/6 63/1 68/14 71/4 112/6 133/4 142/6
reassure [1] 46/3
rebuttal [1] 153/22
recall [6] 8/16 18/9 83/1 83/6 92/21 127/5
recalled [1] 102/5
receipt [1] 110/1
receive [2] 87/8 123/25
received [13] 5/18 27/1 56/22 57/10 64/6 64/8 98/21 101/25 107/17 108/18 116/7 120/16 155/19
receiving [3] 101/13 141/11 141/18
recent [6] 20/2 23/19 24/8 24/24 27/1 53/14
recently [3] 24/23 49/7 62/15
recognise [3] 52/20 63/19 127/20
recognised [2] 42/21 118/15
recognises [3] 105/8 116/16 120/8
recognising [2] 82/3 86/22
recognition [2] 63/17 72/8
recommend [3] 16/25 145/7 158/11
recommendation [2] 90/20 157/3
recommendations [22] 9/19 34/16 36/8 47/7 54/11 62/10 65/25 77/8 77/13 77/18 80/20 99/11 100/14 127/9 128/17 132/17 133/2 137/1 147/12 156/17 157/22 158/23
recommended [2] 104/12 120/20
reconstruction [1] 157/10
record [4] 22/11 98/25 112/23 154/9
recorded [2] 139/20 155/20
records [1] 67/25

R

recreated [1] 56/9
recruited [1] 123/7
recruitment [6] 48/1 48/13 48/21 48/25 49/5 49/22
rectify [1] 88/12
recurring [1] 149/23
red [1] 70/7
redacted [1] 25/6
reduce [2] 26/5 142/8
reduced [3] 46/4 74/12 117/25
reducing [1] 160/13
reevaluate [1] 87/1
refer [6] 9/4 11/9 11/13 47/21 127/7 149/14
referee [1] 58/5
reference [9] 6/15 7/22 7/25 16/25 24/20 29/11 40/12 60/22 128/22
referral [5] 48/1 48/13 48/20 49/16 52/2
referrals [3] 36/15 151/13 157/24
referred [7] 30/23 50/25 56/25 80/3 88/11 98/18 127/8
referrer [1] 133/11
referrers [3] 36/21 37/20 47/23
referring [1] 154/14
refers [3] 20/9 20/10 20/10
reflect [4] 53/13 53/16 147/18 149/11
reflected [6] 95/2 96/16 104/12 108/9 113/23 150/24
reflecting [2] 83/12 88/1
reflection [3] 63/21 64/5 81/11
reflections [3] 17/5 17/16 20/14
reform [1] 89/8
refuse [1] 83/22
refused [1] 83/24
regard [3] 97/18 110/17 153/16
regarding [2] 86/5 95/19
regardless [2] 69/13 129/3
regards [1] 154/8
region [1] 57/7
regional [1] 35/22
regret [2] 37/12 38/1
regrets [1] 109/4
regrettably [2] 75/19 93/1
regular [5] 68/18 76/21 96/13 115/16 125/6
regularity [1] 7/14
regularly [1] 120/5
regulation [1] 106/20
regulations [3] 4/13 85/14 130/11
regulatory [1] 109/21
rehearsing [1] 83/11
reinforce [1] 148/16
reinforcing [2] 65/12 85/16
reiterated [1] 96/10
reiterates [1] 99/8
rejected [2] 8/25 47/11
rejecting [1] 21/21
rejection [3] 51/7 61/18 83/18
relapse [1] 146/4
relate [1] 67/2
related [9] 4/13 10/25 69/22 91/19 93/20 94/17 122/25 130/7 133/11
relates [4] 67/21 93/14 94/5 94/8
relation [16] 11/18 36/8 40/20 59/17 80/18 92/22 93/15 96/1 98/16 100/24 102/4 116/11 117/3 122/25 127/16 128/19
relationship [8] 6/6 80/14 106/7 106/12 121/12 135/16 135/17 136/7
relationships [7] 45/11 113/19 115/2 121/19 130/25 132/21 132/25
relative [2] 20/24 153/24
relatively [3] 87/13 112/7 153/25
relatives [1] 80/23
release [1] 98/5
released [1] 68/4
relevant [13] 11/16 13/19 21/14 21/16 49/19 57/25 65/4 91/25 92/7 98/16 102/10 105/9 153/24
reliable [5] 90/12 106/8 116/17 148/11 152/24
reliance [3] 112/20 117/25 147/22
reliant [3] 66/23 111/4 136/19
relied [3] 65/4 133/12 138/16
reluctance [1] 74/5
rely [2] 42/14 123/21
relying [3] 9/4 138/25 140/3
remain [4] 75/19 75/20 75/23 75/24
remained [1] 8/13
remains [5] 2/2 62/12 69/2 75/22 99/9
remarkable [1] 113/22
remarkably [1] 61/18
remarks [1] 126/6
remedy [1] 63/19
remember [3] 47/22 83/14 121/4
remembering [1] 113/1
remind [1] 114/10
reminded [1] 65/17
reminding [1] 41/12
remit [2] 71/19 115/13
remote [1] 4/14
removing [1] 56/23
repeat [3] 83/10 155/5 160/9
repeated [3] 65/12 65/14 82/17
repeatedly [1] 69/4
repeating [1] 83/11
replaced [1] 125/17
replacement [1] 124/25
replenish [1] 102/8
report [15] 13/14 41/2 63/2 98/17 98/19 109/1 110/8 142/8 144/17 147/6 150/21 159/15 159/21 159/21 159/22
reported [4] 42/14 49/5 66/13 88/7
reports [4] 13/15 159/19 159/20 159/20
represent [2] 43/1 53/19
representation [2] 89/18 89/19
representative [2] 96/21 106/21
representatives [3] 84/9 96/14 160/4
represented [1] 13/10
Republic [1] 63/11
repurposed [1] 139/11
request [2] 25/7 118/25
requested [2] 101/5 146/8
requests [3] 69/8 69/9 106/15
require [3] 111/8 120/21 120/23
required [13] 47/20 68/16 70/6 73/8 79/18 80/2 93/19 106/20 108/6 123/14 123/23 125/23 130/10
requirement [7] 9/3 9/13 9/15 28/14 35/5 35/11 46/6
requirements [5] 73/7 109/21 121/10 129/6 131/25
requires [3] 53/15 127/22 132/14
research [1] 135/13
reservist [1] 136/12
residential [1] 95/14
residents [4] 64/15 67/5 71/12 126/9
resilience [6] 12/6 60/12 97/25 98/5 119/21 133/1
resilient [2] 104/2 107/21
resistant [2] 107/12 142/16
resolve [1] 119/15
resolved [4] 65/8 65/8 95/23 145/4
resorted [1] 52/13
resource [4] 35/6 74/7 91/15 137/6
resources [9] 4/21 53/2 64/24 79/21 86/2 106/14 111/10 128/19 149/20
resourcing [1] 158/12
respect [9] 11/20 19/14 25/19 43/23 75/21 103/14 134/20 136/1 146/17
respect of [1] 11/20
respirator [2] 144/12 147/4
respirators [3] 83/3 138/10 142/13
respiratory [4] 138/5 142/4 146/19 146/23
respond [5] 63/15 106/11 112/13 120/25 140/14
responding [3] 36/25 37/4 112/8
response [15] 43/19 51/5 53/12 55/4 56/19 62/14 72/11 84/21 87/17 90/7 93/21 116/3 116/4 125/5 155/2
responses [7] 24/21 47/8 54/23 99/12 106/13 152/1 157/12
responsibilities [6] 4/11 5/13 6/4 6/24 38/21 104/9
responsibility [7] 65/10 79/11 81/12 109/25 110/4 111/18 112/16
responsible [9] 4/22 67/17 95/10 107/18 110/13 111/16 111/24 144/20 157/8
responsive [2] 90/13 104/3
rest [3] 38/8 41/18 159/11
restore [1] 148/22
restoring [2] 85/16 158/17
restriction [1] 40/11
restrictions [2] 142/4 143/14
result [8] 51/19 52/6 59/2 68/16 71/16 126/19 145/21 146/3
resultant [1] 158/9
resulted [5] 42/7 53/4 88/15 138/4 140/14
resulting [1] 67/10
results [1] 152/13
resume [1] 146/12
resumé [1] 114/14
retail [1] 45/12
retests [1] 68/9
retrospective [1] 27/20
return [5] 39/22 63/2 85/13 99/17 120/16
revealed [4] 26/23 47/1 85/22 89/13
reverting [1] 112/19
review [12] 23/11 23/12 63/22 98/1 98/13 98/19 108/24 110/7 133/13 133/18 133/19 157/14
reviews [2] 68/19 97/20
revisited [2] 58/17 135/14
Rhys [3] 45/7 140/22 155/17
rhythm [1] 76/21
right [43] 3/14 3/17 5/6 5/21 5/24 7/6 8/2 12/14 13/13 14/13 16/4 16/5 19/14 19/15 20/17 20/17 21/24 22/3 22/24 25/7 27/12 30/8 31/15 39/7 55/16 64/12 71/11 101/19 101/20 102/2 102/3 115/10 115/11 115/12 125/9 125/10 125/10

R

right... [6] 129/2 132/5 146/14 155/22 159/5 159/6
right-hand [1] 12/14
rights [1] 90/24
rigorous [1] 8/20
ripe [1] 55/12
risk [20] 8/14 10/16 33/25 34/1 44/24 51/16 75/14 75/25 80/4 80/7 82/20 83/20 84/1 85/11 119/8 119/17 128/8 128/11 128/21 143/3
risked [1] 150/10
risks [2] 88/1 88/16
risky [2] 152/13 153/3
Ritchie [3] 142/19 146/8 146/10
roaring [1] 45/23
Robing [1] 132/3
robust [3] 77/20 85/15 101/23
robustness [1] 110/7
role [24] 3/25 4/1 4/6 5/7 5/8 38/20 39/4 59/19 62/17 62/21 80/16 93/15 93/16 93/19 94/20 95/13 96/23 97/4 101/11 104/14 106/9 109/19 126/23 139/15
roles [1] 157/24
rolled [1] 116/23
rolling [1] 43/12
Rome [1] 59/5
room [3] 39/11 65/21 132/3
root [1] 43/18
Rosemary [2] 89/23 143/21
rotation [1] 118/19
rotten [1] 59/8
round [2] 11/12 37/11
routes [1] 157/20
routinely [1] 83/19
Royal [1] 58/18
RQIA [1] 95/22
RTS [1] 122/6
rule [1] 44/16
rules [3] 4/17 8/8 79/24
ruling [1] 47/24
run [8] 69/13 95/14 102/6 109/13 118/14 124/23 131/8 143/23
runaway [1] 153/9
running [1] 22/13
runs [1] 40/19
rush [1] 84/5

S

sacks [1] 149/21
safe [3] 53/24 121/24 145/19
safeguard [1] 82/19
safeguards [3] 65/3 79/25 87/3
safety [8] 42/13 84/15 90/25 117/9 142/6 144/15 146/22 147/5
said [39] 7/7 7/16 16/24 23/25 24/21 30/9 32/5 35/2 42/2 44/21 46/1 46/22 50/19 52/3 53/10 57/25 66/19 68/5 68/20 70/10 72/18 84/11 98/9 102/22 113/21 116/9 116/17 118/14 118/21 149/18 151/7 151/18 153/11 153/18 154/10 154/10 155/9 160/10 160/10
same [10] 5/16 7/17 7/18 33/14 34/23 34/24 68/5 96/11 108/12 135/2
Sanchez [9] 44/9 46/1 46/22 50/7 52/8 52/18 84/23 131/21 150/20
SAS [1] 48/23
satisfactory [1] 19/5
save [6] 39/13 41/15 57/2 126/21 154/21 155/12
saves [1] 147/4
saving [6] 42/22 47/18 84/2 140/4 153/1 160/13
savings [1] 152/12
saw [4] 24/17 71/12 78/17 100/25
say [21] 1/13 8/23 13/14 15/20 18/19 25/3 37/20 37/22 39/6 47/19 50/2 61/24 73/12 80/13 82/2 93/10 97/3 97/18 150/23 156/7 156/25
saying [4] 19/1 31/6 87/12 150/13
says [9] 8/3 19/25 23/12 24/3 29/17 52/17 55/16 70/7 131/25
scale [9] 43/14 45/13 58/3 112/3 136/15 154/5 156/24 157/14 158/10
scandal [1] 47/4
scarcity [1] 35/6
scenario [2] 43/22 134/13
scenarios [1] 128/10
science [4] 127/19 127/22 134/2 136/8
Sciences [1] 108/20
scientific [2] 132/15 134/21
scientifically [1] 134/17
scope [1] 131/17
Scotland [25] 60/13 61/21 114/8 114/15 115/3 115/9 116/22 117/14 118/14 118/17 119/5 119/9 121/5 121/24 122/11 122/13 123/4 123/10 123/16 124/15 124/17 124/21 124/22 124/23 162/11
Scotland's [3] 117/8 121/7 121/11
Scottish [43] 36/6 61/23 76/4 76/6 77/2 79/2 80/14 81/1 113/9 113/12 113/15 113/18 113/24 114/11 114/16 114/20 114/20 115/5 115/6 115/12 116/1 116/7 116/15 116/17 117/16 117/17 117/17 118/2 119/2 119/16 120/8 120/14 120/24 121/2 121/10 121/12 121/18 121/22 122/2 124/1 125/8 161/18 162/7
scramble [3] 68/8 78/11 140/11
scratch [3] 70/1 103/18 135/2
screen [4] 17/12 17/17 40/7 40/22
scrutiny [4] 47/11 60/20 75/3 130/19
seated [1] 58/25
second [21] 3/19 3/25 4/6 38/13 38/20 39/3 40/16 50/13 51/6 69/3 72/13 87/15 94/5 124/19 131/21 137/20 142/3 143/18 144/25 147/21 157/3
secondary [3] 107/19 111/19 145/17
seconded [1] 151/17
Secondly [2] 98/12 125/21
secretary [10] 3/20 3/23 4/1 4/7 4/8 10/9 38/14 39/3 91/14 150/11
sector [27] 1/19 43/6 54/2 71/19 72/10 72/15 82/12 84/4 89/11 89/12 95/8 96/15 96/20 96/23 98/22 102/5 102/18 102/21 102/22 103/17 103/20 104/24 107/20 108/5 111/20 115/6 132/23
sectors [4] 42/2 107/24 118/6 136/3
secure [8] 31/1 45/17 51/18 53/25 62/25 84/6 91/19 124/5
secured [1] 99/6
securing [1] 60/11
Security [3] 127/4 127/7 162/14
see [11] 11/23 14/11 15/16 58/10 65/24 77/11 82/9 82/22 96/24 105/15 134/8
seeing [1] 42/18
seek [4] 61/1 77/6 77/7 78/15
seemed [1] 158/4
seems [3] 24/11 72/23 150/1
seen [8] 13/1 17/12 23/6 65/2 80/9 114/15 135/20 157/9
seize [1] 62/23
self [8] 63/21 64/4 64/5 65/5 65/13 92/5 97/3 117/23
self-congratulation [1] 64/4
self-congratulatory [2] 92/5 97/3
self-declaring [1] 65/5
self-examination [1] 65/13
self-reflection [2] 63/21 64/5
self-sufficiency [1] 117/23
sellers' [1] 107/8
senior [15] 4/4 4/18 22/25 37/5 37/16 37/18 37/22 46/1 51/25 60/25 131/14 142/11 142/24 152/4 158/3
sense [3] 7/25 8/5 77/10
sensible [1] 46/16
sensitive [4] 25/8 25/9 40/8 40/11
sent [4] 102/10 118/12 139/16 142/18
sentence [1] 19/24
separate [2] 106/18 130/5
separated [2] 57/14 127/19
separately [3] 19/13 57/3 94/24
September [4] 71/25 96/12 108/8 117/6
September 2020 [2] 71/25 108/8
series [2] 115/18 137/22
serious [2] 138/4 145/3
seriously [3] 138/5 141/13 152/2
servant [2] 3/12 51/25
servants [7] 46/20 48/6 61/19 76/16 116/12 131/14 142/1
serve [1] 86/17
served [2] 57/2 135/22
service [9] 22/6 22/15 44/22 60/25 71/25 108/7 135/22 136/12 136/14
services [26] 43/9 69/7 70/15 71/22 72/9 72/14 73/6 90/18 102/1 102/9 103/2 105/24 106/2 106/19 106/25 109/22 122/10 122/13 123/15 123/15 126/8 126/21 129/20 129/23 162/5 162/11
Services' [1] 73/4
Services's [1] 71/19
session [3] 1/15 3/2 38/3
sessions [3] 80/19 88/21 95/2
set [17] 4/6 6/5 7/18 8/8 10/9 22/12 37/21 44/24 49/17 51/16 54/22 131/17 140/11 141/6 144/16 154/9 160/6
sets [2] 159/18 159/19
setting [6] 4/19 9/20 12/13 12/15 151/5 151/8
settings [10] 77/25 115/15 139/22 140/3 143/3 144/5 144/24 144/24 145/17 147/20
settled [1] 131/18
settlement [1] 132/3
seven [1] 58/15
sevens [1] 134/5
several [3] 56/2 94/11 109/13
severely [1] 148/17
SG [5] 48/1 48/13 48/21 49/5 49/22

S

SG Recruitment [5] 48/1 48/13 48/21 49/5 49/22
shall [4] 39/22 99/16 159/9 159/17
Shamefully [1] 56/18
shape [1] 99/11
shaped [1] 74/9
shapes [1] 146/24
share [5] 79/2 120/15 126/4 149/14 155/2
shared [24] 33/3 69/7 70/15 71/18 71/22 72/9 72/14 73/4 73/5 76/7 86/8 98/22 102/1 102/9 103/2 105/24 106/2 106/19 120/9 152/8 153/22 154/4 154/25 162/4
sharing [2] 104/2 106/15
Sharma [5] 1/5 1/14 23/25 36/2 39/19
sharper [1] 114/3
she [4] 66/22 88/11 115/24 116/2
shed [1] 87/15
sheer [2] 7/25 107/13
shift [2] 88/19 116/2
shifts [1] 134/10
shipment [2] 26/20 26/21
shipping [4] 14/2 14/5 15/23 19/23
shocking [1] 138/10
shocks [1] 85/18
shoots [1] 154/6
shops [1] 42/14
short [10] 39/25 74/25 89/5 99/19 107/22 112/13 122/13 122/18 149/19 158/14
short-term [1] 158/14
shortage [2] 17/22 142/14
shortages [15] 30/11 69/15 71/2 75/2 75/12 75/16 100/17 102/4 139/3 139/9 139/17 142/21 143/20 144/4 144/16
shortcomings [4] 74/18 84/21 86/17 86/22
shorten [2] 10/14 10/15
shorter [1] 51/12
shortly [2] 63/11 102/11
should [39] 8/4 36/14 36/17 43/11 46/2 46/9 50/8 52/16 54/5 56/8 56/9 58/7 61/19 62/7 64/22 72/6 80/10 91/21 93/22 95/9 104/20 108/16 121/7 126/3 130/13 130/18 131/10 131/15 131/18 133/8 142/23 150/19 154/21 156/18 157/2 157/3 157/13 158/5 158/11
shouldn't [2] 59/6 129/16
show [2] 129/13 133/19
showed [4] 21/3 100/17 133/13 153/16
showing [3] 13/7 24/16 82/5
shown [6] 20/20 48/17 114/13 117/15 121/17 152/7
shows [3] 76/14 126/10 155/4
shy [2] 54/8 77/11
shysters [1] 55/12
sic [2] 25/3 38/8
sick [1] 80/23
side [2] 12/14 12/14
sidelined [2] 84/5 85/3
sign [2] 6/14 16/23
signalled [1] 76/19
signed [1] 13/17
significant [17] 60/18 63/5 64/7 64/10 74/7 81/14 85/20 88/8 88/19 89/13 103/19 112/4 115/4 141/19 145/23 146/15 146/25
significantly [3] 30/21 51/20 97/19
signing [1] 30/25
similar [3] 11/10 27/25 111/13
Similarly [2] 141/5 146/7
simple [2] 12/3 43/3
simply [14] 28/2 28/2 33/4 45/13 64/23 65/14 74/12 102/13 116/9 125/18 133/7 143/1 147/2 158/2
simultaneously [1] 140/13
since [5] 3/22 39/4 117/24 133/20 140/7
single [9] 16/23 34/18 46/10 53/1 53/1 114/18 118/1 130/6 132/11
Sir [4] 4/8 51/24 83/1 140/22
Sir Gareth [1] 140/22
sit [1] 122/1
site [1] 130/6
sitting [2] 66/21 140/24
situation [10] 8/8 15/1 31/12 70/25 79/9 86/7 117/13 119/19 125/5 156/14
situations [1] 18/22
six [3] 13/2 93/10 144/7
six days [1] 144/7
six weeks [1] 93/10
six-week [1] 13/2
sixth [1] 148/16
size [8] 18/19 57/9 87/9 89/15 110/19 112/7 121/11 146/23
sizes [1] 146/24
skilled [1] 114/25
skills [2] 59/20 114/16
SLA [1] 108/9
Slade [5] 69/21 70/9 72/4 104/8 104/24
slavery [1] 60/5
sleeved [1] 69/16
slight [1] 13/22
slightly [3] 29/16 35/7 127/11
slow [3] 67/3 72/12 116/4
slowdown [1] 76/20
small [6] 53/19 55/6 62/24 112/7 112/11 138/16
small-country [1] 112/11
so [106] 4/4 4/6 4/13 6/11 6/24 7/3 7/11 8/12 8/22 8/24 9/11 10/16 12/17 12/20 12/23 14/2 14/8 15/7 15/14 15/16 15/20 15/23 16/10 17/8 17/16 18/5 18/9 18/13 18/17 19/3 19/20 20/19 22/4 22/21 23/20 24/10 24/15 24/16 24/18 25/5 25/9 26/13 26/20 28/4 28/15 29/13 30/9 30/24 31/3 31/5 31/25 32/21 33/23 33/24 35/1 35/4 35/22 36/19 37/4 37/20 38/18 39/14 39/22 52/12 56/15 57/22 63/7 63/16 67/3 70/2 70/12 71/13 74/8 75/14 76/18 80/10 82/2 89/6 90/19 96/24 113/2 119/6 123/7 126/11 130/4 130/20 130/23 131/1 131/11 133/9 134/13 135/4 135/6 136/24 144/20 149/9 149/19 149/19 150/18 151/24 152/2 155/10 155/10 159/14 159/20 160/16
so-called [1] 56/15
social [31] 1/19 2/24 4/5 4/14 5/14 28/15 35/19 42/10 43/6 54/2 57/6 57/12 67/24 68/11 71/9 95/11 102/18 107/24 108/5 110/2 111/1 114/6 115/14 115/18 115/21 121/5 126/9 138/12 139/23 140/3 145/18
society [2] 10/12 160/13
soft [1] 48/22
solely [2] 80/11 133/11
solution [2] 84/12 119/17
solutions [1] 126/5
some [62] 1/11 1/12 6/17 6/19 6/20 12/6 13/3 14/17 14/18 17/2 19/19 22/5 22/19 31/5 32/2 33/1 37/1 37/12 37/16 37/19 37/19 38/2 38/2 38/3 38/4 39/10 40/19 42/24 45/24 45/25 52/6 56/25 56/25 58/1 60/22 62/14 62/17 67/12 71/20 83/22 87/15 88/16 92/18 95/4 97/24 98/7 100/12 108/9 114/12 123/17 125/12 126/6 134/21 146/19 149/11 151/20 152/4 152/22 158/3 158/13 160/7 160/11
somebody [4] 21/13 22/21 31/25 33/18
somehow [1] 152/5
someone [4] 27/5 48/23 50/3 151/7
something [8] 10/3 42/25 53/13 56/16 57/7 132/8 150/20 157/1
sometimes [6] 16/22 16/23 21/6 21/6 36/21 45/18
sooner [1] 159/16
sorry [14] 5/5 18/14 23/25 23/25 24/2 38/23 99/24 100/2 104/16 113/5 113/6 113/6 149/3 160/10
sort [15] 4/8 4/10 4/17 9/18 15/11 16/18 19/1 22/2 22/12 24/21 27/20 33/9 34/6 37/8 38/20
sorts [1] 12/16
sought [8] 52/10 78/19 82/13 94/19 124/4 124/5 131/4 134/7
source [6] 47/2 53/24 55/3 96/7 112/18 115/15
sources [4] 59/25 117/18 152/10 153/1
sourcing [3] 93/25 100/21 151/4
space [1] 38/1
sparing [1] 143/22
speaking [2] 30/22 32/23
speaks [2] 52/21 86/23
spec [2] 19/4 19/6
specced [1] 32/2
special [3] 53/17 57/25 106/22
specialising [1] 152/17
specialist [2] 48/4 136/3
specific [9] 18/9 67/12 93/4 93/24 94/7 94/17 130/13 131/24 147/3
specifically [4] 4/21 30/10 83/3 88/4
specification [2] 91/23 111/6
specifications [4] 88/3 132/7 148/5 151/5
specificity [1] 32/20
specifics [1] 131/4
specified [1] 109/17
specs [1] 30/12
spectrum [1] 18/17
speed [5] 45/3 85/1 131/3 134/16 136/15
speedily [1] 64/13
speedy [1] 51/5
spend [4] 10/13 53/8 78/5 83/10
spending [7] 42/4 78/6 93/19 94/17 131/3 131/8 154/7
spent [14] 3/14 10/15 43/5 45/4 52/20 59/12 59/14 78/2 79/13 79/21 80/22 129/3 129/16 130/22
spike [1] 14/13
spirit [1] 120/15
spoke [1] 48/20

S

spot [1] 48/22
spots [1] 88/24
spread [4] 64/17 67/6 78/11 108/3
spreading [1] 69/18
spreadsheet [1] 141/7
spreadsheets [2] 55/8 156/1
spring [1] 107/8
stabilised [1] 71/23
staff [41] 1/19 2/2 2/7 2/14 2/15 4/19 11/24 42/1 42/13 58/16 64/15 67/4 69/18 70/5 71/12 83/4 98/6 98/25 112/25 115/22 115/25 126/8 126/19 138/12 139/7 139/18 140/19 141/1 141/7 141/9 142/21 143/22 144/13 145/8 145/10 145/19 145/22 146/13 146/18 148/9 148/14
staffed [1] 111/16
staffing [2] 76/9 156/21
stage [9] 16/2 18/4 22/2 49/22 62/25 63/15 109/13 144/23 153/4
stages [5] 96/2 96/20 97/1 100/23 145/20
stagnation [1] 65/22
stakeholder [1] 37/6
stand [5] 16/18 28/6 31/23 106/17 138/23
stand-up [1] 31/23
stand-ups [1] 16/18
standard [7] 85/10 88/4 101/2 109/20 130/12 156/13 157/18
standards [4] 52/4 53/7 53/15 92/9
standing [3] 104/18 131/19 135/4
Stanton [4] 137/14 137/16 149/5 162/17
stark [2] 41/13 82/23
start [7] 1/11 1/24 24/17 35/18 39/22 41/12 125/3
started [1] 70/17
starting [5] 1/6 70/1 129/1 132/4 137/24
State [2] 10/10 150/11
stated [3] 74/24 94/19 96/6
statement [49] 7/7 7/22 11/9 41/8 53/11 54/18 65/11 66/8 76/4 78/22 81/8 91/6 91/9 94/2 98/19 100/3 100/9 101/16 102/17 105/24 113/9 113/11 113/16 114/10 116/10 118/24 122/10 127/3 127/6 128/24 128/25 134/2 137/15 149/7 149/11 149/15 161/8 161/11 161/15 161/18 161/21 161/24 162/1 162/4 162/7 162/10 162/13 162/16 162/19
statements [6] 3/6 31/21 38/4 68/25 91/12 148/23
static [1] 8/15
status [1] 126/4
staunch [1] 56/6
stay [1] 43/11
steer [1] 9/9
steers [1] 9/7
step [3] 10/8 130/18 132/10
stepped [1] 45/15
stepping [1] 49/11
steps [4] 46/3 97/6 123/14 148/8
sterile [8] 14/6 14/7 14/8 18/21 18/22 19/13 19/13 28/23
stickers [1] 138/13
still [8] 39/4 47/1 58/20 65/9 97/16 143/8 155/13 155/23
stimulate [1] 104/22
stock [40] 11/13 11/22 21/11 29/23 31/24 32/2 67/18 68/3 68/5 68/12 68/18 69/7 70/1 70/12 70/12 70/19 70/22 71/10 72/2 73/8 73/20 97/11 98/4 101/18 101/23 102/12 110/10 110/14 116/22 116/25 124/23 124/25 125/1 125/2 125/5 125/6 125/9 125/17 137/25 140/1
stocked [1] 83/2
stockpile [21] 67/17 68/13 100/25 105/11 110/14 110/16 118/9 118/15 118/17 123/12 125/16 125/22 137/24 138/5 138/7 138/11 138/17 138/23 139/3 142/13 147/15
stockpiles [6] 35/8 35/9 43/23 43/25 54/25 67/14
stockpiling [1] 77/16
stocks [14] 69/24 100/17 101/2 101/5 101/14 102/8 103/11 118/10 118/11 118/19 120/10 120/12 143/24 154/18
StockWatch [1] 73/4
stone [1] 49/11
stop [3] 37/23 76/20 144/22
storage [5] 44/1 110/9 110/14 111/12 158/9
store [6] 73/2 102/11 102/12 102/14 110/3 112/18
stored [1] 43/16
stores [5] 72/15 72/20 72/20 73/10 110/11
story [2] 53/15 67/1
straight [1] 154/9
straightforward [1] 136/24
strain [1] 114/2
strategic [4] 88/1 114/19 132/25 135/16
strategies [3] 84/18 87/25 150/19
strategy [6] 68/16 123/11 125/15 125/18 150/24 156/19
straws [1] 152/18
strengthen [1] 97/25
stress [4] 65/23 86/7 139/18 147/2
stresses [1] 2/20
stretched [2] 54/3 111/10
striking [1] 61/9
stringent [1] 85/14
strong [3] 135/17 157/3 157/22
stronger [2] 138/24 147/23
strongly [1] 143/10
strove [1] 121/24
structural [3] 84/21 90/15 90/17
structure [4] 104/3 120/3 120/5 120/19
structured [3] 151/7 152/12 156/4
structures [5] 96/22 103/6 103/16 103/17 123/3
struggle [1] 55/18
struggled [1] 141/7
subject [2] 15/22 51/18
subjected [1] 143/12
subjectively [1] 51/14
submission [1] 126/10
submissions [17] 39/22 40/4 41/5 41/11 48/12 66/11 77/5 77/5 80/12 80/18 81/1 100/8 106/1 137/11 159/4 159/10 159/12
submit [2] 113/23 121/16
submits [1] 120/19
subsequent [1] 97/9
subsided [1] 153/8
substantial [7] 13/24 22/10 57/16 99/1 106/8 108/18 140/23
substantive [2] 89/8 109/7
substitute [3] 29/21 30/7 30/13
substituted [1] 139/11
success [1] 41/22
successful [3] 25/11 58/12 63/4
successfully [2] 109/22 117/17
such [35] 30/16 49/21 58/1 59/24 64/22 65/3 65/13 69/5 69/15 70/14 71/5 73/22 75/1 75/11 75/12 75/17 83/9 97/15 103/8 104/7 114/4 116/23 120/19 125/18 125/24 126/24 131/18 133/3 136/3 137/8 138/16 139/22 154/5 156/3 157/9
sudden [1] 125/19
suddenly [1] 103/6
suffered [2] 146/3 158/20
suffering [2] 113/1 126/16
sufficiency [1] 117/23
sufficient [11] 53/24 59/20 71/20 91/23 97/21 101/14 125/17 142/15 143/1 144/23 148/13
sufficiently [3] 107/21 108/6 109/12
suggest [4] 57/9 58/23 72/1 158/4
suggested [10] 33/2 53/21 68/3 69/21 70/4 70/9 72/24 92/5 94/7 146/20
suggesting [3] 14/19 17/3 56/6
suggestion [4] 47/13 72/23 73/3 73/15
suggests [2] 71/24 141/22
Suit [1] 28/23
suitability [1] 85/12
suitable [4] 36/9 83/3 105/9 147/16
suits [2] 29/5 66/22
summarise [2] 23/8 97/24
summarises [1] 15/1
summarising [1] 35/2
summary [1] 26/14
summer [3] 34/7 108/5 159/16
Sumner [2] 48/21 49/9
sums [3] 78/2 131/9 133/13
superficial [1] 55/3
supplied [12] 32/21 46/14 69/9 70/6 72/14 77/24 91/12 108/6 109/17 109/20 119/4 142/7
supplier [11] 21/13 21/13 26/4 51/7 53/1 108/17 123/25 133/8 133/14 151/10 151/21
supplier's [1] 133/19
suppliers [33] 22/11 36/21 37/19 46/15 51/2 57/8 57/19 57/20 85/24 104/19 115/3 115/17 123/10 123/22 130/14 131/1 131/21 132/12 132/25 141/19 150/9 151/14 151/22 152/14 152/20 152/21 154/19 154/23 155/1 155/10 155/15 155/19 157/17
supplies [24] 42/15 66/23 76/11 78/5 83/8 84/6 85/12 91/19 101/25 102/20 105/9 119/3 119/7 119/9 120/12 121/25 123/1 123/14 124/2 124/13 124/18 124/24 143/5 148/11
supply [63] 2/6 12/1 12/6 25/13 31/1 32/15 42/1 44/2 45/13 45/18 45/20 53/24 54/22 59/25 60/6 62/20 69/22 71/4 71/19 74/3 74/9 74/11 75/16 80/18 90/12 93/6 95/11 97/6 98/4 98/13 99/7 101/7 103/20 104/25 108/11 108/23 110/7 111/3 111/7 112/1 112/20 115/20 117/11 117/18 117/25 120/10 123/13 123/20 124/1 124/6 125/19

S

supply... [12] 133/1 138/2 138/2 138/18 138/19 139/24 140/9 142/5 142/7 144/16 144/24 148/13
supplying [3] 70/16 72/11 101/9
support [14] 2/6 4/7 5/1 5/3 34/3 50/17 98/6 110/21 118/8 122/5 124/16 137/7 148/14 157/23
supported [1] 157/5
supporting [6] 2/15 4/14 4/19 21/9 26/16 157/10
supports [2] 124/11 124/14
suppressed [1] 144/21
sure [7] 11/8 20/16 76/23 83/1 155/13 155/22 155/23
surge [6] 118/20 124/1 136/11 136/24 137/9 156/21
surgical [6] 18/22 68/12 109/23 142/16 144/11 145/7
surplus [1] 97/11
surprise [3] 61/25 105/19 105/23
surprised [1] 7/9
SurveyMonkey [1] 156/2
suspect [2] 56/2 157/21
swamped [2] 78/13 80/1
swiftly [3] 50/24 147/19 158/23
sworn [2] 1/9 161/2
Sylvia [1] 66/19
sympathise [1] 82/6
system [66] 5/4 16/19 22/12 32/7 32/11 32/18 33/21 34/3 34/8 34/12 34/18 35/20 37/4 37/8 37/8 44/13 55/10 56/11 56/15 56/21 57/2 57/24 58/8 59/4 59/8 60/2 62/11 64/24 69/25 70/20 71/9 71/10 72/2 73/5 79/15 80/1 80/1 80/7 80/9 81/20 81/21 84/13 84/15 84/15 85/17 85/20 87/4 97/16 101/2 101/4 111/23 114/1 116/19 116/23 116/24 117/7 121/7 121/9 121/14 125/8 133/6 139/19 140/12 140/19 151/4 153/19
systematic [1] 117/4
systemic [3] 55/21 86/14 89/7
systems [30] 34/6 42/7 47/5 53/4 54/24 61/7 77/22 78/12 81/14 87/2 88/14 88/20 88/22 89/2 90/13 111/11 112/2 112/5 122/22 122/24 123/3 124/11 126/11 127/13 127/21 128/12 135/19 141/5 148/4 156/4

T

table [1] 13/22
take [20] 10/8 10/16 17/1 20/20 30/14 44/21 44/25 67/5 68/6 91/5 92/16 99/10 103/24 107/22 122/16 123/14 126/12 127/8 127/15 147/13
taken [14] 11/8 11/11 26/21 29/24 35/8 36/12 46/2 62/5 79/20 79/23 79/25 98/15 137/9 148/8
takes [2] 24/16 155/8
takes' [1] 45/2
taking [8] 11/13 27/15 33/12 51/14 101/10 112/15 127/11 152/2
talk [1] 149/22
talking [1] 36/9
Tam [1] 142/19
tangible [1] 86/12
target [3] 19/7 30/9 68/13
targeted [1] 32/12
task [2] 18/12 54/25
tasked [1] 121/4
tattoo [1] 42/15
team [23] 4/5 4/18 13/16 15/14 16/13 16/18 21/21 28/13 36/25 37/15 38/5 49/25 49/25 50/21 50/23 51/17 57/18 123/6 133/20 136/13 151/21 159/11 160/5
teams [5] 1/21 9/19 34/4 89/24 122/5
technical [11] 8/21 49/25 50/15 50/21 50/24 75/7 131/24 133/10 133/25 134/2 136/8
technology [2] 59/19 155/25
tell [1] 89/1
tells [1] 72/10
temporarily [1] 115/13
ten [4] 7/6 7/7 151/15 155/8
tenders [3] 153/7 153/23 154/3
tenets [1] 113/23
tension [1] 132/18
tensions [1] 70/5
term [3] 27/15 69/10 158/14
terms [25] 2/9 4/10 5/20 5/22 7/2 9/2 10/1 11/17 14/23 15/25 16/6 17/25 18/15 20/14 24/22 27/9 33/18 34/1 41/19 43/3 57/8 65/19 91/22 105/10 114/5
test [10] 5/1 5/1 34/25 68/7 68/8 133/21 134/15 134/16 136/19 136/22
tested [1] 68/4
testimonies [4] 84/20 85/22 87/23 90/16
testimony [9] 82/23 82/23 85/6 86/8 86/25 87/15 88/9 89/18 153/5
testing [10] 71/13 83/18 109/24 111/9 129/22 133/14 133/15 133/20 133/23 136/17
tests [8] 68/9 128/6 128/14 132/6 134/4 134/12 134/12 134/20
than [48] 1/7 7/8 7/9 10/20 10/21 11/25 12/3 14/3 14/5 15/15 32/3 32/12 36/25 37/10 45/16 47/14 50/25 53/12 55/10 55/19 56/5 56/12 62/22 64/20 70/15 72/19 73/1 73/11 79/22 107/17 112/19 130/10 131/13 138/1 138/25 142/5 144/11 151/5 151/13 152/9 152/21 152/22 153/17 155/6 155/11 157/20 158/21 160/1
thank [64] 1/14 3/3 3/4 5/5 12/9 12/15 17/2 17/18 17/20 19/18 20/4 23/4 23/16 24/4 25/18 29/15 35/25 36/2 38/10 38/23 39/5 39/14 39/17 39/18 40/15 40/22 41/3 41/4 41/6 41/10 54/15 54/20 66/4 66/5 66/10 76/1 76/2 77/3 81/3 91/2 91/3 99/13 99/14 99/17 100/1 105/17 105/18 113/4 122/7 122/8 122/12 126/25 127/1 137/13 137/17 149/1 149/5 149/9 158/16 158/25 159/1 159/7 159/14 160/16
thanks [3] 122/2 122/4 122/19
that [698]
that I [14] 1/21 6/25 10/16 11/5 30/22 34/22 34/23 37/3 38/1 38/8 60/21 124/19 146/6 160/6
that's [26] 2/11 3/15 3/18 3/21 5/6 5/15 5/25 8/9 10/16 11/21 16/5 19/15 22/22 23/16 24/18 25/7 27/7 27/8 27/11 27/17 33/15 37/10 69/7 71/10 157/1 159/6
their [78] 2/20 4/20 6/20 9/14 9/14 11/24 16/2 18/12 22/6 22/18 34/11 42/13 42/18 43/10 46/4 47/14 47/25 48/4 48/6 49/11 49/12 50/6 51/8 53/9 53/10 55/8 55/23 58/25 59/8 61/5 65/11 71/21 73/2 73/7 75/6 76/10 76/14 76/17 77/3 78/18 78/20 80/12 80/23 84/17 90/25 91/22 93/5 95/16 96/16 96/21 98/9 102/8 109/23 111/25 112/16 115/16 117/24 125/20 126/23 129/2 129/7 129/15 131/12 131/24 132/3 136/1 136/21 143/23 144/4 145/12 145/12 145/24 148/14 150/17 151/10 152/5 156/16 160/3
Theirs [1] 58/25
them [39] 6/18 6/21 7/14 14/21 17/3 18/12 30/11 31/22 46/7 47/12 50/17 51/2 51/7 51/8 56/19 59/18 67/2 67/4 73/16 77/2 77/3 80/24 81/21 84/18 92/2 95/20 96/8 96/17 105/6 115/23 126/18 126/23 127/11 127/22 133/24 136/10 145/3 151/23 152/1
theme [3] 9/21 132/16 135/18
themes [2] 98/20 128/22
themselves [9] 2/16 2/18 8/13 22/18 48/24 58/24 68/20 130/21 155/14
then [43] 4/1 4/21 9/6 12/6 12/19 12/25 13/1 13/3 14/4 14/14 15/17 18/7 19/13 19/23 19/24 19/25 20/4 20/5 20/9 20/10 23/1 23/23 24/5 27/6 27/6 29/2 29/6 29/15 29/25 29/25 34/13 38/19 41/5 49/2 51/24 61/3 74/10 92/23 98/2 122/18 124/4 151/9 154/5
theoretical [1] 64/6
theory [2] 53/21 72/14
there [133] 1/12 2/6 3/13 8/22 9/15 10/11 13/9 13/18 15/20 16/13 16/17 16/19 17/21 18/2 19/11 19/11 19/23 20/22 21/8 21/8 21/20 25/4 27/24 28/3 28/24 30/11 31/13 34/2 35/22 36/15 36/20 38/13 38/19 38/25 39/3 39/4 39/4 39/20 40/5 40/16 41/14 42/9 43/13 43/15 43/22 44/5 44/15 44/23 45/23 46/12 46/24 47/11 47/13 50/12 50/12 57/24 59/17 60/19 62/7 62/18 62/23 64/11 65/20 65/21 66/20 66/22 68/18 69/25 70/7 70/9 70/10 70/12 70/21 71/5 72/18 72/22 75/3 75/12 75/24 76/21 77/17 78/7 78/14 78/17 79/18 82/1 88/2 89/11 90/9 95/17 95/24 95/25 96/21 100/16 100/23 102/7 102/12 103/13 107/7 108/13 108/13 108/14 108/21 108/24 109/1 109/9 109/10 110/9 111/2 111/15 113/7 114/7 116/21 117/4 119/14 120/22 124/14

T

there... [16] 125/21 141/12 142/11 142/14 145/5 146/14 147/19 147/21 148/1 148/21 150/14 150/15 150/18 150/23 153/5 156/18
there's [5] 2/5 14/13 28/16 32/25 50/9
thereafter [3] 71/19 102/11 115/19
thereby [3] 45/19 49/12 117/9
therefore [13] 25/14 26/3 40/10 49/16 50/12 63/15 70/6 94/1 101/21 103/22 108/15 114/10 123/9
thereof [1] 97/23
these [50] 2/15 14/20 16/15 16/25 17/4 19/19 20/1 23/6 23/7 24/6 25/19 28/9 29/8 45/15 47/22 51/1 51/19 58/22 60/16 63/14 66/11 75/19 81/1 81/17 82/16 83/25 84/8 85/19 86/17 86/24 87/6 88/11 88/21 88/25 90/20 92/1 95/2 95/23 104/13 106/1 109/4 113/21 114/8 118/11 126/15 139/17 141/3 155/8 156/9 158/22
they [104] 2/8 2/17 3/6 3/10 6/9 6/11 6/13 6/16 6/17 6/17 6/20 7/4 8/13 8/19 8/23 9/9 15/16 16/3 17/8 17/9 18/5 18/5 21/20 23/8 24/14 36/12 36/17 41/17 41/20 41/21 41/22 43/11 47/6 50/2 51/4 51/6 52/11 52/12 57/7 59/1 59/2 59/6 59/11 61/5 61/24 64/9 67/7 68/10 70/1 70/25 72/25 73/1 73/14 76/11 76/18 76/23 77/3 77/10 77/11 79/4 79/8 83/21 83/24 83/25 86/6 86/16 87/2 89/1 89/1 101/12 101/23 103/24 114/24 115/15 116/1 117/14 126/20 127/12 127/24 129/6 129/8 131/15 132/13 133/21 133/24 134/4 134/6 136/1 139/8 141/10 143/23 144/25 145/1 148/10 149/19 149/20 149/20 149/23 149/24 150/13 152/1 152/5 155/9 155/10
they'd [2] 24/14 73/1
they're [3] 3/8 7/15 82/17
they've [2] 27/6 149/5
thing [2] 95/6 154/10
things [5] 16/15 39/21 58/19 149/12 149/19
think [54] 2/4 8/24 8/25 13/23 18/19 21/2 25/2 25/3 25/10 26/13 27/16 27/19 29/13 31/20 31/20 32/4 32/23 33/2 33/9 33/21 34/6 34/19 36/3 37/1 37/6 37/10 37/12 37/13 37/18 39/2 39/7 39/10 39/19 41/5 41/7 54/17 56/7 66/7 76/3 81/5 87/12 99/22 105/20 105/22 113/7 122/9 141/3 149/6 157/11 158/5 159/3 159/5 159/6 159/25
thinking [2] 34/25 37/3
thinly [1] 108/3
third [8] 1/19 5/19 17/1 22/10 71/8 144/2 148/1 157/13
Thirdly [1] 126/3
thirds [1] 71/21
this [247]
this additional [1] 22/16
Thomas [5] 81/5 81/7 81/9 91/3 161/23
those [107] 1/17 1/18 2/2 2/20 5/22 5/23 5/24 6/4 6/8 6/14 7/20 11/20 14/17 15/18 15/22 16/9 19/7 19/12 20/23 20/25 22/12 22/13 27/13 30/10 31/23 32/14 33/20 34/14 35/3 36/24 38/20 41/3 44/20 45/21 46/3 46/11 46/20 47/3 47/10 48/10 49/6 49/20 49/24 50/6 51/4 52/19 53/19 54/9 57/13 58/9 58/13 58/14 58/24 59/8 59/9 63/7 65/6 69/6 69/14 71/12 75/2 75/10 76/9 76/17 76/21 77/5 78/15 78/17 78/19 78/23 80/22 81/18 82/6 84/2 87/25 88/6 91/18 92/2 95/21 96/6 96/25 98/7 98/25 99/5 101/12 103/15 103/17 106/24 108/5 112/25 113/19 116/4 121/8 122/4 122/22 126/13 128/22 131/10 136/18 144/20 149/14 154/3 154/6 154/8 155/14 157/5 158/20
though [5] 10/8 24/8 24/19 61/7 62/17
thought [9] 25/15 32/13 35/14 38/24 42/24 43/21 48/21 50/20 79/9
thousands [1] 69/1
threat [1] 140/6
threatened [1] 83/23
three [13] 5/20 16/24 22/25 122/23 124/15 125/13 127/8 128/22 134/6 138/22 140/1 154/15 158/14
threes [1] 134/5
threshold [3] 6/13 6/23 7/3
through [40] 2/22 4/23 5/1 6/20 8/15 8/19 10/12 13/9 14/12 14/20 16/2 17/3 17/16 17/23 19/19 22/10 22/23 34/12 36/21 37/10 49/19 51/12 57/1 58/18 69/18 83/17 85/22 87/17 106/19 106/24 121/24 133/15 133/22 135/20 135/22 136/20 148/11 148/20 151/25 157/17
throughout [12] 9/21 71/3 76/20 82/1 82/22 83/7 95/1 101/12 106/6 109/10 111/4 121/18
throw [1] 44/25
throwing [1] 149/24
Thursday [1] 1/1
Thus [1] 121/6
tidied [1] 35/23
tiered [1] 58/8
ties [2] 18/20 149/22
Tim [1] 62/15
time [56] 1/8 3/1 8/19 10/7 11/16 15/15 15/17 16/19 16/20 21/19 25/10 25/16 37/11 39/2 45/4 50/9 52/19 58/7 58/20 59/12 59/14 59/17 60/19 66/20 79/21 81/15 83/10 84/11 84/11 86/2 89/4 95/5 97/21 101/24 108/10 109/5 115/12 115/15 117/12 123/5 123/11 124/7 125/10 125/15 125/17 126/15 126/24 129/21 138/18 139/11 140/8 147/22 154/18 155/7 156/16 159/24
timeframe [1] 24/16
timelessly [1] 76/12
timeliness [3] 12/1 21/12 106/13
timely [5] 31/1 98/8 137/21 141/12 154/17
times [19] 42/15 53/9 79/1 79/17 79/17 81/23 85/8 95/25 104/3 111/18 111/23 113/25 116/3 116/4 120/6 151/15 152/22 157/25 158/19
timescales [2] 9/16 27/25
timetable [3] 160/7 160/9 160/9
timing [2] 21/10 134/9
today [11] 1/23 2/4 38/3 58/21 87/11 97/17 100/12 113/12 127/11 128/23 129/11
together [8] 6/16 6/25 15/8 34/4 91/25 106/13 114/19 130/16
told [15] 41/17 43/8 43/10 43/20 45/7 51/10 100/22 101/10 102/8 103/10 143/6 145/13 146/1 153/9 160/6
toll [1] 77/1
tonight [1] 17/24
too [11] 52/6 63/13 63/15 72/11 116/4 121/5 138/1 147/8 153/6 153/6 157/12
took [10] 36/16 44/20 71/18 74/21 77/1 93/15 94/2 97/5 151/11 153/6
tool [1] 148/19
tools [4] 156/3 156/9 157/4 157/9
top [1] 12/24
topic [2] 122/20 124/19
topics [1] 122/17
total [5] 44/6 152/17 154/2 154/6 155/20
totalling [1] 68/25
touch [2] 95/6 133/20
touched [2] 36/7 86/4
towards [2] 36/7 134/19
tower [1] 120/1
Trace [3] 5/2 136/19 136/22
tracing [1] 129/22
track [3] 22/11 34/10 36/10
tracked [1] 134/9
tracking [1] 130/17
trafficking [1] 60/5
tragically [2] 66/17 146/13
trail [2] 84/6 108/24
trained [1] 135/23
training [2] 34/14 59/21
transaction [6] 23/11 30/16 30/19 33/24 33/25 34/1
transactions [2] 25/19 136/13
transformational [1] 157/11
transformed [1] 117/20
translated [1] 121/21
transmission [1] 74/6
transmitted [1] 128/2
transparency [19] 53/7 54/13 77/19 82/25 85/3 85/7 87/21 90/4 90/5 92/9 109/3 127/12 128/25 129/6 129/10 129/25 130/25 132/9 148/17
transparent [5] 44/16 56/20 56/21 63/3 92/13
transparently [1] 80/10
transport [3] 14/2 29/12 29/14
trauma [1] 86/18
traumatised [1] 149/22
Treasury [1] 131/19
treat [1] 42/20
treated [1] 129/6
treating [2] 145/8 154/23
treatment [6] 58/1 60/6 108/16 108/22 141/18 148/20
tremendous [1] 141/25
triage [12] 34/10 36/9 46/10 46/17 56/15 56/23 57/1 57/24 80/1 80/9 116/8 116/9
triaged [4] 33/22 48/20 57/3 116/8
triaging [5] 46/9 46/13 55/10 79/21 156/10
tribute [1] 121/23

T

tried [1] 93/10
trouble [1] 154/11
trousers [1] 19/2
true [2] 3/8 129/3
trust [13] 6/12 7/1 83/11 84/1 90/6 106/19 106/22 138/15 139/21 141/20 145/3 148/17 149/16
trusted [1] 49/16
trusts [7] 43/24 95/12 95/22 96/8 101/22 111/24 143/14
truth [2] 143/8 145/5
truthful [2] 143/9 158/22
try [4] 39/15 58/15 76/22 119/15
trying [10] 18/25 20/13 30/9 39/13 51/18 68/20 76/17 134/14 134/14 140/13
turn [16] 12/12 12/21 20/4 23/15 23/23 24/5 28/16 28/21 29/6 40/4 45/13 67/12 76/3 84/19 116/14 132/14
turning [4] 117/11 119/23 125/12 145/10
turnover [1] 49/1
two [33] 3/5 7/23 13/22 15/10 16/25 17/12 19/12 20/23 20/25 24/25 27/6 27/13 28/2 39/4 39/21 40/5 46/25 48/3 49/3 50/22 52/1 58/8 71/21 93/1 93/13 122/17 127/20 130/5 134/4 137/19 140/20 141/14 144/19
two weeks [2] 15/10 28/2
two-thirds [1] 71/21
type [2] 37/8 107/11
types [4] 20/25 33/6 117/5 132/13

U

UK [58] 24/7 41/9 41/12 42/4 43/7 44/10 45/12 45/17 53/10 54/21 55/1 55/4 59/8 60/25 67/15 74/21 76/8 78/2 78/24 79/3 79/20 79/23 80/14 85/9 109/18 112/14 112/20 119/4 119/6 120/2 120/4 122/23 123/11 123/12 124/18 125/16 125/23 138/12 139/3 140/21 149/7 149/10 150/19 151/11 153/16 153/19 154/1 154/6 154/7 155/1 155/3 156/9 156/19 157/2 157/5 157/11 161/9 162/19
UK Anti-Corruption [1] 149/10
UK Government [10] 42/4 45/17 60/25 78/2 79/3 79/20 79/23 119/4 119/6 120/4
UK Government's [3] 78/24 123/11 155/3
UK's [4] 53/11 54/6 147/12 147/22
UK-wide [1] 112/14
UKACC [3] 150/5 152/8 153/15
UKHSA [14] 127/7 127/23 128/11 128/20 128/22 129/19 131/4 131/6 132/10 135/6 135/11 136/6 137/2 137/12
UKHSA's [3] 127/14 133/13 134/1
Ukraine [1] 156/8
Ukraine's [1] 157/10
ultimately [4] 49/3 55/9 64/25 78/21
unable [6] 42/12 67/5 73/6 96/7 115/15 146/12
unacceptable [2] 37/14 119/17
unacceptably [1] 43/7
unanswered [2] 75/20 75/24
unattended [1] 70/23
unavailability [1] 83/17
unaware [1] 68/18
unbearable [1] 46/21
uncertain [1] 65/20
uncertainty [3] 86/5 124/8 134/21
unchanged [1] 8/13
unclear [1] 34/20
uncovered [1] 89/7
uncovering [1] 81/15
under [15] 23/20 38/5 39/9 39/12 49/2 49/4 107/14 108/23 110/23 111/13 114/1 118/2 126/15 130/10 154/10
underfunded [1] 64/24
undergo [1] 111/8
undermine [1] 52/10
undermined [1] 138/15
undermines [1] 82/12
underneath [1] 29/15
underscored [1] 90/16
underscores [2] 86/12 88/19
understand [12] 1/12 3/11 10/19 37/13 41/19 60/21 72/23 73/3 73/7 75/10 84/7 96/24
understanding [11] 9/12 9/14 10/7 10/24 22/19 33/3 33/5 70/5 114/3 130/19 139/5
understands [3] 112/17 136/4 159/9
understood [3] 72/2 96/16 126/20
undertaken [1] 134/3
undertakers [1] 66/22
undertaking [1] 4/10
undisclosed [1] 65/6
undoubtedly [6] 45/3 45/23 78/17 81/24 114/7 141/15
undue [3] 48/10 61/19 84/1
unelected [1] 47/24
unequivocal [1] 96/5
unethical [1] 60/6
unfit [2] 73/5 139/25
unfocused [1] 151/3
unhelpful [1] 101/7
unified [1] 130/5
unimaginable [1] 78/4
unique [4] 56/18 77/18 132/6 134/11
unit [19] 12/16 12/18 15/4 19/22 20/1 20/7 23/13 23/19 23/21 24/5 25/25 26/2 26/4 26/19 26/24 26/25 27/4 29/7 152/21
United [5] 107/13 109/10 127/3 127/6 162/13
United Kingdom [1] 107/13
units [1] 73/23
University [1] 149/16
unjustifiably [1] 78/15
unjustified [1] 79/4
unknown [1] 138/9
unlawful [2] 46/24 133/5
unlawfully [1] 52/21
unlike [1] 50/21
unmitigated [1] 41/22
unmute [1] 149/3
unnecessarily [1] 71/14
unnecessary [1] 86/7
unpack [1] 17/25
unpacking [1] 59/13
unpaid [1] 123/16
unpicking [1] 59/13
unprecedented [1] 8/12
unprepared [1] 43/21
unprocessed [2] 140/25 141/4
unprotected [1] 71/13
unreasonable [1] 37/1
unredacted [1] 40/8
unscrutinised [1] 75/22
unsolved [1] 70/23
unsuitable [1] 85/25
unsure [1] 86/9
untested [1] 152/14
until [7] 71/18 71/24 108/8 140/7 140/20 141/6 145/5
unwarranted [1] 64/4
up [41] 7/14 11/20 12/5 13/10 16/11 16/12 17/12 17/17 25/10 30/20 31/23 31/25 33/20 34/9 35/8 35/23 38/20 40/7 40/22 41/7 45/13 53/20 54/17 54/22 54/25 55/5 58/23 91/5 101/10 103/5 104/18 109/20 111/13 112/3 131/17 138/23 140/11 141/6 154/6 156/19 156/23
updated [1] 155/25
updates [1] 37/2
updating [1] 135/13
upended [1] 79/23
upfront [1] 21/15
upgrades [1] 148/12
upheaval [1] 65/17
uphold [1] 90/24
upon [5] 80/15 90/22 106/9 121/9 138/16
ups [1] 16/18
urge [1] 54/10
urgency [5] 17/24 51/15 82/9 87/22 90/21
urgent [4] 57/4 86/25 117/22 148/21
urges [1] 74/1
us [22] 9/8 9/19 10/25 13/21 32/16 41/18 53/15 65/17 66/1 79/14 86/10 86/10 87/1 89/1 89/8 90/20 90/22 91/5 135/18 153/9 158/16 159/23
usable [1] 59/24
usage [5] 18/21 35/18 103/11 143/18 143/25
use [17] 18/22 19/5 42/16 67/18 97/17 104/2 104/13 105/6 117/15 118/20 142/4 143/23 144/5 146/8 147/14 148/14 152/3
used [15] 21/14 34/5 42/8 47/17 47/17 53/5 73/22 97/25 117/5 123/16 139/10 148/19 150/19 153/16 156/1
useful [5] 27/17 27/17 56/24 114/21 155/9
user [3] 64/13 111/8 148/7
users [3] 89/3 105/10 109/11
ushers [1] 122/5
using [5] 21/22 30/12 49/10 97/10 118/19
usual [10] 1/7 31/14 44/3 50/11 101/8 103/5 107/19 118/19 120/6 143/16
usually [1] 101/4
utilised [1] 97/11
utterly [1] 138/18

V

Vaccine [1] 135/7
vaccines [1] 129/20
vague [1] 88/13
validation [2] 133/22 133/25
valuable [4] 79/21 86/1 90/3 121/20
valuation [1] 134/3
value [12] 7/14 9/22 10/2 10/17 15/4 25/24 33/16 64/21 92/13 115/8 154/2 157/9
valued [1] 107/5
van [2] 102/10 142/19
Van-Tam [1] 142/19
variants [1] 134/10
variation [1] 117/1
varied [1] 145/16
various [2] 4/12 134/25
vast [2] 7/2 78/2
VAT [1] 26/19
Velindre [1] 106/18
ventilator [5] 80/13 139/3 139/14 139/17

V

ventilator... [1] 148/13
ventilators [14] 4/24 42/23 74/15 74/19 74/21 74/25 75/11 75/13 93/9 93/12 139/4 139/5 139/8 139/11
verified [1] 108/20
versions [1] 96/11
very [51] 3/4 5/5 18/15 20/5 20/7 31/25 32/11 33/15 35/25 36/19 37/18 38/10 40/5 51/1 51/1 54/15 63/24 64/10 65/9 66/5 66/5 69/11 81/3 81/4 82/3 82/13 91/3 91/3 96/25 99/14 99/16 100/23 102/21 103/21 105/18 107/14 117/16 126/14 126/23 127/1 128/3 135/25 137/13 143/22 158/16 158/25 159/1 159/1 159/10 159/14 160/16
vetting [1] 85/23
via [2] 51/3 115/18
viability [1] 58/4
viable [1] 134/17
video [1] 1/24
view [9] 27/15 35/21 52/18 88/9 94/6 96/3 114/21 143/10 147/8
views [2] 96/16 137/18
VIP [41] 46/18 46/24 48/11 49/3 49/14 49/21 50/5 50/14 50/16 50/20 50/21 50/23 50/25 51/11 51/20 51/22 51/23 52/8 52/24 54/9 56/6 58/6 58/12 59/13 60/19 61/17 61/23 79/19 80/12 87/18 87/20 151/16 151/21 152/8 152/20 155/14 155/15 156/11 157/14 157/19 157/23
VIP Lane [31] 46/24 48/11 49/14 49/21 50/5 50/16 50/23 50/25 51/11 51/20 51/22 52/8 52/24 54/9 56/6 58/6 58/12 59/13 60/19 61/17 61/23 79/19 80/12 87/18 87/20 151/16 152/8 152/20 155/15 157/14 157/23
VIP Supplier [1] 151/21
VIPs [1] 56/15
virus [9] 64/18 67/6 86/11 87/7 88/23 135/25 141/2 142/17 145/9
visibility [3] 16/6 116/21 117/4
vital [7] 71/13 79/13 129/11 142/21 148/10 154/19 155/2
vivid [1] 114/4
voice [1] 89/24
void [1] 45/14
volatile [1] 10/22
volatility [1] 13/24
volume [5] 6/21 7/2 91/23 107/13 108/18
volumes [1] 20/24
vulnerabilities [1] 60/1
vulnerability [1] 147/8
vulnerable [5] 64/17 79/15 82/20 88/16 125/19
VVIPs [1] 51/1

W

Wald [2] 40/2 159/5
Wales [49] 60/14 66/13 67/1 67/7 67/11 67/22 67/25 69/4 69/13 70/22 71/10 71/15 72/1 72/11 74/22 74/24 75/6 75/15 100/11 100/18 100/21 101/4 102/1 102/9 102/25 103/2 103/7 105/17 105/24 106/2 106/3 106/17 106/23 107/3 107/9 107/10 107/16 108/1 108/11 108/21 109/1 109/10 109/13 109/18 111/3 112/11 112/19 138/9 162/4
Wales' [1] 73/19
want [10] 8/23 12/20 33/7 36/24 89/5 92/3 124/20 128/23 143/23 157/22
wanted [7] 6/17 10/19 14/13 72/25 73/1 115/24 149/11
wants [1] 84/12
ward [5] 11/25 69/18 101/20 102/3 125/5
wards [1] 67/10
warehouse [1] 69/16
warehouses [1] 139/25
warm [1] 134/24
was [375]
wasn't [6] 14/25 28/2 38/1 55/20 99/23 119/5
waste [4] 43/13 53/2 117/2 158/9
wasted [7] 42/7 43/4 43/16 53/5 86/1 150/7 158/13
wave [2] 35/15 139/7
waves [1] 97/9
way [28] 6/5 8/4 10/22 10/24 16/2 17/4 28/17 32/8 42/23 46/12 46/23 47/14 48/24 53/6 64/10 64/12 78/18 79/15 81/25 84/14 92/4 97/2 108/12 109/7 112/4 136/10 144/13 153/4
ways [4] 7/23 35/23 38/2 152/11
we [242]
we'd [2] 15/9 34/7
we'll [4] 25/18 28/15 37/24 99/16
we're [8] 12/22 12/23 14/17 16/14 31/7 37/23 81/10 155/13
we've [15] 7/10 16/24 17/12 20/22 23/6 28/19 36/11 49/18 81/13 82/22 83/13 84/19 153/22 155/9 155/13
wearing [1] 70/8
website [1] 40/18
week [15] 10/15 11/1 13/2 13/17 15/10 24/24 58/15 76/21 84/20 86/3 86/25 87/15 118/18 143/7 158/14
weekend [1] 22/16
weeks [13] 12/6 15/10 24/25 28/2 51/12 54/7 68/7 93/10 138/1 138/21 140/25 149/12 154/13
weeks' [2] 125/15 140/1
weigh [2] 11/20 81/24
weighed [1] 34/21
weighing [2] 33/20 34/24
weight [1] 58/4
weighted [3] 13/9 27/14 33/22
weighting [1] 35/3
welcome [1] 131/6
well [28] 2/24 5/2 10/15 18/5 18/18 19/9 24/15 26/12 35/9 35/16 52/23 61/1 70/19 78/10 99/16 103/4 106/16 111/13 115/6 121/10 128/3 128/7 132/3 135/23 146/19 147/24 148/12 150/15
well-established [1] 103/4
well-fitting [1] 146/19
well-trained [1] 135/23
wellbeing [1] 2/24
Welsh [44] 67/3 67/16 67/19 68/6 68/15 68/18 68/19 68/21 69/4 70/24 71/17 71/23 72/6 74/23 75/20 75/25 100/3 100/6 100/7 100/9 100/15 100/20 101/16 102/16 103/22 103/23 103/24 104/9 104/14 105/7 105/14 106/4 106/7 106/12 106/14 107/5 109/19 110/6 110/15 110/23 112/13 112/17 112/21 162/1
went [7] 14/15 35/20 47/19 51/12 57/1 105/20 153/4
were [256]
weren't [2] 72/21 99/24
Westminster [2] 41/14 62/6
what [91] 4/2 7/7 8/9 9/8 9/9 9/13 10/4 10/19 11/10 12/15 13/11 13/16 13/17 13/19 13/19 15/1 15/10 15/16 16/7 18/8 20/13 20/15 20/15 20/19 20/23 26/12 27/7 27/22 28/1 30/6 32/5 34/13 35/2 37/22 38/15 43/21 43/24 44/7 44/17 46/5 46/22 47/1 52/17 56/20 59/19 59/22 59/23 63/6 63/9 65/24 67/20 68/14 69/9 69/15 69/23 69/24 70/6 70/6 70/11 72/22 72/25 73/1 74/12 74/22 76/13 77/11 78/14 80/16 80/16 110/10 114/24 117/20 119/5 124/2 124/3 126/20 126/20 127/25 128/6 132/10 135/20 139/21 141/3 142/23 151/6 151/11 151/13 151/14 153/13 154/11 160/6
what's [2] 27/5 29/19
whatever [4] 35/1 56/14 61/9 62/9
when [33] 17/23 26/25 27/15 34/25 37/25 38/12 40/25 44/7 44/14 55/16 55/22 60/22 69/6 69/17 70/17 71/23 71/25 72/2 80/21 81/24 83/12 94/14 95/18 106/16 115/15 116/20 123/11 125/20 128/5 131/12 133/23 153/13 154/18
whenever [1] 97/11
where [27] 8/9 9/1 10/10 10/23 11/21 21/19 24/17 25/10 25/15 30/11 36/8 37/11 45/13 61/6 62/5 69/17 69/24 70/12 78/7 82/4 84/15 85/24 89/22 111/23 117/25 131/22 132/12
whereas [4] 35/4 35/7 144/22 155/1
whereby [4] 93/19 101/2 125/15 137/4
whether [21] 4/25 10/20 14/1 15/3 26/12 27/8 31/10 33/4 33/25 37/20 37/21 44/15 49/16 51/13 75/15 78/18 129/3 129/5 133/8 139/15 157/15
which [121] 1/12 5/8 6/22 7/24 8/17 9/22 10/1 10/2 11/15 13/1 13/8 13/12 15/5 15/22 16/24 17/6 18/18 18/22 19/1 20/19 23/8 25/3 27/15 28/8 28/13 29/19 30/16 30/17 30/17 32/7 32/7 33/21 35/23 36/7 40/5 40/8 40/24 41/18 45/3 48/13 51/7 51/13 56/23 57/3 58/2 58/13 59/17 61/14 61/23 61/24 62/4 62/20 63/2 64/7 67/2 68/5 68/15 80/4 80/8 83/2 87/24 88/15 92/17 92/22 93/18 94/18 96/4 97/15 97/16 97/24 101/4 101/5 101/24 103/5 104/2 104/12 106/7 106/9 106/19 108/9 108/14 108/15 108/25 109/4 109/7 109/20 111/1 111/10 112/4 115/22 115/25

W

which... [30] 121/20 122/22 124/3 125/9 125/16 128/23 130/6 131/3 131/4 132/15 133/13 133/18 133/22 133/25 134/5 138/4 138/14 139/1 139/10 141/7 141/8 143/14 143/24 143/25 144/4 144/21 145/4 145/6 148/24 151/9
while [19] 55/15 59/5 66/1 66/23 72/5 73/25 76/19 77/7 78/19 82/5 99/2 108/7 109/12 110/8 118/10 119/17 135/25 137/8 146/9
whilst [17] 2/10 4/16 5/11 8/12 37/16 45/20 51/18 60/7 64/10 66/17 68/3 70/23 97/4 98/7 116/2 116/2 140/12
whipped [2] 53/20 58/23
who [65] 1/17 1/18 2/2 2/18 14/21 23/2 34/5 48/8 48/23 49/15 49/21 50/6 50/12 51/2 52/2 52/5 54/9 55/17 58/14 58/16 58/19 59/8 59/9 67/16 69/14 71/12 76/16 76/22 78/15 78/17 78/19 78/23 81/18 81/19 83/15 86/18 87/5 88/7 91/14 92/2 94/15 96/21 99/5 100/19 105/6 109/15 115/11 115/22 123/22 132/2 135/22 135/24 142/1 146/8 146/13 151/13 151/22 152/24 154/18 155/19 155/22 155/22 157/17 158/20 159/23
Whoever [1] 131/25
whole [4] 18/8 19/6 107/3 107/10
wholesalers [1] 45/12
wholly [5] 47/15 54/25 63/23 76/14 85/25
whom [6] 6/12 58/14 58/16 74/4 76/23 121/23
whose [3] 58/17 87/19 104/8
why [25] 14/13 25/5 57/23 59/6 67/3 67/4 67/7 68/14 70/19 70/23 75/4 75/10 75/12 75/13 75/14 75/15 99/24 99/25 100/16 128/5 133/4 155/10 156/8 157/19 160/9
wide [5] 67/15 74/21 112/14 130/10 156/19
wide-ranging [1] 130/10
widely [1] 145/16
wider [5] 37/6 53/13 104/24 128/9 147/16
wield [1] 47/25
will [73] 1/7 3/2 11/6 21/8 22/12 24/17 40/24 55/14 55/18 55/23 55/24 56/1 58/10 59/11 60/21 61/25 62/9 63/2 67/2 71/6 74/11 77/4 77/6 77/7 77/10 77/13 77/17 78/14 80/13 80/17 81/23 83/6 83/12 92/21 99/10 100/9 100/12 103/22 105/14 116/25 117/2 117/7 117/7 127/5 127/7 127/18 127/20 127/21 128/18 128/24 129/18 129/21 130/11 130/16 131/4 131/11 131/25 132/17 133/18 134/8 134/21 137/6 141/22 145/4 146/23 146/24 152/24 152/25 155/24 156/14 159/14 159/15 160/17
willed [1] 58/19
WILLIAMS [10] 1/9 1/11 3/4 35/25 38/11 39/18 45/7 140/22 155/17 161/2
Williams's [1] 1/7
willing [1] 10/16
willingness [1] 10/13
window [1] 50/11
wish [6] 1/13 58/20 76/15 77/3 112/23 121/22
wished [1] 38/8
wishes [2] 84/11 126/12
wishing [1] 97/2
within [41] 4/15 5/13 9/16 10/19 14/6 20/25 30/4 33/6 40/12 43/11 44/22 47/25 48/4 48/11 49/25 51/4 51/10 51/25 52/17 55/9 59/8 59/16 60/16 63/14 68/4 88/19 89/23 90/17 94/11 102/4 102/7 103/12 103/15 110/4 110/12 115/2 116/4 116/22 123/23 142/7 142/10
without [18] 6/14 14/2 16/12 18/13 20/19 25/9 35/20 39/12 52/14 83/20 90/1 94/11 97/2 103/6 112/4 130/23 141/2 160/2
witness [11] 3/5 31/21 38/3 38/7 53/1 53/10 68/25 78/22 85/22 91/12 122/5
witnessed [3] 59/1 59/12 71/2
witnesses [14] 50/1 56/3 75/5 82/4 100/16 103/1 105/3 109/13 128/16 134/25 135/3 146/20 150/22 160/3
woefully [3] 42/3 43/20 137/20
women [1] 68/10
won [1] 154/15
won't [1] 25/3
wonderful [1] 160/4
Wood [1] 140/16
word [2] 19/2 77/10
words [3] 1/12 118/12 140/16
work [32] 2/7 2/16 2/21 4/20 6/9 19/7 28/13 39/11 58/15 76/16 79/5 95/5 96/8 96/25 97/24 100/20 101/8 109/6 112/24 122/3 125/18 126/3 126/19 127/14 129/18 136/17 146/4 146/6 157/5 157/10 159/14 159/20
worked [11] 6/24 9/21 10/3 32/8 58/14 91/25 115/5 117/16 121/23 126/18 128/7
worker [3] 84/16 90/25 144/9
worker's [1] 86/8
workers [23] 42/10 66/23 70/13 71/1 75/17 81/19 82/21 86/1 87/4 87/6 88/6 88/17 105/7 109/15 119/7 141/17 142/2 142/17 142/25 143/7 143/12 144/25 145/11
workflows [1] 156/4
workforce [13] 18/9 30/10 68/11 89/17 111/1 135/22 136/4 136/11 136/24 137/6 137/9 140/23 147/18
workforces [1] 90/2
working [31] 2/3 2/15 4/14 5/3 6/4 6/7 6/15 9/19 23/2 34/5 37/17 38/17 38/19 46/20 55/9 62/23 76/9 76/21 106/7 106/12 106/24 107/2 112/21 114/18 119/15 123/8 126/13 126/14 136/6 142/1 157/17
workings [1] 50/17
workplace [2] 4/15 146/2
works [3] 29/10 29/11 134/15
world [11] 10/10 41/18 41/25 42/9 42/17 42/19 60/3 63/14 65/20 79/19 89/1
worldwide [2] 78/11 142/14
Wormwald [4] 4/8 6/1 38/22 51/24
Wormwald's [1] 83/1
worried [2] 11/22 14/3
worry [1] 34/19
worse [4] 48/8 55/19 65/8 79/10
worst [4] 43/22 46/23 66/1 76/24
worst-case [1] 43/22
worth [6] 49/4 125/15 140/1 152/16 154/7 155/19
would [119] 1/15 6/18 6/19 6/25 8/23 12/7 13/15 13/15 14/2 14/5 14/14 15/7 15/13 15/14 15/17 15/17 15/20 16/13 16/17 16/20 16/22 16/23 17/23 18/7 18/22 18/23 20/16 21/14 21/15 26/10 26/15 27/16 28/6 29/13 30/14 30/20 30/24 30/24 31/22 31/24 31/24 32/3 32/13 32/18 32/24 33/13 33/13 34/15 35/2 35/14 36/24 37/8 40/10 40/10 41/22 46/7 46/16 47/12 49/20 51/11 53/24 56/8 57/9 59/14 60/25 62/4 64/15 65/14 66/25 68/6 68/21 69/9 73/10 73/14 76/24 78/4 86/9 86/10 91/5 92/16 93/13 94/23 95/4 95/6 96/2 96/8 97/23 98/24 104/6 104/25 111/8 112/23 119/20 120/5 120/21 120/22 120/24 121/22 122/1 128/12 131/1 131/6 137/2 138/19 138/22 139/13 140/9 140/9 142/14 142/16 142/21 143/2 143/8 143/8 149/14 157/7 157/11 157/21 158/2
wouldn't [5] 8/24 16/11 16/12 24/14 160/5
wrapping [1] 114/5
writing [1] 63/3
written [19] 5/18 7/22 9/4 49/7 50/19 64/19 64/21 77/5 80/12 94/15 100/9 101/15 102/16 121/17 127/14 128/24 131/5 134/8 159/10
wrong [4] 58/9 87/13 153/20 155/22

Y

Yeah [18] 5/10 7/7 7/18 9/23 10/7 15/24 20/12 23/10 24/12 25/21 26/8 27/12 28/18 29/20 31/9 31/17 33/17 37/4
year [3] 136/21 159/17 159/17
years [6] 2/1 44/21 65/18 66/13 123/8 155/23
yes [22] 3/10 4/4 5/15 8/3 11/21 13/14 16/5 19/15 21/25 24/15 25/9 30/4 30/9 31/16 32/9 33/1 36/5 36/18 36/19 82/1 91/8 122/12
yesterday [7] 56/22 63/24 65/16 91/13 92/19 94/7 151/21
yet [4] 24/13 64/1 64/8 65/8
you [249]
you'd [3] 31/12 38/24 38/25
you'll [3] 21/6 21/6 83/1
you're [11] 13/11 17/9 25/5 27/12 33/23 39/7 41/7 54/17 66/7 99/22 122/9
you've [11] 3/6 3/13 8/9 11/10 14/22 15/23 20/20 32/5 37/22 63/20 104/5
Young [14] 5/18 5/23 6/3 6/7 7/4 7/11 7/16 11/6 14/25 16/9 23/7

Y

Young... [3] 43/8 51/10 57/5
your [63] 3/8 3/11 3/14 3/25 4/1 5/7 5/8 5/21 7/22 8/10 8/17 9/4 9/25 10/1 10/5 11/9 11/11 16/3 16/8 17/5 17/13 17/16 18/1 20/13 22/21 23/11 27/16 28/13 31/5 33/18 36/8 36/18 39/12 39/14 40/6 40/17 41/1 54/5 56/2 60/16 65/25 76/3 80/20 99/14 122/6 127/5 127/23 128/8 128/15 128/20 129/18 131/2 132/4 132/19 132/19 132/21 135/11 135/20 136/11 136/20 136/25 154/21 158/17
yourself [1] 81/22

Z

zero [2] 68/12 125/1
zip [1] 19/3
zoom [11] 12/22 12/24 17/18 19/17 23/23 25/23 26/18 28/23 29/1 29/7 29/25