Witness Name: Matt Hancock
Statement No: 9
Exhibits: MH9/1 - 577
Dated: 07/04/25

UK COVID-19 INQUIRY

NINTH WITNESS STATEMENT OF MATT HANCOCK

I, Matt Hancock, will say as follows: -

Introduction

1. I make this ninth substantive statement in response to a request from the Inquiry dated 31 October 2024 made under Rule 9 of the Inquiry Rules 2006 ("the Request") in relation to Module 7.

2. As this Inquiry works in 'modules', and does not cross-disclose documents between modules, I have transposed paragraphs of my other witness statements into this statement where relevant to the matters under consideration in Module 7 in order that it can be read as a standalone statement, as the Inquiry has requested. Nonetheless, the evidence should not be considered in isolation as the events and decisions considered in each module were concurrent to, and interrelated with, each other.

3. This statement sets out my involvement between January 2020 and 26 June 2021, when I resigned as Health Secretary, in respect of the policies and strategies that the UK Government and Devolved Administrations developed and deployed to support the test, trace and isolate (TTI) system which are the focus of Module 7.

4. This statement is to the best of my knowledge and belief accurate and complete at the time of signing. The Department of Health and Social Care ("the Department") continues to work on its involvement in the Inquiry, and should any additional material

be discovered I will of course ensure that this material is provided to the Inquiry and I would be happy to make a supplementary statement if required.

5. This witness statement is set out in the following sections

   a. Professional background;
   b. Role and responsibilities as Health Secretary generally and in respect of TTI;
   c. Co-working and coordinated decision-making generally and in respect of TTI;
   d. Preparedness and capacity for TTI;
   e. Development of policies and strategies in respect of TTI;
   f. Border measures insofar as they related to TTI;
   g. Adherence, support and enforcement of TTI policy;
   h. Data & modelling in respect of TTI;
   i. Inequalities in respect of TTI;
   j. Cost in respect of TTI; and,
   k. Lessons learned / reflections in respect of TTI.

Professional Background

6. Prior to entering politics, I worked at a data company, as an economist at the Bank of England, and as Chief of Staff to the Shadow Chancellor of the Exchequer. In May 2010, I was elected Conservative MP for West Suffolk and served in that role until 30 May 2024. From 2010, I served as a backbencher on the Public Accounts Committee and the Standards & Privileges Committee. In September 2012, I entered government and served in a number of ministerial roles, including for Skills and Business, and as Paymaster General. From July 2016, I served at the Department of Digital, Culture, Media and Sport (DCMS) as Minister of State for Digital. In January 2018, I was appointed Secretary of State for DCMS. In July 2018, I was appointed as Secretary of State for Health and Social Care ("the Health Secretary" or "Secretary of State").

Role and Responsibilities of Health Secretary

Role generally during the pandemic

7. As I said at paragraphs 5-11 of my second statement **(MH9/001 – INQ000232194)**, as Health Secretary my motivation was to improve the health services in this country and to save lives. In the early days of the pandemic, huge decisions had to be made very quickly on the basis of very limited information. A vast amount of work by a very large number of people was done with diligence, due care and huge effort against the background that any pandemic involves enormous uncertainty; it is a response to a novel disease. My Civil Service and clinical advisers were exemplary.

8. The pandemic created an unprecedented challenge to ordinary decision-making processes. There was no book or report to pull off a shelf to tell us how to handle a pandemic, and there was no-one alive with experience of dealing with a pandemic of this scale. The scientific advice as to what we were facing and the depth of the threat was exemplary, but necessarily changed frequently as new information became available. The logistical requirements were without doubt the most complicated in peacetime history. The reassurances from the World Health Organization ("WHO") that we were one of the best pandemic prepared countries in the world were wrong. We had to build many parts of our response from scratch, including in respect of TTI.

9. Very early on, we found that instead of fighting an influenza virus, which had been the assumption underpinning the plans, we faced a coronavirus. For quite some time we did not know exactly how it could be transmitted; for example, whether the virus could live on surfaces such as the hand rails in public staircases or most importantly whether asymptomatic transmission was possible. We adapted to new information and the changes in scientific advice as we went on and at all times sought as much information as possible.

10. In a crisis of the scale of the pandemic, there are inevitably a vast number of decisions taken at all levels. The approach I took in leading the Department was to set the direction in which we needed to go, based on the best available advice, and encourage and empower all involved to take decisions to the best of their ability. There were

thousands of decisions to be taken every day. One of the central tasks of the Department and wider Government was to make decisions at the right level.

11. I went into the pandemic with experience of crisis management both from my time at the Bank of England and in Ministerial roles for seven years. However, no one in public service had handled a crisis of this scale since the Second World War. As Health Secretary, together with the Department's senior official team, we consistently did our very best to manage the huge number and scale of decisions we had to make.

12. I tried to lead the Department using some basic rules of thumb:

    a. Delegate authority on a principle of subsidiarity, and take accountability;
    b. Empower the team at all levels to make decisions without fear of reprisal if it goes wrong;
    c. Demand as much information as possible to make a decision, but no more than is possible;
    d. Work as a team, and protect the team from undue interference and distractions;
    e. When something goes wrong, ask not the question 'who is to blame?' but rather 'how can we fix this?'; and
    f. Concentrate on saving lives, not how it will look afterwards.

13. A major responsibility of my job as the Health Secretary was ensuring the Department's work was as integrated as possible into the wider Government effort. At first this required pushing the rest of Government to recognise the potential threat of the pandemic. Later, it involved protecting the Department, as much as was possible, from inappropriate political interference from No. 10, so officials could get on with their work. Throughout it involved the proper and appropriate integration of our work with the work of others, across the different parts of Whitehall, often in ways that were not typical before the pandemic.

14. As I set out at paragraphs 82-90 of my second statement **(MH9/001 – INQ000232194)**, when I was initially appointed Health Secretary, as with previous Ministerial roles, I was given a series of 'day one' briefings by officials within the Department to alert me as to its ongoing work.

15. My daily work was heavily diarised and run by my Private Office. Before the pandemic, I would hold regular - usually weekly - meetings on the areas of responsibility I wanted to drive hardest. For example, in late 2019 I would have regular weekly meetings on

    a. The NHS - with Simon Stevens on the management of the NHS;
    b. Technology - improving health technology and use of data;
    c. People - improving the way the NHS recruits and rewards staff;
    d. Prevention - driving the agenda to prevent disease, not just react to it;
    e. Media - to consider communications, including public health communications;
    f. Ministers - to stay in regular contact with Ministerial colleagues; and
    g. Cabinet - chaired by the Prime Minister in No. 10.

16. I would also hold regular meetings on ad hoc topics, such as delivering on manifesto commitments, securing Departmental finances, hosting visiting dignitaries, making statements in Parliament and other speeches to drive forward progress, responding to questions in Parliament, undertaking media appearances, attending cross-Government meetings such as Cabinet Committees or COBR, delivering a myriad of specific projects, like access to Orkambi (a drug to help those with cystic fibrosis), or making visits across the UK and occasionally overseas to represent the Government and listen and learn.

17. In addition to meetings, many decisions were made through paperwork. The primary method of decision making throughout my period as Health Secretary - including in the pandemic - was the formal Departmental submission: a detailed note from the Civil Service, considering an issue from all angles, that would usually put forward options for decision. Cross-Government matters were largely dealt with through formal letters setting out a Department's position, to seek a cross-Government agreed position. Normally I would receive around twenty submissions or letters per day, typically in my evening red box (my 'box'). On top of each submission, Private Office would attach a one-page note which included:

    a. the date of submission;
    b. the deadline for response;

c. a summary of issue and decisions needed, and any interaction with other relevant work;
d. the view of the Junior Minister responsible for that area; and
e. any views from Special Advisers.

18. I split my box into five files:

a. constituency matters relating to my role as MP for West Suffolk;
b. urgent matters (I always completed this file overnight);
c. routine submissions for decision (I usually completed this overnight);
d. reading materials not for decision; and
e. diary questions and invitations.

19. My box would typically take an hour to ninety minutes each day. In addition to this, I would talk to colleagues in person and on the phone and use email and messages in a fairly limited way. Sometimes I would write on a submission itself and then photograph the submission with my notes and send to my Private Office when this was the most efficient way of sending back my views.

20. All major decisions were made and documented in the formal way through submissions within the Department and letters between Departments. This is the entirely standard way Government operates and given the sheer scale of the number and size of decisions, in normal times it works well.

21. Discussions on WhatsApp are best thought of as like an informal discussion, like the conversation that happens around a formal meeting, rather than the meeting itself. Any significant decision was taken in a formal way, based on a submission, even if it had been preceded by a discussion or in principle decision on WhatsApp beforehand. Looking only at WhatsApp messages alone gives a highly partial and skewed account of what happened. Actual decision making was much more formal, whether on paper or in formal meetings.

22. During the pandemic my ways of work changed in the following ways:

a. I would wake at 6am and spend half an hour checking urgent overnight messages and news;
b. Most days, my driver would collect me each day at 07:50 and I would arrive at the Department at 08:20;
c. I would have back-to-back meetings throughout the day, in the Department, 10 Downing Street or Parliament, usually going back home at around 7-8pm, but often later into the evening;
d. I would have a short time to have dinner with my family before going back to my home office to continue working until around 11 o'clock at night. I always tried to get to bed by midnight;
e. Across Government we used WhatsApp far more frequently, as there were fewer in-person meetings across Whitehall, and the necessary speed of decision taking increased radically. Decisions that previously may have been made in a meeting scheduled several weeks hence would be discussed by WhatsApp and formally taken at urgently convened meetings. WhatsApp presented a very effective, socially distanced way of communicating directly with people;
f. I spoke regularly to the Prime Minister by phone to keep him abreast of developments;
g. A weekly G7 call with my Health Minister counterparts was set up each week to discuss how the pandemic was evolving overseas. Ad hoc bilateral international discussions became more frequent;
h. I set up a weekly 'Four Nations' call with my Scottish, Welsh and Northern Irish counterparts to ensure we had as coordinated a response as possible across the UK; and,
i. Administratively, the Permanent Secretary at the Department Sir Chris Wormald, diverted his entire attention to COVID-19 on 22 January, delegating the day to day running of the Department for non-COVID purposes to David Williams, who was appointed Second Permanent Secretary of the Department on the 6 March."

Role in respect of TTI

23. My principal function as Health Secretary was to set policy and strategy in respect of the use of TTI measures to prevent and reduce transmission in order to save lives and, so far as possible, avoid lockdowns, and to oversee the effective implementation of those measures. In summary, and in practical terms, I oversaw and drove the work of

PHE between January 2020 and mid-March 2020 to develop and increase their diagnostic and contact tracing capability and capacity while it retained responsibility for those functions. From mid-March, after I had decided that the Department should take the lead on TTI due to my concerns about whether PHE could deliver testing and tracing at the scale required to combat the virus, I effectively took on executive leadership responsibility for the rapid expansion of testing and tracing until May 2020 when we appointed Baroness Dido Harding as Chair of NHST&T. She then took the lead on policy and operational responsibility for TTI in that role and I resumed an oversight role. I continued to drive the expansion and improvement of TTI functions while they remained in the Department until they were subsumed by UK Health Security Agency ("UKHSA") in April 2021.

Co-working and coordinated decision-making

24. Before addressing the extent of co-working and coordinated decision-making in respect of TTI policy and strategy, I repeat the overview I gave in paragraphs 58-80 my second statement as to the way in which decisions were taken by Government generally during the pandemic, as requested by the Inquiry **(MH9/001 – INQ000232194)**.

Cross-Government decision-making generally

25. Decisions across Government are taken on a formal basis according to well established rules to ensure there is one "agreed" Government policy. It is in the nature of Government that no-one can take all the necessary decisions, and once a decision is taken everyone needs to get behind it. This formal basis is superbly set out in Sir Christopher Wormald's first Departmental statement **(MH9/002 - INQ000184643)** at paragraphs 56 to 223. This formal structure of decision making ensures that decisions can be taken at the right level, with formal advice, and recorded. Within the Department, submissions and minuted meetings remained the formal decision-making process during the pandemic wherever possible. Sometimes a formal minute is replaced with a list of action points due to time pressure. Government could not function without these formal decision-making procedures because action on a decision requires co-ordinated activity by a large number of people, many of whom would not have been involved in making the actual decision.

26. Careful consideration is needed as part of Government decision-making to choose at what level to take a decision (e.g., Does the Secretary of State need to see this? Who needs to be consulted? Do we need to get the views of the Devolved Administrations? Who needs to formally sign off? Do we need to ask the Prime Minister?). Making too many decisions at too high a level is inefficient and cumbersome. Making too many decisions at too low a level risks them being overturned if a more senior decision maker did not know and disagrees strongly. The best senior decision makers can make good decisions quickly, are consistent in approach and only try to change a decision made at a lower level very rarely, i.e., when it really matters.

27. In normal times, No. 10 advises the Prime Minister and seeks to ensure his or her mission is advanced across Government. Ordinarily all No. 10 staff are aligned with the Prime Minister's views and speak for him or her. If a No. 10 staff member does not know, or cannot reliably presume, the Prime Minister's views, they will find out, and in the meantime, not intervene. Whether a request from No. 10 is a direct request from the Prime Minister, or a request in the name of the Prime Minister, is often not clear but it can be reliably presumed to be the will of the Prime Minister. No. 10 operates on the basis of this constructive ambiguity.

28. During the pandemic, four different cross-Government decision making processes were used. From 24 January 2020 to 24 February 2020 the formal COBR system was used to co-ordinate the cross-Government response. Next, the Prime Minister's Chief Adviser instigated a decision-making process from No. 10, which he insisted supplanted Prime Ministerial decision making. This was replaced in March 2020 with a Cabinet Office COVID-19 Secretariat and four Ministerial Implementation Groups ("MIGs") specific to the COVID response, overseen by a COVID Strategy meeting chaired by the Prime Minister. These were in turn improved on when replaced by the COVID(S) and COVID(O) Cabinet sub-committees in May 2020, which worked extremely well and should be considered as best practice when an emergency becomes too big to be handled with ad hoc COBR meetings.

29. At the time, anonymous Government sources criticised the formal decision-making structures, saying that the initial response of Government was a failure of the state. My experience was precisely the opposite. The problem was not the COBR system: it

was that the COBR system was not used properly. When the COBR system was used effectively it functioned extremely well. When the collective experience of the COBR system, combined with the proper authority of Ministerial decision making, was temporarily replaced by an informal series of meetings from which key personnel were excluded, decision making became confused. Effectively, the powerful and experienced COBR system was not used properly. This was a major mistake.

30. To give a practical example of the problems created by this, a No. 10 morning meeting, chaired by the Prime Minister's Chief Adviser, was scheduled at the same time as the already established Departmental morning meeting, to which many but not all of the same attendees were invited. This created unnecessary problems for officials, undermined proper Ministerial decision making, and inhibited the response. These No.10 political morning meetings led to action points which sometimes contradicted Departmental decisions, or even decisions taken by the Prime Minister. I spent a considerable amount of time and effort in protecting the Department from the ensuing confusion and obstruction. The then Prime Minister has apologised to me for appointing his Chief Adviser and for the damage he did to the response to COVID-19.

31. This informal decision-making system was even more problematic because of the constitutional position of No. 10, which cannot formally over-rule or direct a Department, except through the Prime Minister making a cross Government decision within the formal decision making process. By contrast, when the Prime Minister chairs COBR, all decisions carry the immediate and full authority of Government. The entire Government machine respects this system, and so it is extremely effective when run properly. By contrast, informal meetings in No. 10 do not carry this weight and so cannot drive action as fast or effectively. This further undermined the response. In future the formal emergency management system based on COBR should be used to manage an emergency like a pandemic.

Departmental decision-making generally

32. Within the Department, while the formal structures of decision-making changed little during the pandemic, the nature of decisions inevitably changed a great deal:

a. The speed of decision taking had to increase remarkably. Indecision was itself a consequential course of action, and so Government had no choice but to increase the speed of its decision making radically;
b. The speed with which action was taken also accelerated radically. Things that would in normal times have taken months or even years happened in days;
c. The scale of the consequences of many decisions increased radically, and was often not known with any precision in advance;
d. The uncertainty about the information on which decisions were based was colossal; and
e. The changes in scientific advice could rapidly lead to a change of decision or operation.

33. This unprecedented increase in the speed, scale and uncertainty around decision taking had an impact on how Government went about trying to make the best decisions. For example:

a. Full minutes of meetings were often replaced by action points, as even the note-takers were so time constrained; and,
b. There was much more use of technology, especially WhatsApp and Zoom, and many more informal phone calls.

34. One example is the relationship between the Department and devolved health bodies. The formal structure of decision taking was through the 'Council of Nations'. In normal times, since most health measures are devolved, there is little urgent business but during the pandemic a much more co-ordinated UK-wide response was required. So, at the start of the pandemic, I visited the three devolved nations, and with my counterparts we instituted both a weekly Zoom meeting and a WhatsApp group.

35. An assessment of all papers and communications show that during the pandemic my entire Department did whatever we could to save lives.

36. A major challenge within Departmental decision making until November 2020 was that senior figures in No. 10, including the Prime Minister's Chief Adviser, were in fact not aligned with the Prime Minister, yet issued instructions, often to junior officials, as if

they had the Prime Minister's full authority. Even after the formation of the COVID-S and COVID-O structures in May 2020, this caused very significant problems, in particular in the testing programme. The full extent of the issues within No. 10 were not apparent to me during the pandemic and have only recently come to my attention and into public knowledge.

37. Within the areas of the Department's responsibility, there was little change in formal accountabilities, with the exception of the formation of NHS Test & Trace (NHST&T), and later the merger of PHE with NHST&T to form UKHSA.

38. PHE had a more cross-cutting remit in the pandemic and advised across the whole of Government and more widely on the implementation of COVID-19 rules. Despite the exemplary performance of many of its staff, its impact on decision making was undermined by its structure as a body responsible for both non-communicative public health, as well as communicable diseases, and its focus on the former in the run up to the pandemic.

39. In practice, I put in place regular meetings of all relevant health agencies as well as the Department, to bring together the response. These started in January 2020, and continued in different formats throughout my time in office. As we built institutions that had not pre-existed in response to the virus, like NHST&T, the cast list changed, but this regular meeting of the leaders of the many parts of the health system was incredibly important for co-ordinating the response across the Department and its agencies.

40. In a similar way, while the formal role of scientific and clinical advice did not change, the scale and nature of it did. Sir Christopher Wormald's third Department statement at paragraph 32 sets out very clearly the nature of clinical advice, and its role, which became much more important due to the nature of the crisis **(MH9/003 – INQ000144792)**. Scientific advice was given to me as Secretary of State by the Chief Medical Office ("CMO") or Deputy Chief Medical Officer ("DCMO"), and the Government's Chief Scientific Advisor ("CSA"), in formal meetings, including up to Cabinet level, in informal meetings, on the phone, by message, and embedded in formal advice.

41. Overall, decisions were generally collegiate and the Government's best collective attempt to reach the right answer, in the right timeframe, based on as much information as we could get. We constantly questioned and queried the decisions we were making, from all angles, to try to make them better. As new information became available, we queried prior decisions to check if they were still appropriate and were fully prepared to change them if we thought that best. Inside the Department we constantly questioned the best way to make decisions and were self-critical in constantly striving to improve.

42. The bringing in the best of academia and industry to work on fighting the pandemic worked well, as it did with other external leaders on other areas of policy, such as Dido Harding, General Sir Gordon Messenger, Paul Deighton, Kate Bingham, Camilla Cavendish, and many others. In some cases this was done in conjunction with No10, in some cases we did not need nor seek their clearance. I was a strong supporter of the recruitment of external capability, and was personally involved in persuading the most senior external recruits to take on responsibilities, for example for PPE supply, vaccine procurement, test and trace, border quarantine, and others.

43. We put in place both formal structures of accountability and progress reporting, and regular discussions to ensure action was aligned. These structures worked best where they reported through the Department, to ensure the best possible alignment. For example, the Vaccine Taskforce reported both to me and the Secretary of State for BEIS, who chaired a formal Ministerial Board to give oversight and democratic approval for its decisions. On the deployment plans for the vaccine, this worked efficiently because we kept these plans within the Department and its agencies, and only reported to the Cabinet Secretary and then Prime Minister once the plans were fully prepared - and so avoided the inappropriate political interference from No. 10 that had been the hallmark of the testing programme. As a result the vaccine rollout was one of the most effectively delivered programmes in the pandemic, despite being one of the largest logistical exercises in peacetime. When the structures for external leadership did not work, that was generally as a result of muddled lines of accountability with the Prime Minister's Chief Adviser and some others in No. 10 trying to centralise power to themselves, resulting in undermining the teams' ability to

perform their roles. This was unfortunately often the case with NHST&T. No decision in Government is straightforward, and often there is no single clear answer, but second guessing from aggressive personnel outside of the formal line of accountability causes huge problems. After November 2020, many confused lines of accountability were straightened out, and Government operated much better. For example, by winter 2021 the UK had one of the largest testing capacities in the world. The lesson for future is very clear: clear Cabinet accountability and formal Government decision making at pace is best.

44. While the Government was criticised at the time for engaging with the private sector on areas such as testing, vaccines and PPE, on the contrary harnessing the skills of the private sector was vital in our response to the pandemic. We could not have achieved the expansion of testing without the support of the private sector.

45. Contracting with the private sector also changed. Normally contracting with the private sector follows slow processes to ensure the best possible value for money. However, emergency procurement rules pre-existed and were used effectively where we had to speed up buying. When the pandemic hit the UK, we needed a significant and rapid expansion of procurement in many very sensitive areas, including testing.

46. Given that global demand for these products rose dramatically, there were significant challenges in procurement. The Government triggered the emergency procurement rules to speed up purchasing, issued public calls to arms, and put in place a Cabinet Office team to support with procurement. Every contract that was awarded was decided, priced and signed off by the civil service, independently of ministers. This was confirmed by the National Audit Office in its report, 'Investigation into government procurement during the COVID- 19 pandemic'. For tests there was an added complication. It would not have been wise to rely on manufacturers' assertions on the efficacy of tests, so we instituted a testing regime, largely delivered by the team at Porton Down. In many instances companies applied pressure for their tests to be purchased before quality assurance had been achieved. We rightly resisted this pressure, but it did lead to some debate around various tests, and a need for engagement at a technical level with the test manufacturers.

47. Overall, my experience was that every single person who worked in my Department and countless people across Government and its agencies worked incredibly hard. The daily routine completely changed for us all; we just worked on the pandemic round the clock. My team and I worked every day with the one overriding mission of saving lives in the face of a virus which we knew very little about.

48. I also explained at paragraph 215 of my second statement that after a meeting with No.10 Special Advisors ('SpAds') on 27 February 2020 **(MH9/004 – INQ000049457)**, I met with Sir Chris Wormald to discuss governance structures for the response to the coronavirus. The note of that discussion **(MH9/005 - INQ000049458)** records that:

"*SofS outlined that he will be leading the response to Coronavirus as SofS of the Health and Social Care system and will also be leading the coordination across Government to support [other Government Department] ministers to consider the impacts on their services (for instance schools, businesses). SofS decided as chair that he would like to step COBR up to twice a week.*

The Governance structure is as follows:

- *Twice weekly COBR - M meetings, chaired by SofS;*
- *Twice/three weekly COBR - O meetings;*
- *A designated Junior Minister from every Department that works on Coronavirus;*
- *All DHSC junior ministers to have a role to play on Coronavirus;*
- *Daily meetings with the health system (PHE, DHSC, NHSE officials);*
- *Daily conversations with the GMO;*
- *Some PM oversight, he's open to discussion but perhaps a weekly call with the PM could be useful;*
- *A weekly press briefing that will be led by SofS and GMO (joined by lead officials depending on situation)."*

49. At paragraph 297 of my second statement, I explained that on 15 March 2020, the Cabinet Office established the 'C-19 Secretariat' and a committee structure dedicated to COVID-19 decision-making, which stood in the shoes of the Civil Contingencies Secretariat **(MH9/001 - INQ000232194).** This new structure improved the speed of

decision making, and replaced the informal No10-led process which had been deeply unsatisfactory. With hindsight, although an improvement, having four separate MIGs in place did not work as well as they could as all issues were cross cutting, and their replacement in May 2020 with the COVID(S) and COVID(O) committees speeded and strengthened cross Government decision making further.

Departmental and Cross-Governmental decision-making in respect of TTI

50. I understand that the Department is producing a corporate statement in respect of its functions, structures and key decision-makers in respect of TTI, how it worked with other government departments, the devolved administrations, local government, scientific advisors and academics, private industry and international partners. Save where I address those matters briefly below and to the extent they are not covered by the chronological overview on TTI policy and strategy I have provided in this statement, I defer to the Departmental statement.

51. When I made the decision that the Department would take the lead on developing testing and tracing capability and capacity in mid-March 2020, we established a testing cell which was run by Kathy Hall (Lead Director) and Aidan Fowler (NHSI/E SRO & Clinical Lead) and led by Lord Bethell, for which I retained overall responsibility **(MH9/006 - INQ000562635)**. We established weekly testing meetings from that point which I chaired. They were increased to daily from 7 April 2020 after I announced the target of reaching 100,000 daily tests on 2 April 2020. I also established the Testing Taskforce at that time which brought together ministers, experts, industry and other leaders in the healthcare sector to sit alongside the daily meetings which I chaired three days per week. After we launched NHST&T in May 2020, we disbanded the daily test/trace meetings and instead I met with Dido Harding on a weekly basis to track the progress of NHST&T's work. From June 2020 until my resignation in June 2021, I chaired weekly Gold Local Action Committee meetings, which were principally aimed at managing outbreaks. The Gold committee made recommendations to, and raised issues with, COVID-O and COVID-S, which were the key cross-government decision-making fora in respect of TTI from May 2020 onwards. Prior to that, decisions on TTI had been made at COBR and then the MIGs.

Approach to Scientific Advice

52. I reiterate paragraphs 93-94 of my first statement **(MH9/007 – INQ000181825)** and paragraphs 12-14 of my second statement **(MH9/001 – INQ000232194)** on the approach to scientific advice, as requested by the Inquiry. In respect of the Government's preparedness for seeking and considering scientific advice from outside the consensus, this worked well. I saw no issue with the Government obtaining such advice and indeed the Scientific Advisory Group for Emergencies ("SAGE") contains a wide variety of members. Views on SAGE were debated and the overall view, including the breadth of considerations, reported to Ministers through the minutes and in verbal briefings from the CMO and CSA.

53. My view is that Ministers should be 'guided by the science' rather than 'following the science' because this enables Ministers to take into account all considerations including, for example, advice on the operational capacity to deliver a scientific recommendation. In most cases we did follow the science, but in some cases, for good reasons, we did not. For example, when the Government was repatriating evacuees from China at the end of January 2020, PHE advised that they should be given a leaflet and asked to go home to isolate. I took the view that the evacuees should be required to be placed into quarantine, which led to the returnees being placed in Arrowe Park Hospital.

54. From January 2020 onwards, the Permanent Secretary, CMO and I discussed the proper approach to scientific advice. My approach was not to "follow" the science but to be *guided by* the science as presented to me by the CMO, the DCMO and the CSA. To "follow" the science implies accepting scientific advice without wider consideration. To be guided by the science is to take the scientific advice, and base decisions on it, taking into account reasonable challenge, operational and other wider considerations. My job as Secretary of State was to take all considerations into account in making decisions. In very large part, I would follow scientific advice. However, scientific advice was understandably not always clear cut as uncertainty was huge, especially early on. I consider that the scientific advice I received, both before the pandemic and during it, was absolutely world leading.

55. Initially, we did not know how the virus was transmitted, how transmittable it was, whether it could be transmitted asymptomatically, who would be at most risk of illness, or many other key scientific facts that would become crucial to determining the public health response to the virus in later months. To take just one example, despite anecdotal evidence and significant uncertainty, even on 2 April 2020, the WHO stated "*...to date, there has been no documented asymptomatic transmission.*" This assertion placed enormous weight on the lack of 'documented' asymptomatic transmission, whereas, in the face of huge uncertainty, it is important to work on the basis of risk, not certainty or proof.

56. On occasion we would depart from the formal scientific advice, typically for one of two reasons: either (a) scientific advice was not operationally deliverable or (b) the need for a different approach based on wider considerations. For example, I decided we must quarantine individuals returning from Wuhan in February 2020, against the scientific advice, based on a precautionary principle and to maintain public confidence. In doing this we had to depart from scientific advice. On this occasion, as whenever the Departmental position differed from the scientific advice, I would always involve scientific advisers in the final decision to try to ensure that they regarded each decision as reasonable, and at the very least consistent with the best available scientific advice.

Devolved Administrations

57. As I explained at paragraph 247 of my second statement **(MH9/001 – INQ000232194)** and paragraphs 34-35 and 41 of my fifth statement **(MH9/008 – INQ000421858)**, at the start of the pandemic there was no formal mechanism for co-operation across the four nations among Health Ministers, and we all represented different political parties. Co-ordination existed at CMO level, and also at First Minister level, but I felt the lack of health minister co-ordination was a missing piece of institutional infrastructure. Given the devolved nature of health policy, but the cross-border impact of the pandemic, this was clearly critical, so as UK Health Secretary, I took the lead in discussing this with my counterparts in the Devolved Governments, leading to the weekly calls which took place throughout the rest of the pandemic. The calls typically lasted half and hour and we regularly discussed TTI, and co-ordinated as appropriate **(MH9/009 - INQ000279759; MH9/010 - INQ000279763; MH9/011 - INQ000485158; MH9/012 - INQ000279766; MH9/013 - INQ000566156; MH9/014 - INQ000279770;**

MH9/015 - INQ000566171; MH9/016- INQ000279773; MH9/017 - INQ000279779; MH9/018 - INQ000279783; MH9/019 - INQ000279794; MH9/020 - INQ000566227; MH9/021 – INQ000566240; MH9/022 – INQ000566251; MH9/023 – INQ000566259). I do not believe that there were any significant differences of approach to the pandemic between the four nations during my tenure as Secretary of State. Each health system faced its own challenges and at times would adapt its approach in line with local need. Occasionally there were presentational and political differences between politicians involved, but all shared a common commitment to being guided by the science and protecting the most vulnerable.

International collaboration and comparison

58. I repeat what I said at paragraphs 95-97 of my first statement in respect of work with our international partners as requested by the Inquiry **(MH9/007 – INQ000181825)**. At the start of the pandemic international co-ordination was poor. Most countries turned to consider their domestic situation first. Had China closed all borders in early 2020, there is a chance the pandemic could have been contained there. But international health regulations contained an embedded assumption that shutting borders would not be effective in combatting a pandemic. International co-ordination improved with the institution of weekly G7 Health Minister calls from March 2020, and I extensively used my bilateral network of contacts to test policy ideas and compare notes. There was co-ordination of scientific work by the WHO, but their policy advice, for example on declaring a public health emergency of international concern, was slow and behind the curve. The correct response to this challenge is to reform WHO.

59. I supported a new global health treaty to address the need for transparency of reporting, for scientific co-ordination, the appropriate time for border restrictions, co-ordination over vaccine preparedness and other matters. Such a treaty should not allow the WHO to determine a domestic response, but, to maximise its chances of being adopted, should focus on the most important areas on international co-ordination. Reform of the WHO is also needed to ensure it can act faster and with fewer political constraints. I believe that such a treaty is important based on my experience of a Memorandum of Understanding on patient safety agreed with the Chinese during my time as Health Secretary; **(MH9/024 - INQ000184112; MH9/025 - INQ000184115)** whilst this called at paragraph 3.5 for the *"encouragement and*

facilitation of communication and collaboration between appropriate public organisations and companies from both countries," once the pandemic hit, the Chinese drew down the shutters.

60. Many improvements to support scientific co-ordination, strengthen transparency, and improve the international community's ability to collect, share and analyse emerging health data were made during the pandemic. These can and should continue to improve, for example, with improvements to the international coordination and standardisation of clinical trials. The UKHSA has and must continue to play a vital role in leading this global scientific work.

61. In respect of TTI, we frequently interacted with, and compared our approach to, other countries to identify best practice and technology (see, for example: **MH9/026 - INQ000566109;** page seven of **MH9/027 – INQ000106325; MH9/028 - INQ000566145; MH9/029 – INQ000566146; MH9/030 – INQ000566205; MH9/031 - INQ000566147; MH9/032 – INQ000566293).**

Preparedness and capacity

62. I reiterate the concerns I set out in respect of the weaknesses in preparedness and capacity for testing and tracing at paragraphs 68 to 75 of my first statement **(MH9/007 – INQ000181825)** and paragraph 201 of my seventh statement **(MH9/033 – INQ000536350).**

63. The UK's flawed doctrine had consequences that led to weakness in our readiness for a pandemic, because of the wrong attitude and because of operational weaknesses.

64. In respect of both testing and contact tracing there was no capacity for expansion to industrial scale: we had to build both.

65. The UK entered the pandemic with a very small private sector diagnostics industry, and a public sector diagnostic capacity that was either embedded in the NHS and not scalable, or embedded in research labs and so not scalable. This meant we were not well placed. Others will be better placed to explain why that was, but I suspect there

are historical reasons for it and potentially comparatively less focus on diagnostics within the NHS than in other health systems.

66. The early problem was not just that we did not have a big diagnostic capacity ready to scale. Preparedness work was entirely focussed on handling a very small number of initial cases - which was done superbly - and not on preventing the spread once community transmission became entrenched. Unfortunately PHE refused to engage enough with the private sector with the goal of building a huge testing capacity, and shut down their contact tracing capacity. As a result of the failure to expand fast enough, I took the decision to bring control of both testing and contact tracing within the Department in mid-March 2020.

67. The contact tracing system was designed to deal with very small numbers of cases of diseases such as Legionnaires, and simply was not geared towards mass contact tracing. PHE decided that contact tracing should be turned off when community transmission had become so widespread that small scale contact tracing was effectively useless. Instead we should have had the ability to scale that capacity rapidly, rather than having to build that capacity from scratch. On testing, PHE refused to engage private sector testing capacity, despite it being obvious that a massive expansion of testing was necessary, and that the existing capacity was not scalable.

68. In terms of Government facilities, I visited the PHE laboratory in Colindale, North London. The science was impressive but the testing facilities consisted of two scientists in a laboratory side room hand-pipetting samples. Whilst PHE did superbly well in developing a test very early that could detect the COVID-19 virus, it was simply not set up to conduct mass testing. What was required to introduce a large-scale testing operation was the use of industrial production lines. After I removed responsibility for testing PHE and brought it into the Department, we began radically to expand the availability of tests.

69. My insistence on a massive testing expansion, most publicly with the 100,000 tests a day target, was done both to drive the operational expansion, and also to change attitudes from one of highly targeted testing to mass testing. Eventually we built one

of the biggest testing operations in the world, but the consequences of a lack of testing capacity early on are well documented.

70. For the future, a rapidly scalable testing and tracing capacity should be maintained, ready for urgent expansion. I am concerned that at present our current capacity is being dismantled and we will find it much harder to scale again in the future as a result.

Development of Policies and Strategies for TTI

71. I am asked to provide a chronological overview of my involvement in the development of key TTI policies and strategies in England, Scotland, Wales and Northern Ireland between 1 January 2020 and 26 June 2021. I particularly draw from and expand on paragraphs 91-678 of my second statement **(MH9/001 – INQ000232194)**. I understand that the Department will also address the development of TTI policies and strategies in its corporate statements to which I again defer, and take as read.

Developing diagnostics and initial isolation and contact tracing measures

72. At the start of January 2020, there was no specific test for the new coronavirus, though there were pan coronavirus tests which had been previously used during the SARS and MERS outbreaks which could identify a coronavirus **(MH9/034 - INQ000527863)**. There was also no dedicated infrastructure for delivering testing at scale. As a consequence, from January 2020, in response to the emergence of the virus, the Department worked with PHE to ensure that there was capability and capacity to test for the new virus, as well as systems and processes for isolating the first cases, particularly British Nationals evacuated from Wuhan, and tracing their contacts and the contacts of the first confirmed cases in the UK in order to try to contain and disrupt the transmission of the virus. PHE, at that time and as was their usual remit in a health emergency, had responsibility for testing and health surveillance (including contact tracing) in the UK, and the Department oversaw their work in that regard until I decided the Department should take it over in mid-March 2020 (discussed below).

73. On 9 January 2020, the Department's UK Health Security Team provided an update, which noted that WHO had reported no evidence of significant human to human transmission in respect of the novel coronavirus and that the risk to the UK was considered to be low. It further noted that PHE had declared an enhanced incident and

intended to continue monitoring the situation, detecting potential cases in the UK, preventing onward transmission, developing a diagnostic test and preparing guidance for health professionals **(MH9/035 - INQ000233740)**.

74. On 10 January 2020, WHO gave initial guidance which explained that the causative agent of the new virus had not been verified nor had the genetic sequence been published **(MH9/036 – INQ000106556)**. On 12 January 2020, the Chinese authorities shared the genetic sequence, which facilitated the development of a specific diagnostic test **(MH9/037– INQ000183385)**. Prior to the development of a specific test, in cases where there was suspicion of the new virus, diagnosis was done indirectly by testing for alternative causes of illness and using generic all-coronavirus tests **(MH9/038– INQ000106894)**. On the same day, I spoke to Gordon Sanghera, Chief Executive of Oxford Nanopore, who design tests based on genetic sequencing. He said that Oxford Nanopore could develop a specific test in a matter of days.

75. On 13 January 2020, the New and Emerging Respiratory Virus Threats Advisory Group ('NERVTAG') met. Sir Jonathan Van-Tam attended for the Department and fed back to me. I specifically wanted NERVTAG's advice on whether we should start screening people at port of entry. NERVTAG advised against such screening as they considered that it had very low benefit as compared to costs of implementing it. PHE agreed to provide diagnostic information when it was available **(MH9/039 – INQ000023107)**.

76. On 15 January 2020, PHE published guidance for clinical diagnostic laboratories on the handling and processing of specimens for the diagnosis of COVID-19 **(MH9/040 - INQ000273610)**, and its infection prevention and control guidance on COVID-19 for healthcare providers, including in relation to the need to isolate patients who potentially had the virus **(MH9/041 – INQ000074966)**.

77. On 17 January 2020, WHO published guidance recommending that a polymerase chain reaction (PCR) test should be developed **(MH9/042 – INQ000106044)**.

78. On 20 January 2020, I received a submission from Emma Reed, the Department's Director of Emergency Response and Health Protection, which set out the

Department's initial incident response, including initiating daily sitreps calls with PHE, NHSE and the devolved administrations, working with the then Ministry of Housing, Communities and Local Government ('MHCLG') and NHS England and NHS Improvement ('NHSEI') to assess protocols and the capacity of local infectious disease units to identify and manage cases, and an assessment of port health measures **(MH9/043 – INQ000106901)**. It noted that NERVTAG did not support port of entry temperature screening as it was *"neither efficient nor effective and would have a negligible impact in delaying the spread of the disease"*, and that Border Force had been asked to ensure there was isolation capacity at Heathrow which received direct flights from Wuhan.

79. On 21 January 2020, I received a further formal submission from Emma Reed which stated that PHE had by then developed a prototype specific laboratory test for the virus. It also explained that PHE and the CMO (with agreement by NERVTAG) had revised the risk level from the virus to the UK from 'very low' to 'low'. It finally sought my agreement to a package of port health measures and enhanced monitoring (though not screening) which had been proposed by PHE and the CMO **(MH9/044 – INQ000106897)**. I agreed to those measures which were introduced on 22 January 2020 **(MH9/045 – INQ000233742)**.

80. On 22 January 2020, the Department and PHE announced the development of the diagnostic test **(MH9/046 - INQ000106048)**.

81. On the same day, SAGE met to discuss the virus (**MH9/047 – INQ000087535**). SAGE supported NERVTAG's advice to not screen at port of entry in the absence of a simple, specific and rapid test which was deployable at scale across the UK and because temperature and other forms of screening had little value due to the likelihood of high false positive and false negative rates. SAGE supported NERVTAG's advice that the dissemination of public health information on the virus via leaflets, posters and broadcast messages was the appropriate response. I was concerned that this was too little but accepted the expert advice.

82. SAGE also agreed with DHSC and PHE's approach to testing potentially infected individuals; i.e. to test those with symptoms of the virus who had been in Wuhan in the

14 days prior to symptom onset. I enquired at the time about testing all those returning from Wuhan; i.e. not only those with symptoms. I was advised that, for those without symptoms, due to the proportion of false negatives, undertaking a test was worse than not testing. I recognised, therefore, that the need to develop tests which worked on people without symptoms was a critical issue to resolve. I was also not satisfied with the degree of urgency to expand testing capacity. I asked PHE to go faster, and to use the private sector, including people like Gordon Sanghera.

83. SAGE further agreed at this meeting to consider DHSC and PHE's plans for isolating suspected cases and their contacts. At this time, PHE had only a limited contact tracing program which was designed for rare outbreaks, though PHE assured me that its contact tracing system was the best in the world, as rated by WHO.

84. On 23 January 2020, I provided an update to Parliament on the situation, including that we had developed a test for the new coronavirus and in respect of PHE's enhanced monitoring of flights from Wuhan. I also sought a note outlining options to contact people travelling from Wuhan to the UK over the last 14 days to provide advice on the virus symptoms to look out for and who to contact if they thought they have them, and the possibility of expanding this to all flights from China depending on how the situation developed **(MH9/048 - INQ000566034).** The subsequent advice proposed asking airlines to email the customers with public health information. I agreed with that but made very clear that that was a first step and further action was needed **(MH9/049 – INQ000566035).**

85. On 24 January 2020, I chaired a COBR meeting at which the CMO updated that a test had been developed, which was being validated and would be available over the following 2-3 weeks and that testing capacity was at 100 tests a day (**MH9/050 - INQ000056214).** The CMO maintained SAGE's advice that there was no strong scientific basis for temperature screening at ports. Nick Phin, Deputy Director at PHE, updated on PHE's work to raise awareness of the virus across the healthcare system and to the public on the identification and isolation of cases, port health measures which had focused on Heathrow but which were being rolled out to Gatwick and Heathrow (so as to cover all direct flights from Wuhan), and the contact tracing work they had done in respect of those returning from Wuhan. The Permanent Secretary

presented a paper "UK Escalation Triggers and Response Options". It noted that, in line with processes established for Ebola, MERS and Monkeypox, the NHS would isolate any suspected cases and transfer any confirmed cases to one of their High Consequence Infectious Disease Units, and PHE would trace any contacts and advise them to self-isolate. It further noted that if there was significant transmission, contact tracing would cease to be a plausible route to stop the virus (**MH9/051 – INQ000051738).**

86. On 26 January 2020, I read a report from China about the possibility of asymptomatic transmission, which concerned me **(MH9/052 – INQ000047567)**. I sought advice on this **(MH9/052 - INQ000047567)**. The advice from PHE was that there was no clear evidence of asymptomatic transmission and that tests would not work on those without symptoms **(MH9/053 – INQ000047556; MH9/054- INQ000151362).**

87. That day, Owen Paterson put me in touch with Dr Peter Fitzgerald, the founder and managing director of Randox (**MH9/055 - INQ000566036**). He said that they could develop tests for the new coronavirus within two-three weeks, but that they would need samples of sputum containing the virus. He said that they had two instruments, one which could obtain results in three hours and the other within five hours (doing 54 samples at a time) **(MH9/056 - INQ000106930)**

88. I sought advice from the CMO on their proposal and any other proposals that anyone became aware of so that we could explore every available option to expand testing capacity and mitigate the risk of the virus to the UK. I was told by the CMO that the proposal would be reviewed alongside other proposals being received from a number of companies and, if promising, they would be channelled through targeted research funding calls that were being urgently developed. I was content with this response which was entirely proper.

89. On 27 January 2020, I met with the CMO, DCMO, PHE, the Permanent Secretary and Department officials to discuss the virus **(MH9/057 – INQ000106067**). I again raised my concern about asymptomatic transmission and the need to plan for the reasonable

worst case scenario. The CMO essentially repeated the above advice; that the virus was unlikely to transmit whilst patients were asymptomatic but he said that there was a lack of clarity over what China's official position was. I asked the Department to gain clarification from China on whether asymptomatic transmission was occurring and to scenario plan accordingly. I also asked the Department to assess the risks and benefits of quarantine measures. We agreed that PHE would continue to prepare for containment of any case confirmed in the UK. I raised the issue of a travel ban for the whole of China, but was told by the CMO that it was not that straightforward and would not stop the virus coming out of China if it was highly transmissible. I suggested that anyone who had recently travelled back from Wuhan should be advised to self-isolate. PHE estimated that there were 1460 people in that category. I also pressed the need to *"pursue every option possible"* to expand testing capacity, and asked to be kept informed of any resourcing problems so that they could be addressed accordingly.

90. On the same day, I provided an update to Parliament (**MH9/058 – INQ000237587**). I explained that I had directed PHE to take a belt and braces approach, including tracing people who had been to Wuhan in the past 14 days. I also explained, on the basis of the CMO's advice, that, although coronaviruses were not usually transmitted by people without symptoms, there was not 100% certainty that asymptomatic transmission could not occur, such that we were asking people to self-isolate if they had returned from Wuhan in the past 14 days and to contact the NHS if they had any symptoms. I further explained that PHE had developed a test for COVID-19, which it was continuing to refine and that PHE had confirmed to me that it could *"scale up this test so we are in a position to deal with cases in this country if necessary"*.

91. On 28 January 2020, SAGE met (**MH9/059 - INQ000057492**). The minutes record that a specific diagnostic test was expected to be ready by the end of that week, there was capacity to conduct 400-500 tests per day, and guidance was being rolled out to laboratories across the UK. The minutes further recorded that the sensitivity of the test was unclear, particularly in the early phases of the illness or when symptoms are mild, and stated SAGE's view that it was not useful to test asymptomatic individuals *"as a negative test result could not be interpreted with certainty"*. SAGE also supported the principle of self-isolation, but sought behavioural science input on public communication.

92. The day before 27 January 2020 I met with the CMO, DCMO, PHE, the Permanent Secretary and Department officials to discuss the virus (**MH9/060 – INQ000106944; MH9/061**

INQ000106934). The CMO observed that there was by this stage credible evidence of asymptomatic transmission in Germany. PHE, however, reiterated that there was no test for asymptomatic patients and that they would be impossible without invasive tests which might encourage the spread of the virus. I again pushed PHE on expansion and harnessing the private sector. In respect of contact tracing, I was informed that 10% of passengers who had travelled from Wuhan had been contacted via email. We discussed options for quarantining persons evacuated from China.

93. On 29 January 2020, I chaired a COBR meeting **(MH9/062 - INQ000056165; MH9/063 – INQ000056226).** The CSA explained that there was limited evidence of asymptomatic transmission at that point. We discussed the isolation of British Nationals, who were to be repatriated from China, at Arrowe Park in the Wirral.

94. On 30 January 2020, following a meeting with Tedros Adhanom, Director of WHO, on 29 January 2020 at which I had pressed him to declare a Public Health Emergency of International Concern (PHEIC) **(MH9/064 – INQ000107070**), WHO declared a PHEIC, which meant that all countries around the world could (and should) work to the same principles (**MH9/065 – INQ000106079**). WHO advised every country to prepare for containment, including active surveillance, early detection, isolation and case management, contact tracing and prevention to try to slow the spread. WHO also mandated that countries must share full data with it.

95. On the same day, I visited PHE's facilities at Porton Down in Wiltshire to see, amongst other things, its secure testing capabilities (**MH9/066 – INQ000107051**). I was briefed as to the current and planned work by PHE in relation to the virus at both Porton Down and their site at Colindale in North London (**MH9/067 – INQ000107052**). I was informed that the Colindale site was providing PHE's diagnostic capability for potential cases in the UK, was dealing with clinical and laboratory-related queries on case assessment and management, and was the focus of planning for escalation of diagnostic testing, with a particular focus on supporting the NHS.

96. On 31 January 2020, I updated Cabinet that the first two cases of COVID-19 were confirmed in the UK, that 177 potential cases had tested negative, and that the first plane repatriating British nationals from Wuhan was due to arrive back in the UK that day (**MH9/068 – INQ000056125**). Individuals had been allowed to travel on the condition that they entered into voluntary self-isolation in Arrowe Park for 14 days. For anyone not complying with the agreement, the local authority would be able to apply for a Part 2A order under the Public Heath (Control of Disease) Act 1984 (the 1984 Act) to quarantine them; however, this was not necessary as there was full compliance **(MH9/069 – INQ000565499)**.

Scaling and prioritising testing and developing tracing and isolation measures

97. After the first cases were confirmed in the UK, the Department worked, and pressed PHE, to build testing capability and capacity, and to ensure that contact tracing and isolation was taking place as effectively as possible in order to try to contain and disrupt transmission of the virus. I had many allies on the challenge of expanding testing. For example, Sir John Bell, University of Oxford Professor of Medicine, also saw expansion of testing as critical and I remember him talking early on in the pandemic about a world in which mass DIY testing would be available on demand and it would be perfectly normal to get up in the morning and do a coronavirus test before going to work.

98. On 31 January 2020, I received a submission requesting that I note the CMO's recommendation to launch a rapid research call (through the National Institute of Health Research and in conjunction with the Medical Research Council), which was intended to strategically source, fund and manage research to better understand the disease and develop interventions to prevent, control and treat it, including diagnostics (**MH9/070 - INQ000057497**).

99. At the end of January 2020, PHE only had capacity to conduct about 100 tests per day at their Colindale site, with each test comprising various subtests which all had to be conducted simultaneously. However, PHE moved to the use of a simpler single frontline test on 31 January 2020 which increased capacity to about 300-400 tests per day, and they intended to rollout to regional laboratories to increase to around 1000-

2000 tests per day (**MH9/071 - INQ000119465; MH9/072 - INQ000119504**). PHE rolled out testing to 12 laboratories on 10 February 2020 (**MH9/073 – INQ000087567**). While testing capacity at that stage exceeded demand given the limited number of suspected cases in the UK, it was clear that it would be quickly overwhelmed as transmission escalated.

100. On 7 February 2020, I met with Department officials and the CMO to discuss introducing further legal powers to quarantine / isolate individuals as there was a concern that the existing powers under the 1984 Act were too limited **(MH9/074 - INQ000106098)**. I asked that regulations be drafted on quarantining individuals but that they should be broad enough to apply to other circumstances which might arise during the outbreak. I agreed that the default period should be 14 days for quarantine/isolation. While acknowledging that there was a concern in respect of individuals' liberty, I noted that there were clear public policy reasons for quarantine / isolation to reduce onward transmission, increase public confidence and prevent civil disorder. I agreed that there was no need to test people at the end of the 14-day period unless they had come into contact with someone with the virus.

101. On 9 February 2020, I was sent a submission in respect of the draft Health Protection (Coronavirus) Regulations 2020 which enabled measures to screen and quarantine/isolate individuals to prevent onward transmission of the virus **(MH9/075 – INQ000566038; MH9/069 - INQ000565499).** I approved the regulations at the Emergency Regulations meeting later that evening and signed them the following morning **(MH9/076 - INQ000566039).**

102. On 10 February 2020, I met with Department officials and PHE to discuss the trigger point at which contact tracing would no longer be effective if community transmission became widespread **(MH9/077 - INQ000527883; MH9/078 - INQ000527882)**.

103. On 11 February 2020, SAGE met (**MH9/079 - INQ000075784**). The minutes note that it was not possible for the UK to accelerate diagnostic capability to include COVID-19 alongside regular flu testing in time for the onset of winter flu season in 2020/21. They also note that validated serology testing (i.e. antibody testing in the blood) was

about 4-6 weeks away. SAGE maintained its advice that the self-isolation period should be 14 days. One of the actions arising out of the meeting was that PHE would work with the Scientific Pandemic Infections Group on Modelling (SPI-M) to develop criteria for when contact tracing was no longer worthwhile.

104. On 14 February 2020, PHE provided advice to the Department to the effect their modelling showed that their current approach to contact tracing was unsustainable and would be relatively rapidly overcome (**MH9/080 - INQ000527885**). It explained that based on PHE's current estimate of their ability to trace up to 800 contacts per day, with some scope for expansion, then depending on the rate of transmission, their capacity could be consumed within 2-4 weeks. It was clear, therefore, PHE's contact tracing method would be ineffective once numbers started multiplying. I was frustrated by that given PHE's earlier assurances that they had the best system in the world. I sought advice on how we could scale up.

105. By 16 February 2020, PHE's testing capacity had reached 2000 tests per day, with a 24-hour turn around **(MH9/081 - INQ000527886)**.

106. On 18 February 2020, Emma Reed sent me a briefing note in advance of a COBR meeting later that day. In line with PHE's paper a few days prior, it explained that, whilst there were only a small number of cases in the UK (nine at that time), it was possible to do contact tracing. However, when there was sustained transmission within the UK, contact tracing would no longer be feasible or useful **(MH9/082 - INQ000049389)**. On the same day, I spoke with Owen Paterson about Randox's testing proposal. He explained that apparently PHE were refusing to engage with Randox. I contacted PHE to find out what was going on, from which it was evident that Randox had not been sent what they needed. I was, again, frustrated. It caused me to question PHE's ability to act at the urgency and scale required.

107. On 25 February 2020, SAGE met again. The minutes note that PHE were continuing to focus on contact tracing if cases were confirmed, and that they were sourcing commercial solutions for point of care testing in hospitals as a priority **(MH9/083 – INQ000087503).** On the same day, the Department announced, following the surge in cases in Italy from mid-to-late February 2020, that individuals entering the

UK from locked-down regions in Italy should self-isolate for 14 days if they had symptoms **(MH9/084 - INQ000106153).**

108. On 1 March 2020, I sought urgent advice from PHE on a four-hour test being developed by Randox **(MH9/085 - INQ000566040**). PHE responded explaining that they had already engaged with 15 different companies and that their focus was on tests which could be used on instruments already in NHS laboratories for ease of deployment and to avoid the need for further equipment purchase **(MH9/086 - INQ000049481; MH9/087 - INQ000566042).** However, they said that they were also carrying out horizon scanning for other testing instruments that looked promising, and that Randox's instrument had been identified and prioritised as part of that process. They acknowledged that the critical advantage of Randox's instrument (and other commercial instruments) is that it could be used locally by NHS laboratories rather than having to send samples to PHE laboratories which was currently the case. I was deeply concerned at the attitude expressed that further purchases would be a barrier to expanding testing.

109. On the same day, following a request from PHE on 28 February 2020, HSE decided, having first consulted with the Government's Advisory Committee on Dangerous Pathogens (ACDP), that testing for coronavirus could be carried out at Containment Level 2 (CL2) facilities rather than Containment Level 3 facilities provided that certain conditions were met, despite coronavirus having been classified as a Hazard Group 3 (HG3) pathogen as with other coronaviruses (where HG4 is the highest for diseases such as Ebola) **(MH9/088 - INQ000119500)**. That was an important step to opening up laboratory capacity because the processing of coronavirus samples at CL3 facilities (of which there was not many) had been creating a major bottle neck. It meant that testing could be carried out more widely across the NHS, universities and commercial laboratories.

110. On 3 March 2020, I attended a COBR at which the CMO explained that the attempts to establish the source of infection for the last two cases in the UK by contact tracing had been unsuccessful, and that there was now sustained community transmission in both France and Germany (**MH9/089 - INQ000056217**). He explained that, if efforts to contain the virus failed, as appeared likely, the aim would then be to

delay the peak of infections, reduce the peak and minimise loss of life. That day, I commissioned advice on the approach to take to isolation (**MH9/090 – INQ000049516**).

111. On 3 March 2020, the Department published the Coronavirus Action Plan (**MH9/091– INQ000057508**), an earlier but substantially completed version of which I had reviewed and approved on 28 February 2020 (**MH9/092 – INQ000049465**). It set out the four phases of the Government's plan to respond to COVID-19 and circumstances that would trigger moving to a different level:

a. **Contain:** detect early cases, follow up close contacts, and prevent the disease taking hold in this country for as long as is reasonably possible.

b. **Delay:** slow the spread in this country, if it does take hold, lowering the peak impact and pushing it away from the winter season.

c. **Research:** better understand the virus and the actions that will lessen its effect on the UK population; innovate responses including diagnostics, drugs and vaccines; use the evidence to inform the development of the most effective models of care.

d. **Mitigate**: provide the best care possible for people who become ill, support hospitals to maintain essential services and ensure ongoing support for people ill in the community to minimise the overall impact of the disease on society, public services and on the economy.

112. The plan had an important impact on how policy on testing, tracing and self-isolation would be taken forward. When it was published, the UK was still in the Contain phase while numbers of reported positive cases remained low. There were only 35 reported positive cases as at 1 March 2020 **(MH9/093 – INQ000049478**). The plan explained that the approach at that stage, when a case was detected, was to rapidly trace, monitor and isolate close contacts, and that self-isolation was the primary means by which to contain the virus. However, it explained that large-scale intensive contact tracing would be less effective as the disease became more established. It

further explained that the Delay phase was critical to buy time to develop and/or improve tests to help reduce the impact of the disease. That was demonstrated as numbers of cases grew rapidly over the course of the month, which placed a massively increased demand on testing capability and capacity.

113. On 3 March 2020, I received a submission which recommended that COVID-19 should be made a notifiable disease under the Health Protection (Notification) Regulations 2010/659. It meant that doctors would be required (rather than merely doing so voluntarily) to notify local authorities if they had a patient who they suspected had COVID-19, who in turn would notify PHE so as to enable full contact tracing to take place (**MH9/094 - INQ000106146; MH9/095 - INQ000106147**). The CMO had indicated there was a strong clinical case for doing so. I agreed to implement the recommendation on the same day (**MH9/096 - INQ000106148**), and the Health Protection (Notification) (Amendment) Regulations 2020 came into effect on 5 March 2020.

114. On 4 March 2020, I had meetings with the PM and Department where I expressed my continued concerns about testing and the need to dramatically increase capacity, particularly in the face of evidence of the beginning of community transmission in the UK (**MH9/097 – INQ000049512; MH9/098 – INQ000049513**). I pressed PHE to explore how it could unblock barriers to significantly increase testing capacity **(MH9/099 - INQ000566043**). By that stage, testing was being carried out by eight PHE laboratories in England (**MH9/100 – INQ000527907**). While testing demand had not yet exceeded overall capacity, some individual laboratories (Colindale, which was serving London, and Bristol) were reporting that they were close to reaching capacity.

115. I also attended a COBR that day where we discussed, among other matters, the importance of ensuring that workers in key sectors could isolate if symptomatic without fear of being financially penalised, and a SAGE paper that considered a number of non-pharmaceutical interventions, the introduction of which were to be the key change as the UK's response moved from Contain to Delay **(MH9/101 – INQ000056218; MH9/102 - INQ000182333).** The interventions included home isolation of symptomatic individuals for 7 days (whereas current PHE advice was 14 days) and full household isolation for 14 days where one individual is symptomatic. The Department submitted

a paper on these proposed interventions to Cabinet a couple of days later **(MH9/103 - INQ000106157; MH9/104 - INQ000106158)**.

116. On 5 March 2020, and further to my request the day before, PHE provided the Department a briefing paper entitled 'Unblocking Barriers to COVID-19 Testing' **(MH9/105 – INQ000562604).** It noted that PHE's daily testing capacity was still approximately 2000 tests per day, so no greater than it had been on 16 February 2020. It set out the existing intensive process from swab test to publication of result. It stated that the current constraints were laboratory processing of samples at CL3 and competency and availability of staff. It noted that ACDP's decision to downgrade to CL2 would have a beneficial impact. It explained that they were using the "gold standard" test which had been rolled out centrally by PHE which was now being used on the Hologic Panther Fusion platform which was enabling higher testing capacity. It noted that there were 30 commercial tests either available or being developed and that PHE was verifying their kits before releasing guidance. It explained that PHE had identified key suppliers to maintain COVID-19 testing but that some were beginning to see performance issues.

117. On 6 March 2020, at the Department's daily coronavirus meeting, I explained that the note from PHE was inadequate to the task we faced. We discussed the need to move to conducting testing at the point at which the care was being provided rather than in designated PHE laboratories which was slowing the whole process down, and mechanisms for conveying test results immediately (e.g. text alert) to those tested rather than reporting back first to the clinician who had requested the test **(MH9/106 - INQ000566045)**.

118. On 7 March 2020, I sought further information from PHE on current availability, capacity and speed of testing and plans to boost capacity and testing times **(MH9/107– INQ000566046)**. PHE provided a note addressing those matters on 8 March 2020 **(MH9/108 – INQ000566051; MH9/109 – INQ000119745)**. It noted that PHE were using the molecular RT-PCR test they had developed at Colindale. It explained that at that point testing capacity at the PHE laboratories was 2,100 tests per day, but that PHE planned to increase it to 3,600 tests per day by 16 March 2020 by using 9 NHS laboratories adopting the PHE test, then to 4,500 tests per day by 23 March 2020

through the use of Hologic commercial technology in at least 2-3 sites (though there were concerns about the scalability of that process due to supply chain limitations) and that PHE were assessing commercial instruments to determine whether they had comparable accuracy to the PHE standard and were fit for deployment into the NHS with a view to then increasing capacity to 7,500-8,500 tests per day. It also explained that *"point of care rapid tests"* for use on an individual basis at the clinical frontline were being released for research use only, but would not be useable widely before June/July 2020. It set out the intensive process in place from taking the sample to the laboratory releasing the result which it calculated could be carried out within 48 hours in 93% of cases. It said that PHE were making daily improvements to boost capacity and the speed of getting results through *"incremental process improvements"*. It anticipated that by the end of April 2020 demand for testing would likely outstrip supply, at which point testing would have to be targeted at specific populations, and that PHE were developing guidelines for that point which recommended limiting testing to testing to key groups, such as those admitted to hospital, people in vulnerable groups who are more likely to develop severe disease, patient-facing healthcare workers, and clusters where public health action is required (e.g. a cluster in a school). I thought this was an inadequate response to the challenge we faced.

119. On 8 March 2020, I received the advice I had requested on 2 March 2020 about the approach to take to isolation **(MH9/110 – INQ000566054; MH9/111 – INQ000106161)**. It set out three interventions based on SAGE's recommendations designed to delay the virus' peak and reduce the mortality rate in the coming weeks: (i) self-isolation of symptomatic individuals for seven days, (ii) whole household isolation where one individual was symptomatic for 14 days, and (iii) social distancing for over 70s and other at risk groups. The advice that individuals only isolate for seven days, which was contrary to the existing advice that it be for 14 days, was based on balancing the fact that the policy would be applied to a much wider group, that the period should still give the intended benefit and would be less disruptive. The submission set out the nature of the clinical, practical, financial and social support which would be required for those self-isolating, and which needed a major coordinated effort across national and local government.

120. On 9 March 2020, I attended a COBR where we discussed the move to the Delay phase (there being 270 known cases in the UK at that point) and the above planned interventions **(MH9/112 – INQ000056219; MH9/113 - INQ000056179; MH9/114 - INQ000049547)**. The CMO explained that scientific advice supported early implementation of self-isolation for symptomatic individuals.

121. On 10 March 2020, I was briefed by the CMO on the readout of the SAGE meeting. SAGE estimated that the UK probably had 5,000-10,000 cases, up to twenty times the recorded figure (**MH9/115 – INQ000109125**). It noted that transmission was under way in both hospitals and the community, that PHE had a serology test up and running for population-level analysis, analysing greater volume of samples was a priority, and that a test for *"front line diagnostics"* may come from the private sector. The actions from the meeting were that PHE would report at the next SAGE meeting on 12 March 2020 whether available capacity for population-based serology testing was being fully exploited and what their plans were to move from 1,000 serology tests per week to 10,000 and plans for considering of commercial tests for frontline healthcare. There was frustration at the speed with which PHE were carrying out this work. I, myself, asked Duncan Selbie, the Chief Executive of PHE, to produce plans for how he would get testing up from 1,000 serology tests a week to 10,000.

122. On 11 March, I met with Department and PHE officials to discuss testing capacity and prioritisation **(MH9/116 - INQ000527906)**. Sharon Peacock, Director of the National Incident Service and PHE's Chief Scientific Advisor, explained PHE's current testing capacity and plans to increase it in line with their note of 8 March 2020 **(MH9/101 – INQ000056218**. She also explained that it was likely that by the end of April 2020 demand for testing would outstrip supply as community transmission continued to increase and if they continued to test everyone using the current procedures. Accordingly, as we moved from the Contain to the Delay phase of the Action Plan, she explained the need to triage and prioritise testing, essentially based on clinical need and vulnerability. I expressed my view that this response was inadequate, and was surprised that my request of the day before, to expand testing ten-fold, was not part of Sharon's presentation. I again pressed the importance of

expanding capacity so as to offer as many tests as possible and reduce the need for prioritisation.

123. On 12 March 2020, PHE shared the guidelines on the prioritisation of testing for when demand outstripped supply and triaging of testing was required, which had been agreed by PHE, NHSE and DHSC **(MH9/117 - INQ000527899; MH9/118 – INQ000087299)**. The priority order was as follows:

a. **Group 1** (test first): Patients requiring critical care for the management of pneumonia, Acute Respiratory Distress Syndrome (ARDS) or influenza like illness (ILI) or an alternative indication of severe illness;
b. **Group 2**: All other patients requiring admission to hospital for management of pneumonia, ARDS or ILI;
c. **Group 3**: Clusters of disease in residential or care settings, e.g. long-term care facilities, prisons or boarding schools;
d. **Group 4**: Community patients meeting the case definition (over 60 years or risk factors for severe disease) and not requiring admission to hospital with prioritisation given to age;
e. **Group 5**: Community patients meeting the case definition (under 60 years with no risk factors for complication) and not requiring admission to hospital;
f. **Group 6** (test last): Contacts of cases.

124. PHE's strategy on testing and prioritisation at that point was essentially to prevent and control infection in settings with vulnerable groups and to ensure essential services were maintained by preventing or reducing transmission of COVID-19 into them while allowing those people with COVID-19 symptoms to confirm if they needed to self-isolate. As stated in the minutes of the SAGE meeting on 13 March 2020, the effect of the need to prioritise testing meant that community testing had to be put on hold **(MH9/119 – INQ000061523)**. However, SAGE advised that prioritisation would increase the pace of testing (and delivery of results) for intensive care units, hospital admissions, targeted contact tracing for suspected clusters of cases and healthcare workers, and would bring about faster confirmation of negative results.

125. I attended a COBR on Thursday 12 March 2020 at which we discussed a package of interventions to reduce and delay the peak of the virus in the context of an estimate that there were presently 5,000-10,000 cases in the UK **(MH9/120 – INQ000056221)**. On SAGE's recommendation, it was agreed that anyone with symptoms consistent with COVID-19 should self-isolate at home for 7 days and that the other intervention measures (households isolating for 14 days, vulnerable individuals staying at home for 13-16 weeks and reduction of social contact for over 70s and at risk groups) should be held under active review, and that the timing of their implementation would be guided by the scientific advice. As referred to in the Action Plan, it was also noted that contact tracing would stop at this point (save in high risk settings). That was based on PHE's position that the growth in test and contact tracing could not rise exponentially to keep up with transmission rate. However, that assumed tracing would continue to be done as it had before, which I found frustrating, as it was clear that a large-scale contact tracing operation would have to operate differently, in a mechanised way.

126. The PM announced the requirement for all symptomatic individuals to self-isolate for seven days and the move from the Contain to the Delay phase of the Action Plan later that day **(MH9/121 – INQ000052485)**.

127. On 14 March 2020, Groups 1-3 (above) were prioritised for testing with capacity then at around 3,000 tests a day. The following day PHE circulated an explanatory note to PHE and NHS staff, explaining why not all essential workers could be tested at that point, the main reason being constrained laboratory capacity **(MH9/122 - INQ000527904)**.

128. On 16 March 2020, I attended a COBR where it was decided that, in addition to the need for symptomatic individuals to self-isolate for seven days, a further package of intervention measures would be implemented to delay and reduce the peak of the virus **(MH9/123 – INQ000056210; MH9/124 - INQ000230992)**. They included the need for a whole household to fully isolate where any member was symptomatic, advising specific at risk groups to more rigorously follow social distance guidance which applied to whole population and shielding for the most vulnerable. Modelling predicted that household isolation would delay a peak of infections by 2-3 weeks and reduce the peak by around 25%. I made a statement in the House of Commons

conveying the household isolation advice, and our intention to radically increase testing capacity. **(MH9/125 – INQ000176653)**.

Rapid expansion of testing capacity led by the Department rather than PHE

129. By way of introduction and summary, I repeat what I said at paragraphs 333-340 of my second statement in respect of our efforts to rapidly and massively increase testing capacity to ultimately allow for community testing at scale **(MH9/001 – INQ000232194)**:

> *"333. We increased testing capacity to 10,000 per day by the end of March. Throughout, tests were prioritised on clinical need. In the first instance, this meant for patients with symptoms. As we built capacity, we devised a priority scheme for the roll out of tests as they became available, starting first with NHS staff, ambulance staff and nurses in social care along with their household members with symptoms. This clinical prioritisation recognised the risk that individuals faced, as well as the risk that they posed to vulnerable individuals within their care (MH2/182-INQ000233780). That first group of key workers was estimated to require 250,000 tests per week in England, which would require approximately 36,000 tests per day before tests could then be provided to the next priority group.*
>
> *334. With the testing system not scaling as fast as we needed, I set a target to carry out 100,000 coronavirus tests a day by the end of April. This target was the subject of a lot of criticism, including off the record press briefing from No.10, who made the accusation that this was a publicity stunt. This is categorically wrong and shows a complete failure of mindset. I set this target to galvanise the whole system to deliver more tests. Especially given the wide range of people who needed to come together to deliver this extraordinary effort, I needed to make the target clear and public. This was an intentionally ambitious target which stretched the whole system. At the end of March, just over 10,000 tests were carried out, and I was asking the system to times that by ten in 30 days. Huge numbers of people went out of their way and delivered against the odds to expand testing, in a way they simply had not before. Even on the final days of April, we were unsure whether we*

would hit the target, but what we did know was that testing capacity had massively increased, showing this target was an unqualified success.

335. Professor John Newton and Lord James Bethell worked incredibly hard to lead this system, often with No.10 intervening in ways that made it harder to achieve. This is why it was so important that the Departmental team was completely aligned with clear lines of accountability, so we could avoid the same issues that were occurring across Government. Professor John Newton's blog (MH2/183 - INQ000233805) sets out the important context of how the team achieved this in the face of very little capacity from the start. The UK entered the pandemic without the diagnostics capacity needed to deal with outbreaks, and by 18th May 2020 everyone aged 5 and over with symptoms of COVID-19 was eligible to be tested.

336. The test developed by Randox was approved by the Medicines and Healthcare Products Regulatory Authority ("MHRA") on 27 March, providing an additional 1,400 tests per day using three new hub labs set up specifically for the pandemic through the work of a partnership between Government and industry. I am aware that there was subsequent criticism of the Government's decision to award Randox a contract for testing, but without them and thousands more businesses stepping up to help in the national effort to increase testing, many more people would have unfortunately died. It was vital for COVID-19, and will be vital for future pandemics, that when businesses are called upon to help convert their supply chains to support a particular goal, they step up. I fear that the criticism that many businesses have faced during and since the pandemic will lead to businesses and people deciding to not go out of their way to help in the next pandemic.

337. Some have argued that faster procurement processes were not the right way to award contracts. This argument, in my view, completely underestimates the scale of the challenge we faced at the time. In the face of a novel pandemic where we did not have an adequate capacity to fall back on, we were in urgent need of tests. As Health Secretary at the time, I faced two choices: to operate a business as usual procurement process which can take months to be completed, leading

people without the tests they needed, or to create a faster process which continued to be decided, priced and signed off by the civil service. My aim, and the aim of most countries around the world, was to rapidly scale-up testing in the early months of the pandemic. There was a truly global scramble for these vital items and without this faster process, many more people would have died.

338. In addition to testing being provided by the private sector, the NHS and PHE expanded their existing systems as fast as they could, and contributed significantly to hitting the target. Concurrently, work was undertaken on developing testing for antibodies that could indicate immunity (MH2/184 - INQ000233786). At this stage, the scientific picture was uncertain as regards immunity, and how long it might last: the advice we were given was that immunity was expected following recovery from COVID-19, but that the length of time for antibodies to develop, and how long they would protect a previously infected individual, were uncertain (MH2/185 INQ000233788; and MH2/186 - INQ000233790).

339. Antibody testing was especially important in disproving the false predictions by anti- lockdown voices such as Sunetra Gupta, who said that over half of the population may have been infected by the 24 March (MH2/187 - INQ00023377). This was proven categorically wrong with only 6.78% testing positive for antibodies in the COVID-19 Infection Survey later published on 28 May (MH2/188 - INQ000233813).

340. Partnerships with the private sector were reached appropriately and effectively, and were critical in the minimisation of unnecessary transmission, and in the way that the UK kept cases under control during the first lockdown. I had no oversight of the contractual arrangements themselves. However, the testing system we built ultimately enabled the easing of restrictions, relative to what would otherwise have been needed, and undoubtedly saved lives."

130. Building on that overview, on 16 March 2020, WHO announced the urgent need to escalate testing, contact tracing and isolation which they considered the *"backbone of the response"* to COVID-19 **(MH9/126 - INQ000512530).** We had already by that stage arranged a roundtable to take place on 17 March 2020 with public sector health

officials and representatives from the private sector (including Amazon, Boots, Roche, Thermo Fisher, Altona Diagnostics, and Randox) to catalyse action to rapidly increase testing, which I chaired and the PM attended to open **(MH9/127 – INQ000566056**; **MH9/128 – INQ000233771**). Specifically, the aims of the meeting were to:

a. Receive an update from NHSE and PHE on their immediate plans to maximise the current total public sector testing capacity (up to 25,000 tests per day);
b. Agree the best way to rapidly scale testing beyond NHSE and PHE capacity with a view to procuring a solution from the private sector;
c. Check PHE's progress with developing an antibody test to establish whether individuals had previously contracted COVID-19.

131. As set out above, I had become increasingly frustrated at the slow rate of expansion of testing capacity, and had lost confidence in PHE's ability to accelerate. We recognised that regular, mass testing across the country would be pivotal to the successful navigation of the pandemic, enabling the country to minimise spread as well as providing data that would be central to planning. At the meeting we discussed, among other things: testing capacity; the barriers to expanding it; and what steps the public and private sector could take to break these barriers and accelerate testing. Those barriers included the regulatory requirements on testing (i.e. the requirement to test in CL3 facilities), the short supply of swabs and reagents due to intense international demand and competition for them, NHS/PHE's limited capacity to scale testing within existing infrastructure due to the fact that pre-existing testing systems used multiple small laboratories with multiple testing platforms which were constrained by space, and the difficulties with mobilising a skilled workforce to carry out testing.

132. NHSE and PHE were unable to give convincing plans for developing their testing capacity at the scale required, confirming my concerns which had developed over the previous few weeks. We needed to expand testing on a massive scale, and while PHE had been effective in developing a test, despite my pushing for expansion, their plans clearly would not achieve the expansion in testing required at the pace needed. I therefore decided that the Department would lead on developing a mass testing

programme, rather than PHE **(MH9/129 - INQ000566057)**. I gave Lord James Bethell, Parliamentary Under Secretary of State at the Department, responsibility for the testing programme within the Department, and appointed leads for each strand of work, which we called "pillars". After the meeting, Lord Bethell circulated a 'Testing Action Plan' which set out a four-pronged approach to massively increase the number of tests conducted each day which had emerged from the meeting **(MH9/130 - INQ000566058; MH9/131 - INQ000055915)**, as follows:

a. PHE and NHSE, led by Sharon Peacock, would carry on expanding public sector laboratory capacity for testing in the NHS, with assistance from Roche, suppliers of reagents and other partners in order to reach the 25,000 testing capacity in the short term, with a focus on testing high-priority targets within the NHS. MHRA were to publish specifications for the NHS testing systems so potential private partners could make offers to augment supply.

b. Kristen McLeod, Director of the Office for Life Sciences within the Department, would lead the work to massively expand capacity for reliable antigen testing, especially for front-line workers so that they could be fast-tracked back into their critical work should tests results allow it. This was to be done outside the conventional NHS structures, which were already stretched, and away from the NHS estate, due to the need to test potentially contagious people. It was intended that it would be delivered by a suitable partner (Thermofisher had been identified at that point), and that a drive-in solution at university car parks would be explored as many of the existing testing machines were at UK universities.

c. Hadley Beeman, Chief Technology Advisor for the Department, would lead the development of mass antibody testing which could determine whether someone had had the virus and was therefore no longer contagious. There was an opportunity to use the latest mass-manufactured antibody test which had been successfully used in China, subject to certain regulatory and practical hurdles, and to identify, evaluate and, where appropriate and available, use other tests which were being developed and manufactured.

d. Professor Jeremy Farr, Director of the Wellcome Trust, would lead the work to extend mass population surveillance by the use of serology testing so as to improve understanding of the demographic progress of the virus.

133. Later a fifth pillar was added, and became the 'Five Pillars of the Testing Strategy' discussed at paragraphs 143-145 below.

134. On 18 March 2020, the PM announced that the Government was working to increase testing capacity to 25,000 tests a day in the coming weeks **(MH9/132 – INQ000086755)**.

135. On 20 March 2020, I chaired the first meeting of the COVID-19 Testing Group **(MH9/133 - INQ000129066)**, which became daily from 7 April 2020 and then met most days until June 2020, when Dido Harding took over day-to-day responsibilities for test and trace. Those meetings were solely focused on the rapid expansion of our testing programme, including matters such as: technical evaluation of testing and resulting data; exploring avenues for new methods or forms of testing; and opportunities to expand through the public or private sector. The Department also established a dedicated testing cell, within its wider COVID-19 response team, which was led by Kathy Hall (**MH9/006 - INQ000562635**).

136. Having taken the lead on testing, the Department was heavily involved from this point in discussions with industry in respect of their offers to assist with scaling up testing (see, for example, **MH9/134 - INQ000566074**; **MH9/135 - INQ000591748** **MH9/136 - INQ000566062**; **MH9/137 - INQ000566063**; **MH9/138 - INQ000566064; MH9/139 - INQ000566066; MH9/140 - INQ000566078)**.

137. On 22 March 2020, the PM approved the first draft of the Department's 'Battleplan' at a C-19 Strategy meeting **(MH9/141- INQ000056110)** which had been presented and reviewed at the Healthcare Ministerial Implementation Group ('HMIG') I had chaired earlier that day **(MH9/142 – INQ000198000; MH9/143 – INQ000249529)** At the time, it included six workstreams which formed the Department's response to COVID-19 (which changed and developed over time), and which included the delivery of widespread testing and social distancing (specifically through self-isolation and

household-isolation) as key planks of the battleplan. I exhibit a copy of the various battleplans that were created during my tenure as Secretary of State **(MH9/144 – INQ000234336)**. It was noted at the HMIG that the work on testing needed to address both supply but also the volume of tests administered in totality and to specific groups such as frontline workers **(MH9/145 - INQ000055942)**. At the C-19 Strategy meeting, the Department was tasked with providing the plan to accelerate testing across the whole of the UK (**MH9/143 - INQ000249529**).

138. On 23 March 2020, the PM announced the first national lockdown. This meant that households were effectively isolating from wider social contacts. This critical change in social distancing policy temporarily reduced the demand for testing and contact tracing in the general population. However, it remained pressing for key workers particularly.

139. On 25 March 2020, I was provided an update paper on the testing programme in response to the request at the C-19 Strategy meeting on 22 March 2020 **(MH9/146-INQ000566060; MH9/147 - INQ000233780)**. It detailed progress against the four-pronged approach set out in Lord Bethell's Testing Action Plan, including that antigen testing for acute patients in the NHS had reached 5,800 tests per day, was expected to reach 10,000 the following week and aimed to reach 25,000 by the end of April; the first test centre (outside the NHS and PHE) for antigen testing for priority key workers and their families had gone live the day before and it was expected that it would conduct 2-3,000 tests over the next week; the first tests to allow for mass-market home based testing were in the process of being procured; and the first 1,000 samples for national mass population surveillance would be delivered by the end of the week. It explained that there were three main steps on the path to achieving the testing ambition: (i) securing the supply of tests (which it noted was the main limiting factor for antigen testing and where urgent efforts were being focused); (ii) logistics of transporting tests and getting results to patients and the public, and (iii) prioritisation with a currently limited capacity for tests with the present focus on testing patients in hospital and priority key workers if space capacity. The paper included PHE's proposals for prioritisation of testing.

140. On 29 March 2020, I was sent a submission on prioritisation of testing for key workers which proposed a short-term focus on NHS staff, followed by social care domiciliary workers and any other group deemed immediately essential for legal or security reasons (e.g. prison) **(MH9/148 - INQ000566072; MH9/149 - INQ000566073).**

141. On 30 March 2020, I was sent an update on the work to develop a programme of mass-market home-based testing for immunity (MH2/184 - INQ000233786**; MH9/150- INQ000566077)**. It noted that immunity tests for COVID-19 were still at an experimental stage at only 6-8 weeks old, but were in massive demand by countries around the world. The Department, with assistance from the COVID Testing Scientific Advisory Committee, had identified the most promising tests and placed bulk orders of 17 million. Work was being carried out to rapidly validate the reliability of tests before undertaking a short, focused pilot of 1000 individuals and then rolling out a national antibody testing programme.

Five-Pillar Testing Strategy, National Testing Programme Plan and Testing Taskforce

142. On 29 March 2020, I attended a meeting with the PM, CMO and Simon Stevens and Department and No.10 officials to discuss the critical path for testing. Kathy Hall produced a paper for that meeting which set out the aims, progress, trajectory and barriers to the 'COVID-19 National Testing Programme' which built on the Testing Action Plan which had emerged from the roundtable meeting on 17 March 2020 and set out progress since then, including that we had reached over 7,000 test per day and opened four new test centres **(MH9/151 - INQ000566068; MH9/152 - INQ000566069)**. At my request, the Department also produced a short document on how to industrialise testing in the face of a lack of available supplies due to international competition, limited system capacity to administer and process tests and unavailability of specialist staff to conduct the tests **(MH9/153 - INQ000566065; MH9/154 - INQ000497129; MH9/155 - INQ000566071)**. It explained the pressing need to secure our supply from the major diagnostic firms, boost national capacity through cash incentive schemes, understand the true level of demand through modelling, create stronger scientific leadership and improve/refine the testing programme, bearing in mind it had been generated from scratch. I updated at the meeting that we would reach 10,000 tests per day the next day, but that, while we could test patients and NHS staff, we were

unlikely to meet NHS demand and be able to expand to other key workers until mid-April. I explained that the supply of consumables for testing equipment was the key constraint at that point **(MH9/156 - INQ000566076)**.

143. At the end of March 2020, I requested that the Department publish its strategy to increase testing capacity **(MH9/157 - INQ000566067; MH9/158 - INQ000566075)**, including meeting a target that I subsequently announced on 2 April 2020 of being able to carry out 100,000 tests per day by the end of April and to explain to the public how this increased capacity would be used **(MH9/159 – INQ000237310)**. As set out above, this was an intentionally ambitious target designed to galvanise the whole system to deliver more tests **(MH9/160 - INQ000566080; MH9/161 - INQ000566079)**.

144. On 4 April 2020, the Department published its testing strategy in a paper entitled *"COVID-19: Scaling up our testing programmes"*, for which I did the ministerial foreword **(MH9/027 - INQ000106325)**. It set out the strategy objectives which were grouped under five "pillars" or workstreams, which built upon the earlier four-pronged Testing Action Plan. The five pillars were:

1 – Scaling up NHS swab testing conducted by NHS and PHE laboratories for those patients with a medical need and, where capacity allowed, critical key workers in the NHS with a target of achieving 25,000 swab tests per day by the end of April;

2 – Mass swab testing for critical key workers in the NHS, social care and other sectors using new testing sites (five at that time) and the creation of a mass testing infrastructure in partnership with universities, research institutes and companies;

3 – Mass antibody testing to determine if people have immunity to the virus which could potentially be carried out at home and deliver rapid results;

4 – Population surveillance testing to understand the rate of infection and spread of the virus across the UK, to assess the impact of measures taken to date, to inform current and future actions and to help develop tests and treatment; and,

5 – Spearheading a national diagnostic effort to build a mass testing capacity at a completely new scale.

145. These pillars would become central in our mission to ramp up testing. While the strategy ultimately aimed to ensure testing was made available to anyone who needed it, it made clear the need to adopt a phased approach prioritising patients who needed a test to support their treatment, then NHS and social care staff given the risks to the vulnerable people they work with and the importance of maintaining that workforce, then other critical workers before being expanded into the wider community. The strategy reiterated the target of achieving 100,000 tests per day across all five pillars by the end of April, and then 250,000 tests per day in the medium term.

146. On 5 April 2020, I established the Testing Taskforce to sit alongside the daily meetings, which was intended to bring together ministers, experts, industry and other leaders in the healthcare sector to help drive progress, unblock barriers and find creative solutions to increase testing capacity across the five pillars **(MH9/162 - INQ000566081; MH9/163 - INQ000233789; MH9/164 - INQ000497424)**. I chaired the Taskforce, which met three times per week.

147. On 7 April, I requested that the Department's weekly testing meetings become daily given the importance of delivering in this area at the speed I wanted. I exhibit the minutes of those meetings **(MH9/165 - INQ000566083; MH9/166 - INQ000566085; MH9/167 - INQ000566089; MH9/168 - INQ000566099; MH9/169 - INQ000566100; MH9/170 - INQ000566102; MH9/171 - INQ000566105; MH9/172 - INQ000566106; MH9/173 – INQ000566110; MH9/174 - INQ000566114; MH9/175 - INQ000566120; MH9/176 - INQ000566122; MH9/177 - INQ000566123 ; MH9/178 - INQ000566124; MH9/179 - INQ000566127; MH9/180 - INQ000566135; MH9/181 - INQ000566137; MH9/182 - INQ000566141; MH9/183 - INQ000566144).**

148. On 8 April 2020, I was sent the draft 'National Testing Programme Plan' which had been produced by Kathy Hall and her team, and which set out the plan for how the

Government would deliver on testing strategy published on 1 April 2020 **(MH9/184 - INQ000566090; MH9/185 - INQ000233793)**. This was an extraordinarily good piece of work, produced under huge pressure in a very short timeframe **(MH9/186 - INQ000566095)**.

149. On the same day, I hosted a webinar with industry and set four challenges for them **(MH9/187 – INQ000566087; MH9/188 - INQ000566088)**:

a. To provide additional testing consumables that are in short supply, such as swabs, tubes and components for test kits;

b. For universities, research institutes and private companies to donate additional lab testing capacity for coronavirus tests, supported by best practice guidance on specific requirements;

c. To develop new technology to diagnose coronavirus quicker than ever before and new methods of delivering tests widely across the UK safely;

d. Put forward proposals in support of reliable and accurate antibody testing. These should be scalable, resilient and scientifically robust. Proposals could include a range of ideas for end-to-end solutions or address specific challenges in the supply chain.

150. A press release that day noted that an online portal had been launched on GOV.UK providing companies with specifications for our most urgent requirements, and the NHS Business Services Authority has set up a new engagement team allowing companies an easier, more focused route to offer their support, in order to develop a large British diagnostics industry **(MH9/189 - INQ000551308)**.

151. The response was overwhelming. A message from Lord Bethell to MPs on 17 April 2020 illustrates the scale of the response **(page 88 of MH9/190- INQ000551339)**:

"*We have received 5,000 enquiries in the last two weeks from companies. We have a huge team at BSA handling them. We have engaged with many and have spent*

£100ms with UK companies which meet our brief. But many companies are offering tests which are not relevent [sic] for our battleplan. https://www.gov.uk/government/news/health-secretary-sets-out-plan-to-carry-out-100000-coronavirus-tests-a-day do not meet our standards. I appreciated [sic] many are frustrated, but we do have high standards and it is reasonable to apply these to protect the british [sic] people. https://www.gov.uk/guidance/guidance-on-coronavirus-COVID-19-tests-and-testing-kits And many of the labs that are offering services do not have the correct validation, the right safety environment or access to reagents (and if they get them, it means taking them out of a very constrained supply chain. [sic] This is a difficult message to deliver. We are not closed to new ideas, but we are drowning in helpful suggestions while at the same time being very focused about delivering some very tough deliverables. If there are any stand-out companies that you really think we're missing, do pls email me (lordbethell@dhsc.org.uk) and I have a fast-track process. But also please be aware that there might be strong clinical or practical reasons why we cannot take up every offer for help."

Lighthouse Laboratory Network

152. On 1 April 2020, I received a proposal on the option of creating a decentralised network for PCR testing **(MH9/191 - INQ000562617)**. It was ultimately rejected on the basis that it would require the Department to 'micro-manage' a complex network of partners and increase logistical complexity, and matching the testing capacity of one centralised laboratory would require 100 smaller sites to deliver 1,000 tests. Further, as stated, in Chapter 6 of the Technical Report, page 189, without a full and integrated system of testing and reporting and quality control mechanisms, using many smaller facilities did not easily provide a solution to delivering rapidly scaled and integrated mass testing **(MH9/192 – INQ000203933)**.

153. However, in order to provide mass community testing across the UK with a single shared IT system and end-to-end processes which could manage the delivery and processing of tests and results at an unprecedented scale (i.e. tens of thousands of patient samples each day), we set up large 'Lighthouse' laboratories with the support of private sector, academic partners, existing laboratory staff and experts to provide

high throughput test processing at speed. We set up regional and mobile testing sites for community testing and a digital infrastructure to track and locate tests and communicate results. It was vital to link national infrastructure back to local teams. It was the biggest diagnostic laboratory network in British history.

154. On 9 April 2020, I officially opened the first Lighthouse laboratory at Milton Keynes **(MH9/193 – INQ000566098)**. Two further lighthouse laboratories were opened in Alderley Park and Glasgow in the following weeks **(MH9/194 - INQ000566096; MH9/195 - INQ000566101)**. That was in addition to, by then, 13 drive-through sites we had set up for NHS frontline staff and their families to help provide the NHS/PHE laboratories with patient samples **(MH9/196 - INQ000566092)**. The day before, the Department published guidance on how organisations with laboratory capability could partner with an NHS Trust to support the testing programme **(MH9/197 - INQ000566086)**.

155. We continued to expand on that infrastructure 12 June 2020 **(MH9/198 - INQ000562660)**. In September 2020, we set up a further lighthouse laboratory in Loughborough **(MH9/199 – INQ000566222)**. By March 2021, when we announced that three further lighthouse laboratories had been set up in Brants Bridge, Gateshead and Plymouth, there were 1000 other testing sites across the UK, seven Lighthouse laboratories, 90-drive through sites, 514 walk-through sites, a large number of mobile units in addition to home testing and satellite kits. By that point, there was capacity to conduct 750,000 tests per day.

Prioritisation of key workers and expansion of testing eligibility

156. On 7 April 2020, I received advice on key worker prioritisation for swab testing. It recommended that commercial swab testing remained prioritised on NHS workers but where there was capacity, other high priority keyworkers, starting with social care workers, should be able to access testing **(MH9/200 - INQ000562622**; **MH9/201 - INQ000562623)**. I fed back my comments, which were fed into a paper for HMIG the following day **(MH9/202 - INQ000327823; MH9/203 - INQ000562624; MH9/204 - INQ000562627; MH9/205- INQ000083645).**

157. The principle was to extend testing in the right order, to save most lives, as we built up capacity. I was acutely aware of the need for more tests, and the demand for those tests, and was determined to ensure that testing was rolled out in a way that saved most lives, given the increasing understanding of the way in which COVID spread, and the nature of transmission.

158. At the HMIG on 9 April 2020, we discussed and agreed that social care staff should be tested at the same levels as NHS staff given the level of staff who were isolating in that sector and the importance of their work, and that more groups would become eligible as testing capacity further increased **(MH9/206 – INQ000083704; MH9/207 - INQ000562632; MH9/208 - INQ000562633).** The Department immediately set to work to make testing available to social care staff and users **(MH9/209 - INQ000562630; MH9/210 - INQ000562631).**

159. On 15 April 2020, the Department published its Action Plan for Adult Social Care **(MH9/211 - INQ000233794)**. It announced that all hospital patients would be tested prior to admission to a care home, whether or not symptomatic, which had the dual benefit of freeing up hospital capacity, while also giving care providers the risk mitigation that they sought and required. Importantly, it also advised that those discharged into care with a negative test should still be isolated for 14 days to guard against the risk of a long incubation period and false negatives. In addition, it announced that all symptomatic care home residents and staff members and their families would be eligible for testing.

160. On 17 April 2020, as we had increased testing capacity, in addition to NHS and social care workers, I announced that testing was being extended to a wider range of symptomatic frontline workers and their families/households, including the police, the fire service, frontline benefits workers and those working with vulnerable children and adults **(MH9/212 - INQ000308713)**.

161. On 23 April 2020, as we had increased capacity to 50,000 tests per day, I announced that all essential workers (based on the list for schools and education) would also be eligible to get a test **(MH9/213 – INQ000237529; MH9/214 - INQ000088444)**.

162. On 25 April 2020, I received a submission on scaling up the availability of tests which could be delivered at home from 5,000 tests per day to 18,000 tests per day **(MH9/215 - INQ000566125; MH9/216 - INQ000527935**). I agreed and said that I was content to approve any subsequent decision to expand further if that was the recommendation **(MH9/217 - INQ000527936)**. I was strongly supportive of home testing, which was novel in the NHS, but absolutely vital for the very large scale testing.

163. On 28 April 2020, in addition to the above groups, eligibility for testing was expanded further to include anyone over the age of 65 with symptoms **(MH9/218 – INQ000106391)**. I was, however, frustrated by reports of tests being under-utilised, given the widespread need and desire to access tests, and repeatedly sought to make clear that any 'spare' tests should be re-distributed to ensure that capacity was fully utilised **(MH9/219 – INQ000566133; MH9/220 - INQ000566136)**. For example, notwithstanding testing capacity had reached 73,000 tests per day by this point, I was informed that take up was much lower at circa 43,000. There were reports that NHS staff were avoiding taking tests as they did not want staff to test positive and then be required to stay at home, impacting staffing levels. I was astonished to hear this, bearing in mind not only the impact on staff, but also on vulnerable patients in hospital for reasons other than COVID-19. I discussed this problem repeatedly with Simon Stevens.

164. By late April 2020, testing capacity exceeded 100,000 tests a day **(MH9/221 - INQ000566139)**.

Track and Trace and the COVID-19 App

165. When easing the first lockdown, the Government sought to introduce measures that would keep the transmission rate down and avoid further lockdowns. As part of which, on 6 April 2020, I received advice from the CMO that a 'track and trace' approach, involving the rapid identification and isolation of cases and their contacts, could be used to reduce the need for social distancing measures. He explained that it was a variant to conventional contact tracing and isolation which could be automated to allow it to happen at scale and quickly (e.g. through phone-based tracing) provided it was accompanied by widespread and rapid PCR/antigen testing. He considered it

should be seen as an enhanced and targeted version of the contact tracing and isolation measures which had been in place earlier in the pandemic **(MH9/222 - INQ000566084; MH9/223- INQ000068683)**.

166. In fact, I had already agreed on 10 March 2020 to NHSX, a joint unit of the Department and NHSE, developing an app which, with user's consent, could use geolocation and Bluetooth technology to identify proximity to other people known to have, or suspected of having, the virus **(MH9/224 - INQ000279898; MH9/225 - INQ000566052; MH9/226 - INQ000279899)**. The user could then be advised or instructed to isolate so as to assist with preventing or reducing onward transmission of the virus. China had used it successfully but by making it effectively compulsory.

167. On 9 April 2020, I was provided further advice on the app **(MH9/227 - INQ000566093; MH9/228 - INQ000566094)**. The advice noted that PHE's manual contact tracing systems through their Contact Tracing and Advice Service (CTAS) were important but were resource intensive. It explained that PHE were currently in the process of creating an enhanced mobile version of CTAS to support the expansion of contact tracing, which was distinct from the NHSX app. It further explained that PHE had established a Case Notification Direction to enable NHS Digital to receive patient identifiable information on COVID-19 cases from the Second Generation Surveillance Systems (SGSS), which captured laboratory data on infectious diseases, and would enable PHE to contact more people with COVID-19. However, the advice explained that the NHSX app, which was under development, was designed to reach a much larger number of people, faster and more accurately than would be possible using PHE's existing means.

168. On 14-16 April 2020, we discussed the use of the NHSX app at a number of Departmental meetings, and potential pilots in a hospital setting or on the Isle of Wight **(MH9/229 - INQ000566103; MH9/230 - INQ000566104; MH9/231 - INQ000566107; MH9/232 - INQ000566108)**. I made clear that the mobile version of PHE's CTAS and the NHSX app should be brought into one project so the public were not having to do deal with two apps. I also made clear that, while privacy and data protection were important considerations, we should not allow those factors to outweigh the development and use of the app in the fight against the virus in order to save lives. I

did not consider that PHE's manual contact tracing would be large enough or quick enough to effectively reduce transmission **(MH9/233 - INQ000566117; MH9/234 - INQ000566119).**

169. On 17 April 2020, we conducted a deep dive on the Track and Trace programme at a COVID-19 Strategy MIG meeting **(MH9/235 - INQ000088414; MH9/236 - INQ000088416)**. I provided an update on the development of the app, which I believed could be used, alongside the PHE's existing manual (or human) contact tracing capability, as a critical element of the strategy to keep the R number low and to prevent a second national lockdown, given the need for contract tracing to occur at a significant scale and to extend contact tracing beyond merely those people known to the person who had tested positive **(MH9/237 - INQ000088664)**. The Group agreed that development of the app should proceed at speed, and that a test on the Isle of Wight should take place, with a view to rolling out nationally in mid-May if successful.

170. On 1 May 2020, I approved the pilot of the NHSX app on the Isle of Wight **(MH9/238 - INQ000566148),** which started on 5 May 2020 **(MH9/239 - INQ000527940)**. We chose the Isle of Wight as a good place to run the pilot, as its self-contained nature meant it could be run in proper scientifically-controlled conditions, comparing the effect with what was going on in the mainland to consider its impact.

171. On 8 May 2020, we conducted a further deep dive into the Track and Trace programme looking specifically at international comparators and the lessons to be learned from their experiences **(MH9/240 - INQ000088574; MH9/241 - INQ000088578; MH9/242 - INQ000088651)**.

172. On 12 May 2020, I was presented with NHSX's responses to various questions from No.10 in respect of the app **(MH9/243 - INQ000566149; MH9/244 - INQ000566150)**. On the same day, I presented the results of the Isle of Wight pilot to the C-19 Strategy Committee **(MH9/245 – INQ000088653).** I explained that it had gone well but that there was further work to do to connect the work into the wider testing and tracking programmes, and to ensure that the testing platform and the call centre tracing capabilities were not overwhelmed.

173. On 18 May 2020, I received advice on whether to maintain the current approach to the NHSX app or to shift to a new Application Programme Interface (API) developed by Google and Apple, which recommended continuing with the existing approach to avoid delay but building a second version of the app using the Apple/Google API to potentially be used in the longer term **(MH9/246 - INQ000566157)**.

174. On 27 May 2020, a senior meeting at No. 10 was held ahead of the announcement about the Track and Trace app launching on 1 June. For reasons I still do not understand, I was not invited to that meeting, which was unfortunate given that the functioning of the app and the performance of the tracing programme was inherently intertwined with the Department's work, and I was accountable for the programme. After the meeting, Dido Harding updated me that the decision had been taken to trial the obligation to self-isolate once contacted by Track and Trace as a "civic duty", and that if people routinely ignored the request it would be made mandatory in law.

175. On the same day, I announced the launch of the NHST&T service (discussed below), including that it was anticipated that the app would be rolled out in the coming weeks **(MH9/247 - INQ000565912)**.

176. The pilot programme for the app found that it worked well on Android devices, but that it was only picking up a small proportion of cases on Apple phones. In discussion with Apple we discovered that they were blocking the effectiveness of the app, because the data generated would be available to the Government **(MH9/248 - INQ000566170; MH9/249 - INQ000566172; MH9/250 - INQ000093920)**. The app had, reasonably, been designed in this way so that the NHS would know where the app was picking up cases, and so that we could use the information to monitor the virus and make life-saving judgements. Over the ensuing weeks the NHSX team engaged Apple, up to a very senior level, but they refused to allow the app to work in a way that would allow us to make decisions on the public health response which was tailored to the data **(MH9/251 - INQ000566178).** It was very unfortunate that they took that approach.

177. Consequently, on 16 June 2020, I received a formal note from Matthew Gould, CEO of NHSX, which explained that NHSX's version of the app was only picking up a small proportion of contact events on Apple phones and therefore was not ready for national rollout **(MH9/252 - INQ000566174; MH9/253 - INQ000566175)**. While the Apple / Google version was also not ready for national rollout, it was more likely progress could be made improving the Google/Apple version. Accordingly, the note recommended that we stop development of NHSX's app and shift our efforts to the version using Google/Apple's API. I discussed the matter with Dido Harding and Matthew Gould later that day and, on their recommendation, agreed that we should shift to developing the app which used Google/Apple's API and to developing an app that supported the whole of the test, trace and isolate journey **(MH9/254 - INQ000566176)**.

178. On 18 June 2020, I announced that change of approach which ultimately led to the creation of the COVID-19 App **(MH9/255 – INQ000308726; MH9/256 - INQ000566177)**.

179. We developed, trialled and tested the COVID-19 app over the Summer **(MH9/257 - INQ000566190; MH9/258 - INQ000566198; MH9/259 - INQ000566199; MH9/260 - INQ000566200; MH9/261 - INQ000566201; MH9/262 - INQ000566202; MH9/263 - INQ000566203; MH9/264 - INQ000566204; MH9/265 - INQ000566220; MH9/266 - INQ000566231; MH9/267 - INQ000566232; MH9/268 - INQ000566233)**, which included addressing and ensuring its interoperability with equivalent apps being used across the four nations (with Scotland and Northern Ireland developing their own apps using the same provider as the Republic of Ireland, and Wales ultimately adopting our app) so that there was a UK-wide approach, and also with other countries (see **MH9/269 - INQ000566208; MH9/270 - INQ000566209; MH9/271 - INQ000566211; MH9/272 - INQ000566212; MH9/273 – INQ000566213; MH9/274 - INQ000566214; MH9/275 - INQ000566216)**.

180. On 9 September 2020, I approved the launch of the COVID-19 app **(MH9/276 - INQ000566221; MH9/277 - INQ000566223)**. After No.10 approval, I announced its launch on 24 September 2020 **(MH9/278 – INQ000237570)**.

181. Notwithstanding and acknowledging that the app was not perfect and took some time to become fully operational, the Department had built the app and the supporting technological systems from the ground up: the NHS had gone from lagging in its use of technology, to pioneering an important app that provided data and advice in real time. As set out in National Audit Office report dated 25 June 2021 entitled 'Test and Trace in England – progress update', by April 2021, the app had been downloaded 23.3 million times, and it had sent 1.8 million contact tracing alerts in England. In the week commencing 22 April 2021, 16 million people had the app fully or partially enabled on their phone (which was one of the methods used to estimate how many people were regularly using the app) **(MH9/279 – INQ000287601)**. NHST&T (discussed below) funded an external assessment by the Alan Turing Institute and Oxford University on the app's effectiveness which reported on 9 February 2021 and estimated based on a number of assumptions, that it may have prevented between 200,000 to 900,000 cases from October to December 2020, as against 1.89 million people who tested positive for COVID-19 over that period **(MH9/280 - INQ000562944)**.

NHS Test & Trace

182. During April 2020, there was extensive discussion on how test, trace and isolate measures could be used to keep transmission down as social distancing measures were lifted (for example, **MH9/236 - INQ000088416; MH9/281 - INQ000566130; MH9/282 - INQ000566131; MH9/283 - INQ000566134)**. Given the amount of work that would be required to effectively implement such measures and the obvious advantages of having policy and operational responsibility and accountability for them sitting in one place, we decided to establish a dedicated unit within the Department to oversee them **(MH9/284 - INQ000566132; MH9/285 - INQ000566140)**. We, therefore, established NHST&T, who took on responsibility for developing policy and operational oversight of testing, tracing and isolation **(MH9/286 - INQ000566142)**.

183. On 7 May 2020, we appointed Baroness Dido Harding as chair of NHST&T to lead these efforts **(MH9/287 - INQ000107093)**. As a condition of her appointment, No10 officials insisted that she formally report directly to the PM, but in practice she reported to me as part of the Department's senior team. As set out in paragraph 26 of Sir Christopher Wormald's Third Witness Statement, ministerial accountability for NHST&T remained at all times with me as Health Secretary **(MH9/003 –**

INQ000144792). Dido Harding and I necessarily liaised extensively given the centrality of the Department's work to the Test and Trace programme. She had extensive experience in both the NHS and private sector, having run a FTSE 100 company and as Chair of NHS Improvement, and therefore was impeccably placed to lead Test and Trace, which required integration of the health system and scaling up of private industry.

184. At this point, I disbanded my daily testing meeting, and shifted to a weekly meeting with Dido Harding to track progress **(MH9/288 - INQ000566151)**.

185. Over May 2020, we worked on developing the Test and Trace strategy **(MH9/289-INQ000566154; MH9/290 - INQ000566152; MH9/291 – INQ000566153; MH9/292 - INQ000566155; MH9/293 - INQ000566160; MH9/294 – INQ000566158; MH9/295 - INQ000565517; MH9/296 - INQ000566162; MH9/297 – INQ000566163; MH9/298 - INQ000566164)**. The strategy built on the existing testing strategy. It had controlling the rate of reproduction, reducing the spread of infection and saving lives as its core objectives. We established the NHST&T Service as a central part of that strategy. Its role was to bring together testing, contact tracing and outbreak management into an end-to-end service. It consisted of four main components:

1 – Test: increasing availability and speed of testing;

2 – Trace: using dedicated contact tracing staff, online services and local public health experts to identify any close recent contacts and alert those most at risk of having the virus who need to self-isolate, which was to be complemented by the rollout of the app in due course;

3 – Contain: the Joint Biosecurity Centre (discussed below) working with local authorities and public health teams in PHE including local Directors of Public Health, to identify localised outbreaks and support effective local responses, including plans to quickly deploy testing facilities to particular locations; and,

4 – Enable: learning more about the virus, including as the science develops, to explore how we could go further in easing infection control measures.

186. The Test and Trace strategy sat alongside *"Our plan to rebuild: the Government's COVID-19 recovery strategy"*, which was published on 11 May 2020, and which committed to increasing testing capacity to over 200,000 tests per day by the end of May **(MH9/299 - INQ000198892)**.

187. As of 18 May 2020, we had expanded testing capacity to the extent that, following clinical prioritisation, all people in the UK with symptoms were able to access a test, which was a significant milestone and was an important foundation for the roll out of the NHST&T Service, given that it allowed for targeted isolation guidance and contact tracing to flag linked cases which helped to identify local outbreaks and clusters **(MH9/300 - INQ000050569, page 3-4)**. In particular, it enabled people who were self-isolating because they or another household member had symptoms, to stop self-isolating if the person with symptoms had a negative test result. This had important social and economic benefits. It meant that, if an individual had symptoms, that individual only had to self-isolate during the period while they were awaiting their test result (if the result was negative), or if they had been identified as the close contact of someone who had tested positive.

188. On 27 May 2020, I announced the launch of NHST&T with Dido Harding **(MH9/301 - INQ000107094)**. On 30 July 2020, NHST&T published their plan on 30 July 2020 entitled 'Breaking chains of COVID-19 transmission to help people return to more normal lives: developing the NHST&T service' **(MH9/302 - INQ000527961)**. This was superseded by the Test and Trace Business Plan published on 10 December 2020 **(MH9/303 - INQ000059228)**.

189. As I explained at paragraph 427 of my second witness statement **(MH9/001 – INQ000232194)**, we never expected Test and Trace to be able to replace all lockdown measures, as some hoped for (notably those who did not believe a vaccine would happen so focused undue emphasis on testing). Test and Trace could only ever be one string in the bow. Unfortunately, expectations for Test and Trace were set far too high, to a large extent by No.10, and so its significant contribution to saving lives was seen by commentators as a disappointment, when in fact building such a huge and effective testing and tracing capability at such incredible pace was a huge

achievement, kept R lower than it otherwise would have been, reduced the need for other lockdown measures, allowed the enforcement of local action in areas of particularly high prevalence, and saved many lives. While I am aware of the criticisms of the implementation of NHST&T – for example, the findings of the NAO report in December 2020 that capacity in the national tracing service had not been effectively utilised. I do not consider that those were failures in NHST&T in principle, rather operational challenges for what was a relatively newly-established institution and test and trace infrastructure, which we needed to overcome and learn from in the face of a dynamic and fast-changing pandemic. They do not diminish from my view that NHST&T was a success.

Joint Biosecurity Centre (JBC)

190. We set up the JBC at end of May 2020. It was to provide a UK-wide analytical function to deliver insights across the UK by providing evidence-based, objective analysis, assessment and advice to inform local and national decision-making in response to COVID-19 outbreaks, including local outbreak management **(MH9/304 - INQ000233814; MH9/305 - INQ000255193; MH9/306 - INQ000233817; MH9/307 - INQ000233815; MH9/308 - INQ000233818)**. In essence, it was the 'strategic brain' of NHST&T Service **(MH9/309 – INQ000233836)**. I strongly supported its establishment, which complemented existing work in PHE and the Department. It reached initial operating capability on 1 June 2020, although still not at full operating capability. We had worked incredibly hard in the months to June 2020 to improve the data available for decision making. The JBC was an important step forward in this data gathering and analysis.

The Contain Framework

191. On 11 June 2020, I attended a COVID-O to discuss the JBC and local lockdowns **(MH9/310 - INQ000088793)**. A number of papers were presented and discussed at this meeting: (i) an early draft of the Contain Framework which was created by NHST&T in conjunction with local authorities, Directors of Public Health, PHE and government departments and which set out a framework to clarify national and local responsibilities for outbreak management (discussed below) **(MH9/311 - INQ000088722)**; (ii) an update paper on the JBC, which provided an overview of the JBC's data sources and its data operating model **(MH9/312 - INQ000088727)**; and,

(iii) an NHST&T Service - 'Contain' Ambition and Operating Model **(MH9/313 - INQ000088728)**. The Committee decided that further clarity was needed on the balance of powers between local and central Government and on available data sources and integration **(MH9/314 - INQ000088734)**.

192. To manage local outbreaks, on the advice of the Permanent Secretary, we introduced a new Gold, Silver, Bronze Local Action Committee structure for (i) reviewing the information and analysis provided by the JBC about local outbreaks, (ii) providing oversight of the local containment aspects of the Test and Trace programme, and (iii) escalating any issues requiring national decisions, support and/or intervention **(MH9/315 - INQ000106469; MH9/316 - INQ000069650; MH9/317 - INQ000106471).** I chaired the weekly Gold meetings from 11 June 2020 until my resignation in June 2021. They covered the latest epidemiological briefing and assessment; assurance for containment action underway; discussed the implications of any trends identified; and conveyed recommendations, issues and actions to COVID-O and COVID-S on a weekly basis, or more frequently if needed.

193. On 22 June 2020, I requested a publication setting out the local and national process for preventing and managing a local outbreak **(MH9/318 - INQ000566179)**. This led to the publication of the Department's "*COVID-19 Contain Framework: a guide for local decision-makers*" on 17 July 2020 **(MH9/319 - INQ000562663; MH9/320 - INQ000566185; MH9/321 – INQ000566186; MH9/322 – INQ000566191; MH9/323 – INQ000566192; MH9/324 – INQ000566193; MH9/325 – INQ000566194; MH9/326 – INQ000566195; MH9/327 – INQ000566196)**, which was discussed and approved at COVID-O on 14 July 2020 **(MH9/328 - INQ000088800)**. The Contain Framework set out how national and local partners were to work with the public at a local level to prevent, contain and manage outbreaks **(MH9/329 - INQ000233882)**. It explained that Upper Tier Local Authorities (UTLAs) were to lead local outbreak planning by way of their own Local Outbreak Plans, but within a national framework, and with the support of NHST&T, PHE and other government departments.

194. While we had properly initially focused on increasing central capacity for both testing and tracing, as set out above, it was right that over Summer 2020 we took steps to ensure that the national testing and tracing arrangements built on local capability,

expertise and learning and that the national infrastructure was integrated with local teams so as to reduce and manage local outbreaks. As set out in NHST&T's policy paper/business plan dated 30 July 2020 entitled "*Breaking chains of COVID-19 transmission to help people return to more normal lives: developing the NHST&T services*", the operating model was *"local by default"* and required local planning, response and insight to effectively counter the virus, and work with local government and local communities with the aim of successfully managing local outbreaks and reducing the risk of local outbreaks (**MH9/302 - INQ000527961**). It was, therefore, a core tenet of NHST&T's plan to minimise the spread of COVID-19.

Increase to self-isolation period for those who tested positive

195. On 17 July 2020, I was advised that, in view of evidence that the virus had the potential for transmission beyond 7 days after symptoms start, the CMOs for each of the four nations had agreed that the self-isolation period (for symptomatic individuals with a positive test result) should be increased from 7 to 10 days **(MH9/330 - INQ000106537; MH9/331 - INQ000070122)**. This was discussed at the COVID-S on 22 July 2020 where the change was agreed **(MH9/332 - INQ000088277)**. The change was announced by the CMO on 30 July 2020 **(MH9/333 - INQ000106546)**.

Disbanding PHE and creating NIHP (later UKHSA)

196. As I said at paragraphs 493-498 of my second statement **(MH9/001 – INQ000232194)**, on 18 August 2020, I announced the formation of a new organisation, initially called the National Institute for Health Protection ("NIHP") **(MH9/334 - INQ000086612)**. There were two reasons for the change. First, the operational aspects of the response to the pandemic had ended up in several separate organisations with messy accountability arrangements, including in PHE, NHST&T and JBC, and the NIHP would bring them together under joint leadership and clear accountability. This was important during the pandemic, and so prompted the decision to announce the change in summer 2020.

197. Second, one of the major flaws in pandemic preparedness was the lack of a single institution responsible for communicable diseases. The NIHP would focus on controlling communicable diseases; protecting people from the external threats to the country's health. The organisational design of PHE was flawed. As often happens

when an organisation has both regular, ongoing responsibilities (for example with respect to tackling obesity), and responsibility to prepare for and respond to low frequency, high impact events, PHE's leadership had inevitably focussed on the more immediate work of protecting against non-communicable diseases. Instead, we need for the future a single organisation focussed on preparation for, and fighting pandemics.

198. Even the work to tackle non-communicable public health issues suffered from the existing organisational design, because policy levers to improve non-communicable public health are largely cross-Government - for policies like tackling air pollution and obesity. As an arm's length body PHE had failed to achieve as much impact on these policies as I had hoped. These policy areas would therefore in the future be the preserve of the Department and led by the CMO, with an improved ability to influence across Whitehall.

199. The Department produced the initial proposal on my behalf on 9 July 2020 with input from the CMO and Dido Harding **(MH9/335 – INQ000233878; MH9/336 – INQ000233879; MH9/337 – INQ000233880)**. NIHP was to subsume NHST&T (specifically its responsibilities for testing, tracing and containing COVID-19) and JBC (with its responsibility for analytics, insight and alert levels on COVID-19) and the health protection functions of PHE (including its emergency response centre and regional and local public health structures).

200. On 21 July 2020, I met with Dido Harding, the Permanent Secretary and the PM to discuss our proposal (**MH9/338 – INQ000233892; MH9/339 – INQ000233893; MH9/340 – INQ000233894; MH9/341 – INQ000233895)**. In terms of implementation, we needed to get the immediate benefits of uniting leadership over operational response, while minimising any potential of change to disrupt delivery, which I acknowledge. In light of this, we put forward a number of options for delivery, including immediately creating a single overall Chief Executive (initially Baroness Harding) and leadership team for NIHP, which would incorporate PHE, so that they could lead the organisational design and change over the winter **(MH9/342 – INQ000233903)**. The Prime Minister agreed to the proposal and that approach. With hindsight, I am confident that the unification of operational tasks and strengthened leadership

improved operational performance, and the potential risks were largely successfully mitigated.

201. The Department subsequently put in place a more detailed timetable and implementation plan to deliver on it **(MH9/342 – INQ000233903; MH9/343 – INQ000233905; MH9/344 – INQ000233904; MH9/345 – INQ000233925)**. The transition to the UKHSA took place between April and October 2021. As I left my role as Health Secretary in June 2021, I cannot comment on the effectiveness of UKHSA in respect of TTI, as it did not become fully operational until October 2021.

Asymptomatic Testing

202. I have covered this subject extensively in my earlier statements, and again invite the Inquiry to consider the statements of the CMO about asymptomatic transmission (his first witness statement at paragraphs 6.55 to 6.63 and his fourth witness statement at paragraphs 5.19 to 5.25). As the CMO makes clear, it was a gradual process of accumulation of evidence that led to asymptomatic transmission being considered a major part of the force of transmission of the virus. I agree with the views set out by the CMO, which should not be surprising as we discussed it regularly during this period.

203. As I have explained above, the initial, very clear, scientific advice was not to test those without symptoms. I was told categorically by PHE that the tests would not work on people without symptoms, and that to test someone without symptoms would risk a false negative, i.e., someone incubating the virus could be given a negative test result **(MH9/053 – INQ000047556; MH9/054 - INQ000151362; MH9/059 - INQ000057492; MH9/346 – INQ000074909)**. I was advised that this would be even more dangerous than not being tested, as it would give a false assurance.

204. On 2 April 2020, the WHO restated their position that there had been no documented asymptomatic transmission of COVID-19 **(MH9/347 - INQ000074894)**. This reflected initial scientific thinking that because asymptomatic transmission was understood to be rare with other coronaviruses (SARS and MERS), that was likely to

be the case with COVID-19. However, at the time of WHO's announcement on 2 April 2020, the US Center for Disease Control (CDC) also published a study which demonstrated that asymptomatic transmission was likely to be occurring, with over 50% of residents in one care home having been asymptomatic but having tested positive for COVID-19 **(MH9/348 - INQ000233785)**. Following this, PHE reported their own study to NERVTAG on 24 April 2020 which had observed similar results **(MH9/349 – INQ000120161)**. Further evidence was presented to SAGE on 14 May 2020 **(MH9/350– INQ000120519)**. It was estimated that between 10% and 35% of individuals may be asymptomatic but that they might be less infectious. On 18 June 2020, SAGE met and concluded that individuals likely causing super-spreading events may be asymptomatic or paucisymptomatic **(MH9/351 – INQ000120527)**. On 9 July 2020, WHO published a report finally acknowledging asymptomatic transmission **(MH9/352 – INQ000203997)**.

205. However, before this official scientific advice was given to Ministers, we took the decision in April 2020 on CMO's advice to act in respect of TTI on the assumption of asymptomatic transmission after seeing the CDC evidence. At first, we still did not have enough tests to test everyone, and the clinical advice on test prioritisation remained to test those with symptoms in hospital. However, on the 15 April 2020, as we were ramping up testing capacity and with this growing evidence of asymptomatic transmission, we decided that all patients (i.e. including asymptomatic patients) being discharged from hospitals into care homes should be tested **(MH9/353 - INQ000093326; MH9/354 - INQ000292604; MH9/355 - INQ000292605)**. There was subsequently a change in scientific advice due to operational constraints, as I discussed in my third witness statement at paragraph 53d **(MH9/356 – INQ000273833)**.

206. On 20 April 2020 I met with officials and emphasised the need to get going on survey testing in hospitals, including asymptomatic staff. My Private Secretary's note records that the Permanent Secretary raised a previous meeting with the CMO and noted that there remained a number of unknowns from a scientific perspective **(MH9/357 - INQ000478882)**.

207. On 26 April 2020, I received a written update from officials on asymptomatic swab testing. That paper noted **(MH9/358 - INQ000478887)**:

> *"PHE has confirmed there is no barrier to testing symptomatic people in any setting or to including asymptomatic people where clinically appropriate. In the first instance, this will include: expanding testing to all hospital admissions to help guide improved infection control; testing more people in care homes when outbreaks occur, whether they are symptomatic or not; as well as staff in care environments to understand the prevalence of asymptomatic disease and develop protocols to minimise the number of staff in these environments who are potentially asymptomatically infectious."* (emphasis added)

208. By 28 April 2020, due to the Department's rapid expansion of testing capacity, we extended testing to all asymptomatic care home staff and residents **(MH9/218 – INQ000106391).**

209. As testing capacity increased further, we began regular asymptomatic testing on targeted high-risk populations. On 18 June 2020, I received a submission recommending asymptomatic testing for those in high-risk groups via community testing centres and those in high-contact professions via their employers **(MH9/359 – INQ000527956; MH9/360 – INQ000527957)**. I agreed with the recommendation **(MH9/361 – INQ000566180)**. The results of these initiatives would inform decisions on whether further interventions were needed and would help ensure testing capacity was being used for populations with the greatest need based on their risk.

210. As discussed below, the development of Lateral Flow Devices (LFDs) which were sufficiently reliable and accurate to test for COVID-19, meant we were able in late 2020 to begin implementing a programme for mass routine asymptomatic testing, initially in specific institutions (including hospitals, care homes, schools and prisons) and specific sections of the population and then to the wider community, which was designed to allow individuals to assess their likelihood of infectiousness on a day-to- day basis, which was particularly important for high-risk settings.

Operation Moonshot

211. On 15 July 2020, we received an interim report from a Southampton testing pilot into the use of RT-LAMP saliva tests, which indicated that (i) it was a reliable and acceptable form of COVID-19 testing at population level and (ii) that it had potential for scale **(MH9/362 – INQ000233898; MH9/363- INQ000566197; MH9/364 - INQ000233890; MH9/365 – INQ000591749)**.

212. The report was picked up by No 10 **(MH9/366 – INQ000233900)**. On 22 July 2020, I attended a meeting with Professor Keith Godfrey, who was running the pilot, the PM, the CMO, the CSA and others about using the testing to test whole populations with lower sensitivity, higher scalability tests. The premise of population testing was that if you test everyone, and everyone who tests positive isolates, you can control the virus without the need for social distancing for all. I was sceptical of this final part of the premise, but keen to use testing as much as possible to reduce the need for lockdown measures.

213. On 23 July 2020, Professor Godfrey wrote to the PM seeking support for that program, which he called the Phoenix Program but also described as a 'Moonshot' program **(MH9/367 – INQ000137242; MH9/368- INQ000233901)**. As he put it:

> *"Such an approach might allow much more widespread testing in the population and could help control the spread of COVID-19, with* less *reliance on social distancing. It would make 'test and trace' much more effective in three ways: i) asymptomatic* cases *would be detected, ii) many symptomatic* cases *would be detected earlier, and iii) contact tracing would be simpler and isolation quicker. These approaches could be used to protect care* homes, *hospitals and other at risk* sites *or could even be expanded for whole-population testing."*

214. On 24 July 2020, I attended a further meeting with the PM, Professor Keith Godfrey and various others about the program to discuss progress so far, next steps to take it forward and accreditation of the tests **(MH9/369 – INQ000233907; MH9/367 – INQ000137242; MH9/370 – INQ000062435; MH9/371 – INQ000233910; MH9/372 – INQ000233911; MH9/373 – INQ000233912)**. Part of the discussion centred on scaling to whole population testing **(MH9/374 – INQ000233914)**. While I was supportive, I was

concerned at the time that aiming for whole population testing immediately was too ambitious and that we ought to focus on a city pilot in the first instance **(MH9/375 - INQ000129433)**, particularly in light of a discussion I had had with Gila Sacks, Director of Testing Strategy & Policy, the previous day about scalability **(MH9/376 – INQ000233906)**. Dido Harding and her team at NHST&T were tasked at this meeting with taking the program forward.

215. On 2 August 2020, I wrote to the PM about the proposal to test an entire city in order to test the hypothesis that effective population surveillance, including first detection of outbreaks and containment, depended largely on frequency of testing and speed of reporting. I proposed a geographical pilot in the first instance to test that hypothesis, in the hope that, if successful, it would allow the Government to roll out regular mass asymptomatic testing of the whole population across all settings so as to avoid another national lockdown **(MH9/377 – INQ000062482)**. As stated, I considered that this was a more realistic approach to scaling and testing the new technology than trying to scale immediately to whole population testing.

216. I attended a further meeting about population testing on 5 August 2020 which was held by the Prime Minister **(MH9/378 – INQ000233926; MH9/379 – INQ000233927; MH9/380 – INQ000233928**; **MH9/381 - INQ000233929; MH9/382 – INQ000471024)**. He was very enthusiastic about the idea and wished to deliver population testing nationwide by the start of October **(MH9/383 – INQ000102218; MH9/384- INQ000129445)**. While I was also very supportive of the idea, I recognised that there were challenges in developing, manufacturing and ensuring a high take-up of the tests and the cost of the same. I also did not consider the start of October was feasible, but committed to coming back with a plan to rollout tests across the country.

217. On 12 August 2020, I attended a further meeting with the Prime Minister, Dido Harding and others about mass testing **(MH9/385 – INQ000233932; MH9/386 – INQ000233933; MH9/387 – INQ000233934)**. As things stood, subject to the outcome of the validation results, we aimed to scale to the level required for mass population testing by Christmas. The Prime Minister stressed the importance of removing any obstacles that might slow down the work being carried out by Dido Harding to implement this and to try to bring that date forward.

218. On 19 August 2020, I attended an update meeting on mass testing with the Prime Minister, Dido Harding, the CMO, the CSA and others about mass testing **(MH9/388– INQ000233942; MH9/389 – INQ000233943; MH9/390 – INQ000233944 ; MH9/391 – INQ000233945)**. I then attended a further update meeting held by the Prime Minister about it on 27 August 2020 (**MH9/392 – INQ000233975**; **MH9/393 – INQ000233956; MH9/394 – INQ000233957).** The update was that all of the most promising technologies were being worked on in parallel, together with the manufacturing, workforce and data architecture required for wider roll-out. The Prime Minister emphasised the great urgency of this work and asked the team to redouble their efforts.

219. On 27 August 2020, there was a call to arms roundtable meeting with invited representatives of the manufacturing industry **(MH9/395 – INQ000566215)**.

220. The Chancellor agreed to allocate £500 million of preliminary funding, including to proceed with investments in new testing technologies. This funding was announced on 3 September 2020 **(MH9/396 - INQ000237326)**.

221. On 10 September 2020, I updated Parliament on the plan to deploy mass testing.

Lateral Flow Devices and Community Testing Programme

222. On 8 November 2020, further to a Department request to identify the most promising LFDS with the best performance characteristics **(MH9/397 – INQ000566219)**, PHE and Oxford University provided their rapid evaluation of LFDs for mass community testing, which showed that the LFDs had *"acceptable viral antigen detection with high specificity, sufficient sensitivity and low kit failure rates"* **(MH9/398- INQ000396180)**. We had purchased 223.5 million LFDs on 5 October 2020, given the promise of the technology. Though, we had previously had to cancel orders for earlier prototypes of lateral flow test kits in April 2020, which had failed a validation exercise in respect of their sensitivity and specificity **(MH9/399 - INQ000562621)**. We had been using PCR testing for asymptomatic testing prior to this, but the turnaround times needed for laboratory processing and relatively high cost and resource of PCR testing meant that it was not feasible to conduct routine mass asymptomatic testing by PCR testing. While LFDs generally had lower sensitivity and specificity than PCR testing,

once they had been validated as sufficiently reliable and accurate to test for COVID-19, given their relatively low cost and rapid turnaround times, we were able to begin using them to implement a mass community testing programme.

223. On 21 November 2020, we discussed a paper prepared by the COVID-19 Taskforce on the Community Testing Programme at a COVID-O **(MH9/400 – INQ000136695**. It was intended that whole community testing would use rapid LFD tests to assist in locating and isolating hidden positives cases, manage transmission risk and drive down prevalence. In this context, whole community testing described population testing of asymptomatic individuals at scale. It was also referred to as mass testing, and it effectively superseded Operation Moonshot. In the short-term, it was seen as an important component of the Government's strategy to exit the second national lockdown. In the longer term, it was anticipated that it would assist in keeping transmission rates down and avoiding the need for future lockdowns, alongside the vaccine rollout. It was to take place alongside the targeted asymptomatic testing of high-risk groups and settings which was already taking place. The Committee discussed some of the challenges to community testing, including ensuring that it did not hinder the vaccine rollout and that there were adequate levels of testing participation given the low take-up which had occurred during the community testing pilot in Liverpool **(MH9/401 - INQ000090954; MH9/402 - INQ000054189**. Nonetheless, the Cabinet agreed to the Community Testing Programme the following day **(MH9/403 - INQ000089062)**. On 23 November 2020, the PM announced the launch of the Community Testing Programme as part of the Winter Plan **(MH9/404 – INQ000054192)**.

224. We worked hard to implement the Community Testing Programme over ensuing weeks and months, specifically to widen the availability of whole community testing initially from local authorities with high prevalence of COVID-19 to all local authorities nationwide **(MH9/405 – INQ000566255; MH9/406 – INQ000062993; MH9/407-INQ000566257; MH9/408 – INQ000566263; MH9/409 – INQ000566265; MH9/410 – INQ000566266; MH9/411 – INQ000566272; MH9/412 – INQ000566273; MH9/413 – INQ000566274; MH9/414 – INQ000566275; MH9/415 – INQ000566276; MH9/416 – INQ000566277; MH9/417 – INQ000566281; MH9/418 – INQ000354993)**.

225. The use of mass or whole community testing with LFDs became an important element of our strategy, alongside the vaccine rollout, to progress through the steps on the roadmap out of lockdown in 2021, which included rapid testing for care home visitors, students returning to universities and testing in schools **(MH9/419 - INQ000092458; MH9/420 - INQ000091901; MH9/421 -INQ000092063; MH9/422 - INQ000092474)**.

Decrease to self-isolation period for contacts of people who have tested positive

226. On 16 November 2020, the four UK CMOs conducted a review of modelling evidence from PHE, SPI-M and SAGE on the 14-day isolation period for contacts, and SAGE also considered the potential effects of using LFD tests or PCR tests to either reduce the duration of isolation for contacts of cases or to replace quarantine altogether by testing repeatedly **(MH9/423 – INQ000061576)**.

227. Following which, on 1 December 2020, the CMOs sent me a submission proposing a reduction to the self-isolation period from 14 to 10 days for contacts of people who have tested positive, in addition to conducting a pilot on contacts taking daily tests for five or possible seven days rather than isolating **(MH9/424 - INQ000234637; MH9/425 – INQ000071961)**. I agreed to the reduction to the self-isolation period and that it should also apply to those self-isolating on return from travel to a high-risk country **(MH9/426 – INQ000565566)**. A key factor was to reduce its burden on people and encourage more people to come forward for testing and greater adherence with the self-isolation rules. That had to be balanced with the increased transmission risk from those who were still infectious beyond the end of the quarantine period. The CMOs' view was that a 10-day isolation period was of adequate length to ensure people were not likely to be infectious at the end of it, thus its introduction would overall reduce transmission.

228. The CMO made a further recommendation on 8 December 2020 to more precisely define the calculation of the isolation period to align the approach between the four nations **(MH9/427 – INQ000566258)**. I agreed to it on 9 December 2020 **(MH9/428 – INQ000234639)**. I signed the regulation giving effect to these proposals on 11 December 2020 and they came into force on 14 December 2020 **(MH9/429 – INQ000234212; MH9/430 – INQ000236064; MH9/431 - INQ000234642)**.

Borders

229. At paragraph 89 of my first statement **(MH9/007 – INQ000181825)**, I explained that border measures were undermined by an error in the 1984 Act. The UK border is clearly a UK Government responsibility. However, because health measures are devolved in the Public Health Act 1984 (1984 Act), health measures at the border are devolved too. It is likely this mistake was unforeseen by those framing the 1984 Act, because the decision makers at the time would have been the relevant Secretary of State in the UK Government. Now that there are Devolved Governments, this did not work, and created huge confusion and complications.

230. Border policy is usually led by the Home Office. However, due to the pandemic, the Department was involved in and led some elements of border policy.

231. As I explained above, when the pandemic first broke, we were concerned with what border health protections measures were put in place. The scientific advice was that there was little to be gained by clinical or temperature screening people at port of entry **(MH9/039 – INQ000023107; MH9/043 – INQ000106901)**. Instead, we put in place a package of port heath measures, including dissemination of public health information, and enhanced monitoring which had been proposed by PHE and CMO **(MH9/044 – INQ000106897; MH9/047 – INQ000087535)**. I also decided in early February 2020 that we should quarantine individuals returning from Wuhan, against the scientific advice, based on a precautionary principle and to maintain public confidence **(MH9/074 - INQ000106098)**.

232. In April 2020, as we were considering the exit from the first national lockdown, we discussed whether to impose further measures to prevent and reduce the importation of cases from abroad and transmission from those cases within the UK **(MH9/432 – INQ000566097; MH9/433 – INQ000566115; MH9/434 – INQ000566116; MH9/435 – INQ000566118)**. At that point, due to the reduction in international travel as a consequence of lockdowns, imported cases accounted for less than 1% of COVID-19 cases so the effect of introducing further health monitoring measures at the border was considered to be limited. Nonetheless, we determined to introduce additional measures, including increasing the health

information provided to incoming travellers, especially in respect of social distancing, and obtaining contact detail declarations from them **(MH9/436 – INQ000566128; MH9/437 – INQ000566129; MH9/438 – INQ000566138)**.

233. At the start of June 2020, as the volume of international travel increased, we introduced additional border health measures to guard against the risk of importation of COVID-19, which included requiring international arrivals from outside the Common Travel Area to provide contact, travel and accommodation details on a passenger locator form and to self-isolate for fourteen days **(MH9/439 – INQ000083546; MH9/440 – INQ000566166; MH9/441 - INQ000566168; MH9/442 – INQ000566167; MH9/443 – INQ000236040)**. I signed the Health Protection (Coronavirus, International Travel) (England) Regulations 2020, which brought those measures into force on 2 June 2020 **(MH9/444 – INQ000566169)**.

234. Over June 2020, we considered implementing a risk-based country approach to border measures, which involved removing the requirement to self-isolate for passengers arriving into the UK from 'green' (low risk) countries and approaching 'amber' (moderate risk) countries to determine whether their health measures were considered sufficient to exempt passengers from those countries from the self-isolation requirements but keeping the requirement for those travelling from 'red' (high risk) countries **(MH9/445 – INQ000566182; MH9/446 – INQ000566183)**. Where a passenger was not required to self-isolate because their country of origin was exempt, this was known as travel corridor. JBC in consultation with PHE and the CMO developed an approach to assess the public health risk associated with inbound travel from specific countries and territories. We agreed to implement these risk-based measures at a COVID-O on 26 June 2020 subject to reviewing and finalising the country list **(MH9/447 – INQ000566184)**. I signed the Health Protection (Coronavirus, International Travel and Public Health) (England) (Amendment) Regulations 2020, which brought these measures into force on 6 July 2020 **(MH9/448 – INQ000566187; MH9/449 – INQ000566188; MH9/450 - INQ000566189)**. Though the list of countries on the travel corridor list was subject to continual change, the travel corridor regime itself stayed in place until early 2021.

235. At the end of June 2020, we began to consider proposals for shortening the self-isolation period for incoming travellers by testing in order to support an uplift in demand for international travel and to assist business, while also being careful to mitigate the risk of importing COVID-19 into the UK **(MH9/451 – INQ000566181)**. The Transport Secretary was ultimately charged with delivering the regime. We assisted with developing the regime over Summer 2020 **(MH9/452 – INQ000566206; MH9/453 – INQ000565535; MH9/454 – INQ000566207; MH9/455 – INQ000566210)**. On 17 September 2020, I attended a COVID-O at which we agreed that the Department and Department for Transport would establish a new Global Travel Taskforce with industry to implement the 'test to release' scheme for international arrivals based on a single private test **(MH9/456 – INQ000566224; MH9/457 – INQ000053752; MH9/458 –** INQ000053770 **)**. Department for Transport led on the paper regarding test to release for international travellers, with input from the Department **(MH9/459 – INQ000566239)**, that went before COVID-O on 3 November 2020 **(MH9/460 – INQ000566241; MH9/461 – INQ000566242)**. It was agreed by COVID-O that there should be a testing regime for international arrivals which tested them on day five after arriving in the UK **(MH9/462- INQ000091128)**.

236. Over November 2020, the Department and Department for Transport worked on the implementation of the *"test to release"* scheme (**MH9/463 – INQ000566243; MH9/464 – INQ000566244; MH9/465 – INQ000071628; MH9/466 – INQ000071653; MH9/467 – INQ000566247)**. On 18 November 2020, the Transport Secretary and I presented the *"Report of the Global Travel Taskforce"* on international travel to the PM, which included various recommendations including to rollout the "test to release" scheme from 15 December 2020 **(MH9/468 – INQ000566248; MH9/469 – INQ000566250; MH9/470 –** INQ0000049273 **)**, which had been agreed by COVID-O that day **(MH9/471 - INQ000090932)**. The *"test to release"* scheme was announced on 24 November 2020 **(MH9/472 - INQ000086813)**.

237. In early January 2021, due to the emergence of variants that could threaten the success of the UK's vaccination programme, there was a shift in focus to establish stricter measures at UK borders. We discussed those measures at a COVID-O on 15 January 2021 **(MH9/473 - INQ000091660)**. We agreed to temporarily suspend

the travel corridor policy in place at the time, required all international arrivals to complete a passenger locator form, take a negative COVID-19 test up to 72 hours before departure, self-isolate for 10 days on arrival, and took steps to strengthen enforcement of isolation **(MH9/474 - INQ000091668)**. We further discussed the need for stricter border measures at a COVID-O on 26 January 2021 to address gaps in the current border regime which could lead to a new variant being imported and establishing itself in the UK **(MH9/475 - INQ000566291; MH9/476 – INQ000566292; MH9/477 - INQ000091682; MH9/478 - INQ000153669)**. The Department was tasked with (i) considering how further checks on those isolating at home could be increased, including through increasing the number of calls from the Isolation Assurance Service, (ii) developing and implementing a managed isolation/quarantine system for arrivals for countries with international travel bans (or red-list countries), and (iii) making proposals on whether the border testing regime should change **(MH9/479 - INQ000092305)**.

238. I led on that work with the Department, Home Office and Department for Transport in order to strengthen our health protection at the border **(MH9/480 – INQ000091715; MH9/481 - INQ000091717)**. On 9 February 2021, I gave an oral statement to the House of Commons in respect of the outcome of that work, which was a strengthened end-to-end system for international arrivals that comprised three elements: (i) a Managed Quarantine Service which required all international arrivals who had visited a red list country in the last 10 days to quarantine in an HMG approved facility; (ii) strengthened testing with a three-test regime for all arrivals (pre-departure test and test on day two and day eight of quarantine) with a further ten days of quarantine if a positive test was returned and genomic sequencing to establish if the individual had a variant of concern; and, (iii) strong enforcement of both hotel quarantine and home quarantine including fines for failure to take the mandatory tests and/or to quarantine.

239. I signed The Health Protection (Coronavirus, International Travel) (England) (Amendment) (No. 7) Regulations 2021 on 12 February 2021 which gave effect to those measures from 15 February 2021 **(MH9/482- INQ000234290; MH9/483 – INQ000566294)**. They remained in place until 17 May 2021 when we began

reopening the borders as part of Step 3 of the roadmap for lifting lockdown **(MH9/484 - INQ000092126)**.

240. Building the system to put this policy into practice was an enormous effort. We brought in a leading Civil Servant Shona Dunn, and General Sir Gordon Messenger to lead the project, and they delivered the hotel quarantine on time incredibly quickly. One huge learning from the pandemic is of the vital importance of border protection measures. We must use the geographical advantage of being an archipelago to protect people. Work is needed now to be able to implement.

Adherence, Support and Enforcement

241. As with other measures, the effectiveness of TTI strategy and policy depended to a significant extent on how far individuals followed, complied with and adhered to TTI rules and guidance. We had that firmly in mind throughout my time as Health Secretary during the pandemic. I received regular data and advice on it, which informed our approach to communications with the public, what support we provided to underpin measures, our decisions as to whether measures would be voluntary or mandatory, and how they would be enforced. I set out below a chronological overview of some of the key advice, discussions and decisions about adherence, support and enforcement in relation to TTI measures.

242. On 4 March 2020, at COBR, we discussed the introduction of various NPIs **(MH9/101 - INQ000056218)**. In respect of modelling/forecasting, it was noted that there was a lot of uncertainty and, according to the behavioural scientists, the biggest variable was the public's compliance with interventions. It was noted, therefore, that there would need to be clear public messaging about interventions so that the public clearly understood why certain measures were being taken in order to ensure greater compliance. A SAGE paper for the meeting considered that high levels of compliance over long periods of time may be unachievable **(MH9/102 - INQ000182333)**.

243. We also discussed at that meeting introducing changes to sick pay so that key workers could isolate if symptomatic without fear of being financially penalised and to ensure that all the messaging and communication reinforced that workers would not be without support if forced to isolate. I had pressed Simon Stevens on that issue a couple of days earlier to ensure that all health workers received sick pay if they were required to self-isolate **(MH9/485 – INQ000176786)**. The measures were brought in on 12 March 2020 by the Statutory Sick Pay (General) (Coronavirus Amendment) Regulations 2020 **(MH9/486 - INQ000566044; MH9/487 – INQ000566048; MH9/488 – INQ000566050 ; MH9/489 – INQ000566049)**.

244. On 6 May 2020, SPI-B produced a rapid review paper on the key behavioural issues relevant to TTI which "*strongly recommended monitoring and rapid research into adherence rates to all key behaviours and how to improve them*" noting that the Department's tracker suggested that only around 50% of people were reporting self-isolating for at least 7 days when symptomatic **(MH9/490 -INQ000197096)**. It made various recommendations as to how to improve engagement with symptom reporting, contact tracing and self-isolating following testing/tracing.

245. On 8 May 2020, I was provided a paper by Department officials which set out options for voluntary and mandatory approaches to self-isolation **(MH9/491 – INQ000527941; MH9/031 – INQ000566147)**. It noted that there had, thus far, been high compliance with self-isolation measures on the basis of strong and consistent communications encouraging people to comply with self-isolation measures for their personal safety, to protect the NHS and to save lives. However, it raised a concern that over time, repeated request for individuals to self-isolate, could lead to diminishing compliance. It recorded SPI-B's advice that, if the public do not think a policy is sensible, they will find ways around it. It considered a range of voluntary and mandatory measures but noted that there was no evidence at that stage that mandation would result in higher compliance and that it could increase transmission. In particular, it advised that enforced compliance might undermine public cooperation with testing. It, therefore, contended for continuing to adopt a voluntary approach and recommended:

a. Developing a strong approach to communications and engagement that promoted the benefits to society of self-isolation, strengthened people's motivations to self-isolate when asked to do so, and created peer pressure to do the right thing.

b. Providing tailored support to those who need it to ensure the inconvenience of self-isolation does not present an insurmountable barrier.

246. On 30 June 2020, I attended a COVID-O at which Dido Harding presented a NHST&T paper on compliance with self-isolation **(MH9/492 - INQ000088756)**. It reported that there was no accurate way of measuring cooperation and compliance with isolation advice and that polling suggested that 75% of people who should have been self-isolating would leave their home at least once during the isolation period. It advised that the evidence showed that the main reasons people did not consistently self-isolate were financial and practical. It explained that NHST&T would implement three actions over the next month to improve compliance, namely: (i) better communications at key points of the test and trace end-to-end user journey, reinforcing the importance of self-isolation and signposting support; (ii) contact tracer calls to those self-isolating; (iii) daily messages to those self-isolating. It recommended that further consideration be given to providing financial compensation for lost earnings and to offer accommodation to isolate outside the home (e.g. at a hotel). Though the paper reported that polling showed that 55% of people considered that mandating self-isolation would make them more likely to comply, it recommended better information should be obtained on the nature/extent of non-cooperation, factors driving low cooperation and the likely behavioural response to making it an offence not to self-isolate before legislating for it. It noted that improved compliance with self-isolation after a positive test, had to be weighed against the risk of people not coming forward to get a test because of a mandatory requirement to self-isolate. It was agreed that NHST&T should monitor compliance with self-isolation advice, gather evidence about communications messaging to reach key groups and that COVID-O should conduct a further stocktake of the interventions proposed to drive higher compliance in a few weeks **(MH9/493 - INQ000088761; MH9/494 – INQ000088856)**.

247. On 1 August 2020, the Prime Minister conveyed his concern to me, the CMO, the CSA, Simon Case, Dominic Cummings and Lee Cain about the public's compliance

with the social distancing rules (following the lifting of certain measures over the Summer which had had the effect of reducing overall compliance), and that the government's communications in respect of the rules had become confused and difficult to comprehend. He sought 'a big reset' in respect of communications involving the reiteration of simple messages **(MH9/495 - INQ000102213)**. He was right.

248. On 18 August 2020, I was provided a Departmental submission on the emerging concerns about the lack of public compliance with social distancing and isolation measures **(MH9/496 – INQ000234441; MH9/497 – INQ000234442)**. It offered various explanations for this: complexity and frequency of changes of rules and guidance; perceived contradictory messaging about limiting social contact in the home but encouraging people to visit COVID-19 secure settings with larger number of people; excessive emphasis on what people should do and insufficient emphasis on why they should do it; lack of targeted messaging directed at high risk and low compliance groups; perceived inequalities between what is allowed in work, social and private settings; perception guidance is irrational in some areas; public had become less concerned over time about COVID-19; and, belief that enforcement action was not being consistently and universally taken and that others were not complying with the legislation. It explained that the three broad levers for improving compliance were: (a) communication and engagement, (b) legislation and enforcement, and (c) a hybrid approach. It again noted that mandating self-isolation may result in fewer people reporting symptoms, taking tests or downloading the NHS COVID-19 app, and that there was a high risk of legal challenge. It recommended continuing for the time being with developing the communication and engagement strategy, but working on increased enforcement measures and looking at options for introducing legal requirements.

249. On 4 September 2020, I was provided with a SAGE paper on adherence to the TTI system **(MH9/498 – INQ000566217; MH9/499 – INQ000566218)**. The SPI-M summary of the SAGE paper stated that the surveys had found that self-reported adherence to TTI behaviours was low (self-isolation 18.2%; requesting an antigen test 11.9%; intention to share details of close contacts 76.1%), but intention to adhere to protective measures was much higher. Further, it found that non-adherence was higher for: men, younger age groups, those with a dependent child in the household,

people from lower socio-economic grade, those who had faced greater hardship during the pandemic, and those working in a key sector. The results suggest that financial constraints and caring responsibilities were significant impediments to adhering to self-isolation, sharing details of close contacts and quarantining of contacts. SAGE, therefore, advised further that self-isolation rates would be improved by providing financial and non-financial support to those required and improving communication on how, when and way to self-isolate **(MH9/500 – INQ000234010; MH9/501 – INQ000422304**

250. On 17 September 2020, I was sent a Departmental submission with proposals to improve compliance with self-isolation **(MH9/502 – INQ000566226; MH9/503 – INQ000565542)**. In particular, it recommended that we offer a payment of £500 to those asked to self-isolate, but limited to people on specified benefits, and that we implement a legal requirement to self-isolate if a person is notified of a positive test or identified as a close contact, with a £1,000 penalty for non-compliance. On 18 September 2020, I was provided a paper by the COVID-19 Taskforce for a COVID-O that day which also recommended taking a 'carrot-and-stick' approach to self-isolation by introducing a legal duty on individuals to self-isolate with fines for non-compliance, and an isolation support payment of £500 **(MH9/504 – INQ000234007; MH9/505 - INQ000566228)**. It also invited ministers to agree that employers should not knowingly enable or encourage their employees to break the law on self-isolation, which had emerged as a problem. These measures were discussed and agreed at the COVID-O that day **(MH9/506 - INQ000234011)**, and also on 21 September 2020 **(MH9/507 – INQ000090177)**.

251. On 22 September 2020, I attended a COBR meeting to discuss the response to the current COVID-19 situation. The Committee was invited to agree, among other matters, a strong UK-wide message on the need for behavioural change, increased compliance and stronger enforcement, and a package of measures to bring about the same **(MH9/508 – INQ000083802)**. The Committee agreed that there was a need to be clearer on the message and tough on enforcement **(MH9/509 - INQ000083849)**. All four nations endorsed the measures proposed (with some differences in implementation) and agreed to publish a joint statement demonstrating their shared commitment to tackling the disease **(MH9/510 – INQ000234037)**.

252. On 25-26 September 2020, I received further advice on introducing the legal requirement to self-isolate, the support payment and the introduction of fixed penalty notices **(MH9/511 – INQ000566234; MH9/512 - INQ000565545; MH9/513 – INQ000566235; MH9/514 – INQ000566236)**. I confirmed again that I was content with the proposed policy and approach **(MH9/515 – INQ000566237)**. On 27 September 2020, we made The Health Protection (Coronavirus, Restrictions)(Self-Isolation) (England) Regulations 2020 which brought the legal requirement to self-isolate into force for those who had tested positive and for their close contacts, and which provided for the imposition of fines ranging from £1,000-£10,000 for those who failed to self-isolate having been notified to do so by NHST&T **(MH9/516 - INQ000234515; MH9/517 - INQ000236061 MH9/518 – INQ000566238).** I considered that these measures were necessary and proportionate steps in the fight against the virus.

253. By this point our strategy was, therefore, a fourfold one:

1. Communications: improve awareness of when people need to self-isolate, what this involves, its importance in stopping the spread of the virus, the support available and the consequences of breaking the rules;

2. Practical interventions: provide social and emotional support for those who need it, organised by local authorities and community groups;

3. Financial support: for people who need it to support successful self-isolation;

4. Enforcement: action against both individuals and employers for the most serious breaches of the legal self-isolation requirements.

254. On 24 November 2020, I was sent a submission informing me that, based on advice from the Police and CPS, the information provided by NHST&T to the police for enforcement purposes was not meeting the evidential threshold to issue fixed penalty notices and to prosecute non-payment of them **(MH9/519 – INQ000566252; MH9/520 – INQ000566253; MH9/521 – INQ000203762)**. On 10 December 2020, I was sent a Departmental submission with a proposal to increase enforcement of self-isolation

rules by allowing NHST&T to share additional data with the police identifying whether an individual was under a legal duty to self-isolate (either as a positive case or trace contact) so that the police had sufficient evidence to enforce compliance **(MH9/522 – INQ000566260; MH9/523 – INQ000566261; MH9/524 –** INQ000234518. Lord Bethell and I agreed with the submission but requested that NHS numbers be taken for all tests, rather than ID verification **(MH9/525 – INQ000566264; MH9/526 - INQ000203818)**. We amended the Health Protection (Coronavirus, Restrictions) (Self-Isolation) (England) Regulations 2020 on 28 January 2021 to give effect to those proposals **(MH9/527 – INQ000566288; MH9/528 – INQ000566289; MH9/529 – INQ000566290; MH9/530 - INQ000110491; MH9/531 - INQ000110498)**.

255. On 11 December 2020, as described above, I signed the Health Protection (Coronavirus, Restrictions) (Self-Isolation and Linked Households) (England) Regulations 2020, which reduced the time period of self-isolation for a close contact of an index case from 14 to 10 days and made changes to when a person's period of self-isolation began **MH9/431 - INQ000234642; MH9/429 - INQ000234212)**. A key factor in implementing the shortened isolation period was to reduce its burden on people and encourage greater compliance with the rules, whilst still ensuring the isolation period was of adequate length, thus overall reducing transmission.

256. On 15 December 2020, further to discussions we had been having in the Department **(MH9/532 - INQ000566254**; **MH9/533 – INQ000203689)**, I was sent a Departmental paper for COVID-O about how to improve adherence to self-isolation by enhancing support measures **(MH9/534 – INQ000566268; MH9/535 – INQ000566269)**. According to a Departmental isolation survey and SPI-B's paper on the impact of financial and other targeted support on rates of self-isolation and quarantine, the evidence suggested there was mixed compliance with 50% of symptomatic individuals reporting leaving their home during the isolation period, and 42% of contacts reporting doing so. The paper noted that two of the main barriers to compliance were lack of consistency and reliability of local support and the financial consequences of self-isolation. It, therefore, recommended that arrangements be made for local authorities to provide increased targeted support to people self-isolating, including establishing a medicine delivery service, and that eligibility for the isolation support payment be widened. I proposed that there should be a

straightforward universal £500 support payment for anyone who tested positive to improve compliance, but the Chancellor strongly opposed any extension to the eligibility criteria save for limited edge cases **(MH9/536 – INQ000566267; MH9/537 – INQ000566270)**.

257. On 14 January 2021, I was sent a further Departmental paper for COVID-O entitled *"Removing Barriers to Self-Isolation and Improving Adherence"* and advice on the same **(MH9/538 – INQ000566278; MH9/539 – INQ000091662; MH9/540 – INQ000566279)**. It recommended and sought my agreement to (i) ramping up national and local communications to further improve the clarity of messaging around self-isolation requirements and the support available, (ii) working with local authorities to provide more consistent, visible and accessible practical, financial, social and emotional support for people self-isolating, (iii) extending eligibility for the support payment for those who have tested positive beyond those on means-tested benefits but discontinuing eligibility for payment for contacts of confirmed cases in view of the impending introduction of daily contact testing, and (iv) updating information sharing provision between NHST&T and the police to enable enforcement. I was broadly content with the approach **(MH9/541 – INQ000566280)**. However, despite opposition from the Treasury, I continued to press the need for universal payments to all positive cases or at least for all those individuals who could not work from home **(MH9/542 – INQ000566285; MH9/543 – INQ000566284; MH9/544 - INQ000091662; MH9/545 – INQ000566283)**. It was essential to have robust measures which not only drove up self-isolation of people with the virus and their contacts, but ensured high take-up of testing **(MH9/546 – INQ000566286)**.

258. On 22 January 2021, there was agreement at COVID-O to ramping up communications, providing greater funds for discretionary support payments and increasing non-financial support, but not, despite my arguments, for making universal support payments **(MH9/547 – INQ000566287; MH9/548 – INQ000091673 MH9/549 - INQ000092295; MH9/550 - INQ000054522)**.

Data & Modelling

Data

259. I repeat what I said at paragraphs 50-56 of my second statement in respect of the use of data to inform decision-making **(MH9/001 – INQ000232194)**:

> *"50. Throughout the pandemic, work was undertaken to use data as effectively as possible. We started from a position of very little information, and ended with some of the best operational and data management tools I have seen in public service. Likewise, operational data and data sharing was poor at the start of the pandemic despite significant recent work to improve it, which was invaluable. A number of pieces of work to improve the use of data to save lives are worth noting. Several of these have taken backward steps since the pandemic, and progress needs to be restored.*
>
> *51. The most important change was freeing up front line services from onerous and regressive data protection rules that had become completely outdated. In March 2020 we introduced a new data protection protocol, designed by NHSX, aimed at front line staff, to allow them to use modern data tools so long as patient data was protected, which was notified by letters dated 17 and 20 March 2020 and signed on my behalf (MH2/08 to MH2/109 – INQ000101772; INQ000233781). Previously rules had been confused and complicated, and NHS staff had been prevented from using many modern tools such as email and WhatsApp, despite these standard tools having much better data protection and cyber security than the authorised in-house NHS versions. This saved many lives, and should be made permanent, but unfortunately has been made more cumbersome since the pandemic.*
>
> *52. The second vital change was to bring in credible external data experts to develop data dashboards for management purposes. These became invaluable, and their use should be expanded for day to day and strategic management of health and social care.*
>
> *53. Third, we worked incredibly hard to improve data linking, for example between GPs and hospitals, and between health and social care settings. These links saved many lives, and should be strengthened. Data linking across the four parts of the*

NHS in the four nations of the UK is still inadequate, and data sharing should be required.

54. Fourth, we allowed citizens to see their health data through the NHS app, which helped them manage their own health.

55. Fifth, by using data in a progressive, modern way, we developed the best clinical trial in the world (the RECOVERY trial) and also delivered the first vaccine in the world. Neither of these would have been possible without the most cutting-edge use of data, and the insights from their operation are vital lessons both for the next pandemic, and the day to day operation of health and social care in the UK.

56. The clearest validation of the decision to take a strongly progressive approach to the use of data is the success of the vaccine programme. In all four elements of the vaccination programme: research; purchasing; regulation and rollout, we used cutting-edge data techniques, which helped make it the most successful in the world. Without a modern use of data that would not have happened. These lessons are vital for the next pandemic, and work is needed now to ensure we are as well prepared as possible to use data to save lives from the start. Furthermore, the vaccine rollout shows that the NHS can and should interact with patients using modern digital techniques, including for the basics like booking appointments and updating the patient record. There is no longer any excuse."

260. As to how data was relied upon to inform policies and strategies for TTI, we worked incredibly hard in the early stages of the pandemic to improve the data available for decision-making, which was initially lacking. The data was typically fed back through the Department's daily SitReps. As testing rapidly increased so also did the availability and reliability of data at a national and regional level on the incidence and prevalence of cases (including case details and demographics), transmission rates, and testing and tracing usage and capacity, which we were able to use to inform our decision-making. The establishment of the JBC at the end of May 2020 was an important step forward. It provided invaluable data-based and objective analysis, assessment and advice to inform local and national decision-making in respect of TTI and other policies

and strategy. As I explained above, it essentially became the *"strategic brain"* for NHST&T - see, for example, the section entitled "*Improving the use of our data"* in the NHST&T Business Plan dated 30 July 2020 **MH9/303 - INQ000059228)**. I considered and relied on that data through the data packs that were provided to me at the weekly Gold Local Action Committee meetings. Once we got to the point of more routine asymptomatic testing across specific institutions and sections of the populations (e.g. healthcare workers) from late 2020 onwards, we had much more complete data with which to make decisions on TTI. Our reliance on data is addressed in detail in Chapter 4 of the Technical Report **(MH9/192 – INQ000203933)**.

Modelling

261. I repeat what I said at paragraph 98 of my first statement in respect of the use of modelling **(MH9/007 – INQ000181825)**:

> *"Modelling was useful for indicating possible future scenarios. By their nature no model will always make precise forecasts but, properly understood, modelling is a useful way of organising discussion around unknowable potential future scenarios. Communication of modelling is difficult, especially when policy is changed in response to the model. So for example, some criticise the modelling of the reasonable worst case scenario, because the modelled outcome did not happen. But the reason it did not happen is that we took action to stop it happening. The data were starting to follow the reasonable worst case scenario in an extremely worrying way, and other measures, like the doubling time in the number of cases, corroborated the model. Much can be learned about the presentation of modelling, for example from the Bank of England's fan chart models that do not imply undue accuracy in any forecast."*

262. The modelling conducted during the pandemic is addressed in detail in Chapter 5 of the Technical Report **(MH9/192 – INQ000203933)**. In respect of forecasting and modelling in respect of TTI, this was principally carried out by SPI-M-O through SAGE and by PHE, JBC and NHST&T before they were subsumed into UKHSA. We used the product of their modelling to inform our decision-making on TTI. For example, the decision we made at COBR on 12 March 2020 to impose a 7-day self- isolation period was made considering modelling which had initially been carried out by Imperial

College with input from SPI-M-O and which had been discussed by SAGE **(MH9/551 – INQ000056209; MH9/120 - INQ000056221)**. For further example, the section entitled *"Improving the use of our data"* in the NHST&T Business Plan dated 30 July 2020 describes our use of modelling to understand the impact of different interventions and to more accurately 'nowcast' and 'forecast' the prevalence of COVID-19 and its patterns (**MH9/303 - INQ000059228)**.

Inequalities

263. I reiterate the evidence I gave in respect of inequalities at paragraphs 169-173 of my fifth statement **(MH9/008 – INQ000421858)**. Our purpose throughout the pandemic, including in trying to determine who was most vulnerable to the virus, and instigating the first lockdown, was to protect those in society most vulnerable to the virus. Considering the effect of policy decisions on the vulnerable was at the heart of the Government's strategy. My overall priority was to protect health and well-being. The actions we took to stop the spread of the virus, protect people with vaccines, instigate a huge shielding programme, and ensure the NHS was never overwhelmed all considered the needs of minorities, and disproportionately benefitted vulnerable minorities.

Equalities

> "*169.As mentioned in paragraph 17 above, our purpose throughout the pandemic, including in trying to determine who was most vulnerable to the virus, and instigating the first lockdown, was to protect those in society most vulnerable to the virus. Considering the effect of policy decisions on the vulnerable was at the heart of the Government's strategy. My overall priority was to protect health and well-being. The actions we took to stop the spread of the virus, protect people with vaccines, instigate a huge shielding programme, and ensure the NHS was never overwhelmed all considered the needs of minorities, and disproportionately benefitted vulnerable minorities.*
>
> *170. I considered the impact of my decisions upon disabled people, people who were clinically vulnerable, clinically extremely vulnerable and severely immunocompromised, those from minority ethnic backgrounds or lower socio-*

economic backgrounds and/or other groups with existing health inequalities throughout the pandemic. Indeed many of the decisions we made were put in place precisely with their protection in mind. I received expert advice from world-leading clinicians, including the CMO, on how to reduce the unequal impact of the pandemic. I also received impact assessments and equality impact assessments from Departmental officials. The effect of this advice was to reinforce my decision to try to limit the spread of the virus, increase NHS capacity and find a vaccine as quickly as possible, in order to protect all members of the public and particularly those worst- affected by the virus.

171. As I set out in my second witness statement, for example, I stated that I wanted SAGE's advice identifying risk factors for the outcome of contracting covid from 7 April 2020 published so that those who were at risk of particularly acute effects of a COVID-19 infection were aware of this, and could take precautions accordingly.

172. I had received a briefing on emerging evidence on obesity and COVID-19. As discussed in paragraph 25 of my third witness statement, I was concerned about the unequal impact of the virus across wider society, particularly given that the first doctors to die in the UK from the virus were all from ethnic minority backgrounds and I had received an update from the CMO prior to the circulation of the minutes of the 16 April SAGE meeting where it had been identified that black people had a higher risk of being admitted to hospital and of dying, and that a disproportionate number of BAME healthcare workers were dying (MH5/166 INQ000075780 1 I was worried by this data, and recall discussing it with the CMO.

173. Upon my request, the CMO commissioned PHE to report on disparities in outcomes and risks from COVID-19. On 30 April 2024 I asked my special adviser to share these concerns with the media so that the public would be aware that we were taking action to look at and try to understand the basis of these potential risk factors (MH5/167 - INQ000478888; MH5/168 - INQ000478889). On 12 May 2020, PHE provided a rapid interim review on the current data already available on ethnicity and health outcomes and the CMO sent me a note on the same (MH5/169 - INQ000233807; MH5/170 - INQ000233808; MH5/171 - INQ000069220 I

MH5/172 - INQ000069223 1; MH5/173 -I INQ000069218 I also read Ben Goldacre's excellent work on these matters, which analysed the disproportionate instances of Covid-19, and highlighted the differential risks faced by different people according to their characteristics. Understanding this — and what we could do about it - was at the front of my mind throughout."

264. I considered the impact of my decisions upon disabled people, people who were clinically vulnerable, clinically extremely vulnerable and severely immunocompromised, those from minority ethnic backgrounds or lower socio-economic backgrounds and/or other groups with existing health inequalities throughout the pandemic. Indeed many of the decisions we made were put in place precisely with their protection in mind. I received expert advice from world- leading clinicians, including the CMO, on how to reduce the unequal impact of the pandemic. I also received impact assessments and equality impact assessments from Departmental officials. The effect of this advice was to reinforce my decision to try to limit the spread of the virus, increase NHS capacity and find a vaccine as quickly as possible, in order to protect all members of the public and particularly those worst-affected by the virus.

265. In which respect, I reiterate in full the evidence I gave in paragraphs 84-90 of my fifth statement as to the steps we took to shield those who were most vulnerable to the virus **(MH9/008 - INQ000421858)**:

"84. Throughout the pandemic our focus was on protecting those who were most vulnerable to the virus. We knew that a lockdown would pose particular challenges for those likely to be vulnerable to the virus because of age or pre-existing health conditions. Work on a policy that came to be known as `shielding' began in February 2020 and was led by Deputy Chief Medical Officer Professor Dame Jenny Harries. I strongly supported the development of the policy.

85. As I explained in my second witness statement, a stay at home policy; social distancing guidance; and guidance on the additional precautions that should be taken by those who were believed to be vulnerable to COVID-19 were agreed at a COBR meeting on 16 March 2020. Shielding was vital for the protection of the

most vulnerable. By the time No10 became involved in the policy, significant work had already been undertaken under Professor Harries' leadership. The Government and NHS needed to take urgent steps to identify and assist those who were required to shield, and that communicating with those being asked to shield would be extremely sensitive, as they were many of the most worried about the disease.

86. Data held by the DWP and NHS identified a significant number of the most vulnerable people in the country who needed to shield for twelve weeks. However, there were difficulties in linking data to enable us to contact those individuals and give them the help they needed. This frustrated me, as I felt that data and privacy concerns, whilst important, could not be given priority ahead of saving the data subject's health or even life. I made it very clear, both to NHS Digital, and at meetings of the Health MIG, that I wanted this issue to be sorted urgently. For example, I held a meeting to discuss data protection and security to respond to the pandemic on 10 March 2020 (MH5/45 - INQ000478854) and received advice on this issue on 12 March 2020 (MH5/46 - INQ000478856), which I accepted (MH5/47 - INQ000478857). My Private Secretary received an update about providing notices on 18 March 2020 (MH5/48 - INQ000485148).

87. I was ultimately required to issue four notices under Regulation 3(4) of the Health Service (Control of Patient Information) Regulations 2002 on 17, 20 and 23 March 2020, which directed the NHS to share the relevant data for these purposes (MH5/49 - INQ000485150; MH5/50 - INQ000233781; MH5/51 - INQ000101772; MH5/52 - INQ000485153). These had a very significant positive impact on the ability to deliver services, and one lesson from the pandemic is that this sort of data sharing should become the norm to improve and save lives.

88. Those present at a HMIG meeting on 18 March 2020 decided that the letter to clinically vulnerable individuals should not include a phone number (e.g. for the national call centre) to avoid overwhelming services, but it should include advice on measures for individuals to take independently before a package of support is in place (MH5/53 - INQ000055912). Ultimately it was possible to include

a phone number in the letter as a technical solution to prevent the phone number from being overwhelmed was devised (MH5/54 - INQ000478860).

89. The NHS sent a letter on 21 March 2020 to the 1.5 million individuals identified to be vulnerable and who were required to shield, to explain what they needed to do, and the steps that we were taking to support them, including arranging food and medicine deliveries (MH5/55 - INQ000233778). On 14 April 2020 we brought in Chris Townsend, who had previously led the Government's broadband roll-out, to manage the rollout of the project (MH5/56 - INQ000478873). Chris also did an exemplary job.

90. I was kept updated about changes to criteria for the shielding list throughout my time as Secretary of State. A comprehensive list of these changes is included at paragraph 366 — 390 of Sir Christopher Wormald's fifth witness statement, dated 25 August 2023. We wrote repeatedly to the shielding population, including in specific locations, to explain the latest advice, reiterating advice, underpinned by decisions made on a clinical basis as our understanding of vulnerability to the virus developed. For example, I sent letters with the Secretary of State for Housing, Communities and Local Government, on 22 June 2020 (MH5/57 - INQ000381345), 1 August 2020 (MH5/58 - INQ000058020), 31 December 2020 (MH5/59 - INQ000059396) and 7 January 2021 (MH5/60 - INQ000059496).
Professor Harries, Chris Townsend, and their teams deserve significant praise for their work on the shielding programme, which I am convinced saved many hundreds of thousands of lives."

266. I was also concerned about the unequal impact of the virus across wider society. On 7 April 2020, SAGE identified that there were particular risk factors for poor outcomes from contracting COVID-19, namely age, gender (men being more vulnerable than women), obesity and ethnicity. I sought that that advice be published so that those who were at risk of particularly acute effects of a COVID-19 infection were aware, and could take precautions accordingly. I also received an update from the CMO in respect of the SAGE meeting on 16 April 2020 where it had been identified that black people had a higher risk of being admitted to hospital and of dying, and that a disproportionate number of BAME healthcare workers were dying **(MH9/552 -**

INQ000075780). I was worried by this data, particularly given that the first doctors to die in the UK from the virus were all from ethnic minority backgrounds, and I recall discussing it with the CMO.

267. Upon my request, the CMO commissioned PHE to report on disparities in outcomes and risks from COVID-19. On 30 April 2020, I asked my special adviser to share these concerns with the media so that the public would be aware that we were taking action to look at and try to understand the basis of these potential risk factors **(MH9/553 - INQ000478888; MH9/554 – INQ000047889)**. On 12 May 2020, PHE provided a rapid interim review on the current data already available on ethnicity and health outcomes and the CMO sent me a note on the same **(MH9/555 - INQ000069218; MH9/556 - INQ000233807; MH9/557 - INQ000233808; MH9/558 - INQ000069220; MH9/559 - INQ000069223).** On 31 May 2020, PHE provided its full review 'Disparities in the risk and outcomes of COVID-19' which highlighted important disparities **(MH9/560 - INQ000233822 ; MH9/561 - INQ000233826; MH9/562- INQ000207437 ; MH9/563 - INQ000233823; MH9/564 - INQ000069494).**

268. The Government commissioned, Kemi Badenoch, then Minister for Equalities, to carry out further work to understand the drivers of those disparities to inform decision-making. I announced that work on 2 June 2020 **(MH9/565 - INQ000233827).** The Department periodically fed into it to ensure we were building in proper responses to protect those who had been disproportionately impacted by COVID-19. The work and progress on the recommendations was periodically reviewed at COVID-O meetings I attended; for example, on 18 September 2020 **(MH9/566 - INQ000090026)**, 24 September 2020 **(MH9/567 - INQ000090034; MH9/568 – INQ000090183)**, 29 October 2020 **(MH9/569 – INQ000090144; MH9/570 - INQ000090185)** and 8 December 2020 **(MH9/571 – INQ000325294 MH9/572 - INQ000091044)**; 4 May 2021 **(MH9/573 – INQ000091903).**

269. I also read Ben Goldacre's excellent work on these matters, which analysed the disproportionate instances of COVID-19, and highlighted the differential risks faced by different people according to their characteristics **(MH9/574 - INQ000381220**. Understanding this — and what we could do about it - was at the front of my mind throughout.

270. In line with the above, I carefully considered issues of inequality and vulnerability in respect of my decision-making in respect of TTI during my time as Health Secretary. I was provided with frequent advice on the equality implications of proposed TTI policy and strategy which fed into my decision making. For example, on 28 March 2020, the Department provided advice on the prioritisation of testing capacity based on their public sector equality analysis **(MH9/575 - INQ000562642)**. On 17 May 2020, I was provided further advice on the equalities implications of expanding testing eligibility **(MH9/576 - INQ000562650)**. On 22 May 2020, I was provided an Equalities Impact Assessment for the rollout of NHST&T **(MH9/577 – INQ000566161)**. As testing increased and, thus, the availability, reliability and granularity of data improved, we were able to better appreciate the interrelation between TTI measures and its impact on vulnerable and disproportionately impacted groups and, therefore, be more discerning in our efforts to mitigate it.

Cost

271. I understand that the Departmental corporate statements will address how the NHST&T budget was allocated and actually spent, which again I defer to and take as read.

272. As I explained at paragraph 27 of my second statement **(MH9/001 – INQ000232194)**, it matters enormously choosing what is done to suppress the virus. Some measures to suppress a pandemic are much lower cost than others. It is important to use TTI throughout to reduce the number of other measures needed to get the R number below 1. There is no way TTI alone could have suppressed COVID-19, but they are valuable tools because they reduce the amount of more costly measures that may be needed, whether by reducing the time more costly measures need to be in place or by removing the need for them at all. For example, given the enormous and adverse social and economic impact of local and national lockdowns, to the extent TTI shortened the imposition of such lockdown, the money spent on it was money well-spent.

273. Connected to which, and as stated above, while the Government was criticised at the time for engaging with the private sector on areas such as testing, the reality is

that we could not have achieved the rapid expansion of testing without the support of the private sector. While there was inevitably some wastage, the money we spent on harnessing the skills of the private sector was vital in our response to the pandemic.

Lessons Learned and Reflections

274. As I said at paragraph 76 of my first statement **(MH9/007 – INQ000181825)**, the key lesson for the future is that a rapidly scalable testing and tracing infrastructure should be maintained, ready for urgent expansion. I am concerned that at present our current capacity is being dismantled and we will find it much harder to scale again in the future as a result. It is a vital weapon in the Government's armoury to combat any new disease and, depending on the transmissibility and virulence of that disease, may be sufficient alone to suppress and contain it without having to resort to further social distancing measures. In my view, that justifies the cost of building and maintaining testing systems that are rapidly scalable in the event of new variants or an entirely new pandemic.

275. I have also read the reflections and advice for future CMO and GCSAs on testing, contact tracing and isolation in Chapters 6 and 7 the Technical Report respectively, and I agree with them **(MH9/192- INQ000203933)**.

Statement of Truth

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

Signed: 

Dated: 07/04/2025