Thursday, 22 May 2025

(10.00 am)

LADY HALLETT: Ms Cartwright.

MS CARTWRIGHT: My Lady, could Mr Hancock please stand whilst he's sworn. Thank you.

MR MATT HANCOCK (affirmed)

LADY HALLETT: Mr Hancock, thank you for coming back. I do understand how difficult it must be for you to keep coming back and we do appreciate your continued help.

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 7

MS CARTWRIGHT: Thank you. Please can you tell the Inquiry your full name.

A. Yes. I'm Matthew John David Hancock.

Q. Mr Hancock, can I firstly thank you on behalf of Module 7 for the provision of your ninth witness statement.

If that could be displayed, please, INQ000587294, and if we could move, please, to page 96 where we see it's dated 7 April 2025, and can I ask you to confirm, are the contents of that statement true to the best of your knowledge and belief?

A. Yes, of course.

Q. Thank you. Mr Hancock, that statement will be published, so the full context of the additional evidence you've given in respect of Module 7 will be

available, because I appreciate today there will be topics we can cover but the full detail you've provided is set out in that statement.

A. Yeah.

Q. Thank you.

Now, Mr Hancock, having identified that you've given, now, nine witness statements, it's right also that you have now given evidence to every one of the modules to date in the Inquiry.

A. So far.

Q. And in making that point, I just want to make, perhaps what's an obvious point, but it's right, isn't it, that today we're going to be dealing with test, trace and isolate, but when we consider those issues in focus today, the full context is that you had, essentially, a portfolio that covered many areas that this Inquiry has been examining and I think you're particularly anxious that the full context of your work during the pandemic is not forgotten.

A. Well, it's more that when considering lessons for the future, it's important not to take each module in isolation. I understand why it's been looked at in isolation, each one, but -- because all of these decisions, in fact, in reality, run concurrently and you go from a meeting on test, trace and isolate to

a meeting on getting the vaccine going to a meeting on non-pharmaceutical interventions, and there is an interaction between them all.

Q. Thank you. Well, let's then just identify who you are and the roles you were performing for the context and, again, it's right, isn't it, that from July of 2018 you were Secretary of State for Health and Social Care?

A. Yes.

Q. And I think the full detail of your portfolio before that time is within your witness statement. Is there anything else you'd wish to say about your previous knowledge and experience that's going to be relevant to the topics we're going to deal with today?

A. Not over and above what's in the written statement.

Q. Thank you. Can I then start with the first topic, please, of preparedness and preparedness in the context of test, trace and isolate.

A. Yes.

Q. And to do that, can we go, please, to your paragraph 62 which is at page 20. Thank you.

Now, you've given a section of your statement over to assist with your views on preparedness and capacity in the context of test, trace and isolate. You detail that you reiterate the concerns you set out in the respect of the weaknesses in preparedness and capacity

for testing and tracing in an earlier statement.

And please, if you could display the next paragraph. You say:

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

A. Yes.

Q. And the next paragraph, again, please:

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

A. Yes.

Q. And so before we get into the detail, can I ask you, first of all, from the perspective of the relevant minister with the relevant responsibility, can you give your perspective at January 2020 of the readiness and preparedness relating to, first of all, testing?

A. Well, I'm really glad that you've come to this first, and if this module of the Inquiry is to conclude anything, I think it is absolutely critical that it concludes on this point: the doctrine that we had, going into the pandemic, that was shared by most of the western world and the World Health Organisation, was wrong, because it essentially dealt with how to cope

with a pandemic as it affected the whole country, the whole human race, and did not address the need to stop a pandemic from infecting everybody. And we dealt with that in Module 1 where I set that out in more detail.

That had two huge consequences here. The first is that there was a view in the public health community that -- and the advice I received, therefore, from Public Health England -- that we should not need or try to test at scale or contact trace at scale, and as soon as there was community-based transmission, there was no point in testing and contact tracing any further outside of hospitals, because effectively, everybody was going to get infected.

That was the wrong attitude, and it is absolutely critical that next time there's a pandemic, because there will be a next time, we are ready to take the actions to stop it spreading and protect the most vulnerable first.

Second, operational weakness, PHE was brilliant at the early science and at turning the viral sequence that the Chinese published in mid-January into a test within three or four days. They proved entirely incapable of expanding that testing capacity. In their defence, they'd never expected to, because of the wrong attitude, and when the existing UK system, which is essentially

a cottage industry of testing in little centres in -- whether that's in hospitals or in academic institutes like the Crick Institute, or if it's in PHE labs, the ability to expand those at the colossal scale that was needed, not just double or triple the output but multiple it by a thousand or 100,000 times, that was simply not there.

And I know -- I think it's highly likely we'll get on to this decentralisation versus centralisation point, the critical thing is that we absolutely must, as a nation, be ready to expand, radically expand testing capacity once a test is developed. We were not last time. I had to do that.

There are critics who said that it was done in the wrong way. What matters is that it's done and it's planned for next time to be ready to be done.

Q. Thank you. Mr Hancock, then can we put some context on the answer you've just given but particularly to understand what seems to be where you've identified PHE were doing a good job when the test and the assay was there but there came a time where you had concerns about the ability of PHE to have the resources or capabilities or expertise to scale up.

A. Yes, it wasn't about resources. It was about capability. They were good at the science, and there

were lots of good science organisations, but the difference between a scientific-scale testing capacity and an industrial-scale testing capacity is vast, and it's a different capability, building a huge system with, you know, thousands of people, compared to having scientists pipetting, and if I just illustrate this with the one story, I went to one of these labs in either late February or early March --

Q. Just pausing there, this is a PHE laboratory -- (overspeaking) -- in your statement.

A. I went to a PHE laboratory and there were -- I was taken into a science lab, and I -- because I'd asked to see their testing facility, and they took me into a side room that was about the size of your desk, my Lady, and it had two people in, in scientific overcoats, working very hard, no criticism of them whatsoever, to pipette, hand pipette, samples in order to do the tests on this lab bench, and they were very proud because they'd doubled their capacity, and I'm grateful to them for doubling their capacity but it was woefully inadequate.

It was a cottage industry and we needed an industrial-scale capacity, and crucially, next time, we need to move as fast as possible to an industrial-scale capacity.

Q. Thank you. Well, Mr Hancock, for context to the answer

you've just given, the PHE assay was used at the PHE Colindale laboratory to diagnose the first case in England on 31 January 2020, that PHE was able to isolate and grow the SARS-CoV-2 virus from the first UK diagnosed case which was then rolled out to 12 PHE labs across the United Kingdom on 10 February 2020.

Then can I ask you, because we know then the containment level to handle the virus was reduced from a level 3 to a level 2 on 13 February 2020, can I ask you then, we know that on 17 March you essentially took over responsibility for testing from PHE.

A. Yeah.

Q. Can you give us some idea, then, as to when it was you realised that you had to take more control over testing for the scale up that was needed --

A. Well, I took that decision on 17 March, in that meeting. But the history of that is actually both better and worse than you describe. Better is that, even before we had a case in the UK, PHE had developed a test when the -- after the Chinese had published the viral sequence of the virus. So their science was brilliant. That was before even there was a case in the UK.

So they'd done incredibly well at that. And that gave me confidence that what they were telling me in their capacity to build a testing system was good. So

I started out with a high regard for PHE's capacity in this manner, in this area, in the middle of January. And from the end of January, when it became clear that this was likely to become a global pandemic, and from mid-January to the end of January it went from 50/50 to almost certain, the -- I insisted on ramping up the testing capacity. I told PHE they had whatever resources they needed.

But I also wanted them to engage every -- every testing capacity in the country. And despite my repeated insistence, they would not share the serum samples, they would not engage with the private sector companies that had the capacity to develop these tests. And that was a mistake, and it was deeply frustrating because I kept asking them to and they didn't.

And the view was: we just -- we need to keep expanding the PHE labs, the NHS labs, the university capability in this area.

And that argument was put to me over and over again during February, and the first half of March, and I became increasingly frustrated at the slow growth, and then we organised --

Q. Mr Hancock can I -- I apologise to interrupt you. We're going to deal with scale-up, but I want to sort of --

A. Oh, yes --

Q. -- deal with preparedness, and then, please, you will be given an opportunity to provide details of the scale-up, please.

A. No problem.

So the concluding sentence of that answer, if you like, is that I wasn't the only one with this frustration, and Number 10 organised a meeting on 17 March to bring things to a head.

Q. Now, can I -- in answering that question, you've just referenced that PHE wouldn't share the assay, but in fact the assay was shared, so it was available to non-PHE laboratories from February --

A. But not the private sector. So there were a number of private sector organisations that were able to help and could not get hold of what they needed to develop a test.

Q. Well, let's revisit that when we deal with scale-up, because what you've highlighted is cottage industry laboratories. I want to explore with you the alternative option that that provided --

A. Yes.

Q. -- for. So let's -- we'll come to that in a moment.

A. Okay.

Q. So you've given your overview on preparedness linked to testing. But the paragraph we looked at together, if we

can just display again, your paragraph 64, I would now like just to capture -- and again, we're going to deal with the chronology, so please don't think you have to address it all in answering this question, I'd just like to capture your understanding about the question of preparedness by reference to contact tracing.

A. Yeah.

Q. And perhaps can I just add a little bit of extra detail on that to understand, did you appreciate that the directors of public health within local authorities discharged and performed the role of contact tracing? So not just PHE, but there was this resource in every local authority across the United Kingdom that had the resources. I appreciate that in Northern Ireland there was just a single director of public health --

A. Well, you've answered the question, really. Of course I appreciated that. There was one person in each of the upper tier local authorities, and therefore around 100 people.

It was -- they are brilliant people. I engaged with a huge number of them throughout the pandemic. But the idea that they alone could have solved this problem was unfortunately the wrong attitude and led to operational weakness, as the previous paragraph says.

Q. So, from your perspective, you're saying when the

pandemic was coming in and rolling from January onwards, you appreciated the PHE contact tracing capacity but also the capacity that existed in directors of public health --

A. Of course I did, yes. That was the capacity that we had at the time. It was wholly inadequate.

Q. Can I then capture your views as to why you say that contact tracing, from a preparedness perspective, was flawed?

A. It was flawed because there was a reliance on a small number of people doing high-quality contact tracing, typically for localised outbreaks, like Legionnaires' disease, for instance, and they were really good at that.

What they were not organised for, and it wasn't the fault of any individual, what they weren't organised for was a national-scale, indeed a global-scale, catastrophe, and the scale that is needed to respond to that.

Now, eventually where we got to was a merger of a national system and local system, which is, in my view, the best system you can have. But the idea you could just do it with what we had at the start, which was the PHE view, was wrong.

Q. Thank you.

Can I then, with you just dealing with the fact that it was then right to go to a mix system, just deal with that topic now. It may save us time as we go through the chronology.

A. Yes.

Q. We know that when you scaled up your contact tracing, and certainly from 18 March when you moved to the National Testing Programme and the strategies that you implemented --

A. Yes.

Q. -- I think the phrase is used about "starting contact tracing from scratch".

A. Yes.

Q. Obviously, at that point, there were the large numbers of individuals that were hired and recruited --

A. Yes.

Q. -- to work in the call centres.

A. Yeah.

Q. So certainly the strategy appears to have then been without input from local authorities and Public Health England, and so can you assist as to why, then, it had this period where you were not utilising the expertise and skills of local authorities, and solely basing your strategy at that point in time, I think before then it moved again back to needing the local -- just on call

centre contact tracers in a central location that do not have those local connections with their community?

A. So that isn't what quite happened. PHE, of course, infamously turned off the contact tracing system, and that was wrong and a mistake. And they were of course involved in the development of a national contact tracing system, but we found it hard at first to integrate the national and the local. There were all sorts of data transfer issues that should be sorted out in advance. There were -- essentially, the integration of a system where you have a national system doing essentially the easy mass repeat cases, and then the local capability delivering the hard-to-reach cases. That is where we got to, and is what we should seek for and seek for next time.

But this brings us back to the original context, there was one leader of public health per council and they were busy, because they were doing everything else as well, so the idea --

Q. I don't think that's the position across local authorities, certainly in Northern Ireland they had one Director of Public Health but that's not representative across the resources in other local authorities.

A. I think it's worth checking exactly how many there were, but there was one lead public health official in each

local authority, and they had to do, like I had to do, all the other things. They had to do non-pharmaceutical interventions; they had to do preparation for vaccine delivery; they had to do all -- they were involved in PPE, which was obviously absolutely critical at this time. They were involved right across the board. The idea that you could use just the local groups to deliver this is wrong. And we did succeed, eventually, in getting a decent synthesis between the national system and the local system. That is what we should seek next time.

We did have to start from catch because PHE had stopped its contact tracing but the PHE contact tracing capability, it, of course, informed, and many individuals were involved in building the national system. What we couldn't do was base the new national system on the technology used for the -- under the micro-outbreak PHE system because the technology simply wasn't capable of transferring from one to the other. We had to build that from scratch.

Q. Whilst we deal, again, with the contact tracers and the numbers recruited, I think we see it in the strategy, of 20,000 having been identified as being necessary?

A. Yeah.

Q. I think you're probably aware, Mr Hancock, that

Lord Agnew in particular in Module 5 was highly critical of the volume of contact tracers that had been recruited, that he gave his view as to how much they were utilised.

So can I ask you, where did you get the 20,000 figure necessary for the call centres for contact tracing?

A. I don't recall. There will have been -- somebody will have made an estimate based on a piece of advice, but you've got to remember that this was the first time this has happened in living became so it inevitably was an estimate. It's perfectly reasonable, with hindsight, to criticise the efficiency of these things but it was better to have them than not, and we had to have a sense of the scale.

Q. Thank you. And so, Mr Hancock, again, if we use the example of the helpful technical advice that the CMOs and the Chief Scientific Officers are given to essentially assist future individuals that end up in a role.

A. Yeah.

Q. I think you really want to share your experience as a minister, the relevant minister, Secretary of State, as to playbooks for future pandemics.

A. Yes, yeah.

Q. And so is your first headline, from what you said, is for contact tracing, essentially, in a pandemic needs a combination of the local skills but also centralised contact tracers, as well?
A. Yes, and critically, the data structures to allow that integration to work.
Q. Thank you.

Now, can I just on preparedness, ask you a follow-up question, please. Can you assist us as to what contingency plans and framework were already in place to ensure that the TTI could be implemented equitably across all population groups including minority ethnic communities in January 2020, please?
A. The whole purpose of contact tracing is to try to protect those who are most vulnerable to catching the virus. And therefore, it's vital that contact tracing, to be done well, is understood and the messages are received by those who are being contacted.

And, you know, it's not what you say; it's what people hear. So therefore it's vital that the contact tracing happens in such a way as those who are being contacted will act upon the advice that they're given. So naturally, it is critical that this takes into account the diversity of communities that are -- that are being contacted.

So that was at the front of our minds from when I got involved in the contact tracing system around the time that PHE decided to close it.
Q. Thank you. And then can I ask additionally then, please, on this issue of preparedness, were there structural limitations within Public Health England or the Department of Health and Social Care that hindered a rapid and equitable scale-up of test, trace and isolate in the early months of the pandemic?
A. Yes, PHE didn't have the operational capacity to scale.
Q. Thank you. Now, in giving your first headline recommendation around there needs to be a mix of local and national contact tracers --
A. Yeah.
Q. -- you referenced also data.
A. Yeah.
Q. And the Inquiry has already heard quite a bit of evidence around data blockages --
A. Yes.
Q. -- there has been reference to the Department of Health and Social Care.
A. Yeah.
Q. We'll be hearing from the corporate witness to speak on behalf of the Department of Health and Social Care next week.

A. Yeah.
Q. But I wonder whether you can assist from your perspective.
A. Yeah.
Q. So the Inquiry has heard lots of evidence about different data systems not -- essentially operating interoperably --
A. Yeah.
Q. -- in terms of, particularly where it was patient details, so the Lighthouse laboratories, for example, they didn't -- there had to be systems that to make sure the results could be shared.
A. Yeah.
Q. We've heard from the National Police Chiefs' Council that he was pushing for data from the Department of Health and Social Care that he needed --
A. Yeah.
Q. -- that was never forthcoming. And we've also heard about how, even when there were pilots such as the Liverpool Pilot, where they needed access to the data on hospitalisation in that trial --
A. Yeah.
Q. -- that was not forthcoming for months and months.
A. Yeah.
Q. And that data was hugely helpful when it arrived many

months after --
A. Yeah.
Q. -- to inform just how successful that trial had been.
A. Absolutely.
Q. So is there any insight or assistance you can give around the issue of data blockages that seems to be a constant theme across the different -- (overspeaking) --
A. It was absolutely constant. It was terrible. I personally dealt with a whole series of them to try to unblock these data blockages. Previously, I'd been the Digital Secretary and I'd taken the data sharing legislation through Parliament and, indeed, GDPR, so it's an area I know extremely well, and it was deeply frustrating at the lack of appropriate data sharing, which was for, in some cases, for technological reasons, but actually there were far fewer blockages due to poor technology than due to over-officious and absurd, in some cases, data rules.

All of this data was protected under GDPR. GDPR is a more than adequate protection of personal data, health data is not special or different, it's just personal sensitive data. It needs to be treated with respect and it needs to be treated with sensitivity.

Probably the single best thing that we did in this

area was when we wrote -- NHSX, it was Matthew Gould, who wrote a two-page data protection rules for the NHS and the health system. You could get it on two pages. It was written intentionally so that the nurse on the ward could understand what could or couldn't be done. That broke through a huge amount of this legalistic and bureaucratic rubbish that got in the way of data sharing. I found it so frustrating because I'd taken through the legislation that allowed for data sharing, and still persuading parts of the system that it was okay to share data in order to save lives, was still a huge problem.

Again, we come -- I come to a recommendation.

Q. Thank you.

A. Since the pandemic, that two-page set of rules about data sharing in the NHS has been, once again, replaced with an unbelievably unnecessary complicated system. Personally, I would go back to the two-pager. I had advice to remove it when I was still in office towards the end of the pandemic. I refused to. There is no excuse for the poor data sharing that we still find across the system, and if people can't even bring themselves to do the right thing in normal times, as they should now, at least if there's a pandemic can we return to a free flow of protected data? This isn't

about publishing it; it's about sharing it between those parts of the system that need it in order to save lives.

Q. Thank you, Mr Hancock, and again, we've heard similar evidence from the corporate witness Mr Garton on behalf of what was the Department of Levelling Up that efforts can be taken in peacetime to essentially create these policies and procedures to make data sharing work in a pandemic.

A. Yeah.

Q. And it seems that you endorse that position.

A. Strongly. And keep it as simple as possible.

Q. Thank you.

Now, Mr Hancock, I'm going to move next to a topic about asymptomatic transmission and testing.

A. Sure.

Q. And I want to deal with this before we deal with the scaling up --

A. Okay.

Q. -- because I know you've been asked about it in other modules but you'll understand how it's particularly important in Module 7 --

A. Absolutely.

Q. -- because I want there to be clarity because the positions -- there is some evidence that suggests that you may have not had the fullest understanding of

asymptomatic transmission or the ability for a PCR test, even with someone with no symptoms --

A. Yeah.

Q. -- to identify the positivity or infectivity?

A. Yeah.

Q. So can we start then, please, with your paragraph 202, please, where you tell us about your relevant evidence about asymptomatic testing, and then I want to particularly deal with some of the evidence we've had from Lord Vallance on his views on your understanding.

So it's page 66, please, at paragraph 202. Thank you.

You tell us:

"I have covered this subject extensively in my earlier statements, and again invite the Inquiry to consider the statements of the [Chief Medical Officer] about asymptomatic transmission ... 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 [Chief Medical Officer], which should not be surprising as we discussed it regularly during this period."

A. Yes.

Q. And I'll crystallise what you say here and then we'll

build on the topic, please.

"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, ie, someone incubating the virus could be given a negative test result. I was advised that this would be even more dangerous than not being tested, as it would give a false assurance."

A. Yes.

Q. Then you go on to tell us about the WHO advice.

So can we build on this topic together, because the Inquiry has some evidence from Lord Vallance that I think you're aware of, and he's touched upon before, that indicates a timeline where he has indicated that you had a confusion about the efficacy of testing people without symptoms.

A. Yes.

Q. And part of the chain that he relies upon -- so -- is essentially that SAGE's advice from 28 January of 2020 had recognised asymptomatic transmission?

A. Was a possibility, not -- they had not recognised asymptomatic transmission. That -- the difference between recognising that there was asymptomatic

transmission and recognising that there was a possibility of asymptomatic transmission is absolutely at the heart of this challenge.

Q. Thank you. Well, let's, then, move forward to 11 March. And I think we're going look together at the WhatsApp exchange that took place about a public statement concerning the Prime Minister's contact with Nadine Dorries.

A. Yeah.

Q. Was in the context of the positive case.

And can we perhaps work through the messages, which are said to be supportive, from Lord Vallance's perspective, of you not having that full understanding of asymptomatic testing being capable of being picked up on a PCR test.

A. Yes.

Q. Can we please display INQ000102697. And it's page 16 within that document I want to go to.

A. Okay.

Q. That's INQ000102697. Thank you.

Now, if we can pick up, I think at the ... perhaps, in fact, can we go to the page before, just to start the story, at page 15, please. Thank you.

A. Ooh, maybe not.

Q. Maybe not. Let's go to page 16, thank you.

A. Well, it's quite important, page 15.

Q. Thank you.

Well, Mr Hancock, if there's further context that's assessed in a slower time as being relevant to Module 7, that will be disclosed, but I think we can capture the sense of this.

So we can see, we follow the story:

"In this case it is the contact tracing aspect that is the key to who gets tested."

Then we see:

"Do we have a clear view on when Nadine first became symptomatic? My understanding is that she felt a little under the weather ..."

And so on.

Then James Slack, who I think is your special adviser, is that right?

A. No, Jamie Njoku-Goodwin was my special adviser. James Slack was the director of Communications at 10 Downing.

Q. I do apologise. And it says:

"Final below. Line on test not working removed ...

"Re the PM on background.

"We follow the advice of Public Health England and the [Chief Medical Officer].

"The PM has no symptoms so there is no need for

a test.

"The PM was not in close contact with [Nadine Dorries]. The advice is that you would have to be within 2 metres of someone for more than 15 minutes to pass it on. It is also worth restating the advice on washing hands -- which the PM does regularly."

And then I think if we follow that down, I think we get your entry at 10.28.

Thank you. 10:28:17.

So Mr Hancock, MP:

"I'm content with this line. We clearly need to clear up the testing for non symptomatic people.

"Having spoken to Chris Whitty and PHE [people] I'm with now, Patrick what you've said is not right.

"The clinical advice I've had is that the test is NOT reliable on people without symptoms. The reason is that there are so many false negatives when there are no symptoms that testing is counter productive.

"Can the scientists please clear this up urgently."

Then if we follow that through, we see the conversation continues at the bottom of that page, and I don't know if you want to speak us through this exchange, because it suggests -- we can then see Chris Whitty saying:

"Not reliable is correct. It can pick up some

asymptomatic cases. But not advised."

A. Yes.

Q. You then say:

"No. We cannot say this. She has told people she had symptoms on Thursday. We must not cover anything up."

A. That's about a different part of the exchange.

Q. Thank you.

Then Mr Whitty says:

"Patrick and I will do a joint note not on WhatsApp on testing."

But again it's right, isn't it, that Mr Vallance was effectively saying in this that it could detect -- or you tell us your interpretation of the exchange.

A. Yeah, so there's two further things needed before we can address this. Over the page --

Q. Thank you. Let's go to there now. On page 17 --

A. At 10.47, Patrick Vallance:

"Agree 'not reliable' not 'does not work'."

Q. So let's just pause there.

A. Yes. And --

Q. So -- so he's -- so --

A. And for page 15, which isn't shown on here -- I won't read it out, but, for context, Number 10 had proposed a line saying "Testing does not work" and Chris Whitty

had said, "Okay", and Vallance had said, "Not correct, the test does not work on people with no symptoms."

So there was a disagreement of nuance between the two key scientific advisers, and it was resolved in this text exchange that they both agreed on the language, which is that tests are not reliable, and for the reason that Chris Whitty had set out at 10.36 on this exchange.

That was the position I had been advised. It was the position I understood. I had a full understanding of this throughout, and including as the scientific advice changed.

The -- but it was -- to give -- you know, this is totally reasonable that two scientific advisers might have a slightly different nuance in view in what was an area of huge uncertainty. But -- so what I did, which was the right thing to do, was I asked for formal scientific advice:

"Can the scientists please clear this up urgently."

And Chris Whitty said:

"Patrick and I will do a joint note not on WhatsApp on testing."

So I was therefore content. The line I'd been using, which is that testing isn't reliable, was agreed by Patrick and Chris, and I asked for a full note on -- to explain exactly what the position was, because there

was clearly distinction between them on whether -- on the exact nuance around this, and this phrase does not work, which is a colloquialism for "is not reliable and shouldn't be used".

And Patrick then did not raise this subject with me for another month, and so I continued to use the agreed position. And then a month later, on 13 April, I -- or the early morning of 14 April, Chris Whitty told me that their advice had changed -- which was good. This was after some CDC work on asymptomatic testing. So I had a full understanding.

I have subsequently discovered that Patrick now thinks that I was confused, but he didn't mention that at the time.

Q. So, plainly, what this exchange is capturing is what -- a difference of opinion between the Chief Medical Officer and the Chief Scientific Adviser about a very important position, would you agree --

A. I think that's slightly overplaying it. It's a difference of nuance, because everybody agreed that all the advice to me, from PHE, from CMO and CSA, was that the tests were not reliable, and therefore shouldn't be used on people who were asymptomatic. That advice changed on -- to me, on 14 April, and I was -- as you, if you care to look at them, can see in the text

message around that time, when I got that news from Chris Whitty, I was delighted, because it meant that we could use tests reliably on asymptomatic people.

And, you know, policy has to be based on scientific advice. It is harder, as a decision maker, when the scientific advice is not unanimous, but you have to work your way -- you have to make a decision given all the information you have.

The further context I'd put into this is that throughout this period, until the middle of April, the formal PHE advice, scientific advice, was that asymptomatic testing was not reliable. And therefore it would have been very unusual for me to have overruled that scientific advice and said that yes, they are reliable, when your formal advice is that they're not.

Q. Thank you. And, Mr Hancock, obviously you've clarified the issue here is around whether the test is reliable for asymptomatic --

A. This is all about whether testing people without symptoms is reliable, yes.

Q. And that's why I want to just be absolutely clear about, as of March of 2020, had you appreciated that the coronavirus was being transmitted so asymptomatically?

A. Yeah, oh yeah, I had a big worry about that. But again, the clinical advice took a long time to conclude that

that was happening. So in January 2020 I was very worried about asymptomatic transmission. This is -- irrespective of the testing of it, this is whether the virus could get from one person to another person if the person -- throwing off the virus didn't have symptoms.

I spoke to my international counterparts, I spoke to the head of the WHO about this subject. I was very worried about it. The formal advice I was given was that the previous known coronaviruses that affect humans are not transmitted asymptomatically and therefore we should assume that this one isn't either.

But I kept challenging this advice all the way through this period, but the global consensus was that asymptomatic transmission was not proven and that policies should be based on an assumption of no asymptomatic transmission.

On 2 April, the CDC published its first advice that -- its first evidence of asymptomatic transmission, concrete evidence. And I acted on that immediately, and we -- I formally got the advice, again, on 14 April that -- I got the advice from the CMO -- I say the word "formally" because the PHE formal advice didn't change for another couple of weeks, but we'd started making government decisions based on an assumption of asymptomatic transmission, from 14 April.

So I was involved in this debate throughout. I understood the distinction between that there wasn't a "Yes" or "No" answer to this question during this period. It was totally unknown globally. There's various people who have since said, "Well, I was saying that there was asymptomatic transmission."

The key decision makers were discussing the issue of asymptomatic transmission, but the formal advice was that we should not base policy on an assumption of asymptomatic transmission.

Q. Mr Hancock, then, can I ask you, because a difference of approach of understanding seems to be clear from this.

When -- you've now told us, and we'll come to look at the text exchanges of 14 April.

A. Yes.

Q. But was it not essential that you had clarity on that position --

A. But we didn't know. It was a global pandemic with a novel pathogen. You can see from this, Patrick and Chris disagreed -- on a nuance. We came to a view in this text exchange, which is "not reliable", and Patrick there is confirming "Agree, not reliable", and that was therefore the basis of policy until I was advised by them of a policy change a month later.

But the thing that frustrates me looking back, and

especially since I've been accused of being confused, which I obviously wasn't, and this text exchange demonstrates it, is that I asked for advice from Patrick on 11 March and I received it on 14 April.

Q. Mr Hancock, can I explore with you, then, as to whether you thought to cast your net wider for the advice -- (overspeaking) --

A. Of course. No, no, absolutely. I was talking to -- I talked to Jens Spahn in Germany. I spoke to Roberto Speranza in Italy, I spoke to Tedros at the WHO. This was a subject which was much debated.

Q. Can I --

A. Hold on -- if I can just finish my sentence. The challenge is, what do you base your policy on? And I had this problem that the formal advice was as it was until it changed. And you can -- if you go to the text, when I am told on 14 April, it's INQ000093326 --

Q. Mr Hancock, I --

A. If I can just finish -- at 8.16 am, Chris Whitty has done -- from me to my team:

"Chris Whitty has done an evidence review and now recommend the testing of all going into care homes and segregation whilst awaiting results."

Q. Mr Hancock --

A. "This is obviously a good positive step and we must put

it into the document", ie, into policy, so --

Q. Mr Hancock, please don't worry at all, we will display the exchanges so it can be fully contextualised --

LADY HALLETT: We will get through it much quicker, Mr Hancock, if you trust Ms Cartwright. She knows what she's doing.

THE WITNESS: Hmm.

MS CARTWRIGHT: What I am going to consider with you because we're going to look, as well, at letters that were being sent to you from the Crick -- (overspeaking) --

A. Yes.

Q. The Crick had -- were developing, they had developed their test --

A. Yeah.

Q. -- and they were testing, essentially on your doorstep in the London area and they, when they were doing the testing in conjunction as part of the consortium, had identified very clearly on PCR tests that there was clear evidence of asymptomatic transmission that was being picked up on their PCR tests.

A. Mm.

Q. So --

A. What was the date of that?

Q. Well, we'll look at that together and we'll look at the letter.

A. Okay.

Q. And I think you had knowledge of the Crick's work because, in fact, we'll look together at one of the documents, I think, that was published where, essentially, the Department was saying about good things that the Crick was doing.

A. Yeah.

Q. And so at any point, after 11 March, did anyone give you any of the information --

A. Yeah.

Q. -- as to what the Crick had identified; that they were picking up that there was asymptomatic transmission on PCR tests?

A. The -- there was a continued debate in this period, and I -- my initial concern from January continued all the way through this period. I don't recall the specific pieces of evidence. If the letter you're referring to -- well, maybe we should go to the letter.

Q. Well, we'll go to the letter. What we'll do is we'll -- can we just look then, please, together at the scaling-up document where the work of the Crick is identified and then we'll go together to the exchange and then the letter that was also sent on 14 April.

In fact, I know that the messages are important. Let's deal with the messages first and then I'll look at

the policy.
A. Sure.
Q. So please can we display -- first of all, can we display please, INQ000292606. No, I do apologise, INQ000093326. I do apologise.
A. Okay.
Q. That's INQ000093326.
Apologise for the delay, Mr Hancock, because there have been late additions, we are not as agile as we usually are with the exchanges.
So it should be INQ000093326.
LADY HALLETT: You're getting a message that we don't have it loaded.
MS CARTWRIGHT: Well, we'll deal with this as a topic, Mr Hancock.
A. Okay.
Q. We'll deal with it as a topic, as a piece, after the break when it's been uploaded.
A. Okay.
Q. Let's go to the letter from the Crick, then.
A. Okay.
Q. And it's evidence we've heard last week from Sir Paul Nurse, that the letter that was sent to you from himself, please. If you just allow me a moment.
It's INQ000587060. That's INQ000587060.

And Mr Hancock, the full context of this letter will be understood when, after the break, we've gone through the text messages you want to detail.
A. Yeah, okay.
Q. Thank you.
A. The critical thing to note is, I guess, in terms of timing is they are both -- this is sent on the same day as the advice changed early in the morning.
Q. Understood, Mr Hancock. But it's right to say that certainly Sir Paul Nurse had been seeking to make contact to share the work of the Crick from February onwards, but this is the formal letter that identified what they had found. And as you can see, Mr Hancock, the concern in particular with this letter was that what had been said on April 6 at the House of Commons select committee, and it details this:
"We followed the Committee's debate on the adequacy or otherwise of testing capacity within the NHS, but were surprised that, as far as we could hear, no mention was made in that assessment, of the need to test asymptomatic or oligosymptomatic individuals, be they healthcare workers or patients. This is of great concern in view of emerging evidence that a high proportion of infections are asymptomatic, obviously entraining a high risk of transmission between and among

healthcare workers and patients."
A. Yeah.
Q. And then we can see it goes on to say:
"We assume this has already been debated amongst [His Majesty's] -- Her Majesty's, at that time -- government advisers and you might feel that appropriate responses have already been considered. However, there are several reasons for our concern and for writing to you directly in this way. These are as follows ..."
And you can see.
A. Yes.
Q. "Our perception is that, at present, there is reticence about doing more widespread testing of healthcare workers. It will clearly be expensive and yet another challenge for hospitals that are already under pressure. Some have privately expressed their concern that making a positive diagnosis in asymptomatic healthcare workers who might otherwise continue to work will deplete staffing levels at a time of need. Whilst perhaps understandable, these concerns are not productive in terms of the overall goal of controlling the epidemic. Rather it will result in recurrent problems of seeding fresh outbreaks with staff absences and the potential for infecting non-Covid patients in the healthcare environment."

A. Yeah.
Q. "Importantly we consider that these concerns can only be overcome by a clear central directive from you as Minister."
A. Yeah.
Q. And then you can see it goes on to identify the operational issue.
A. Yeah.
Q. And repeated testing for healthcare workers:
"We are concerned that this may not have been fully appreciated. To avoid delays, it is essential that this is done in parallel with the development of testing capacity itself."
And again we can see:
"The most accurate interpretation of testing results is only likely to be achieved by systemic repeat testing in vulnerable groups. Such data collections will be essential for accurate assessment of whether and for how long a particular titrate of antibody against a partial viral antigen is indicative of protective immunity."
A. Yeah.
Q. And then over the page, please, you can see the conclusion and in particular:
"Our concern is that if this is not done, the current initiative to expand testing itself will not

achieve the desired effect and the 'breathing space' potentially achieved by the 'lockdown' will not have been used effectively."

A. Yeah.

Q. So can I ask you, did you receive this letter from Sir Peter Ratcliffe, Dr Sam Barrell, and Sir Paul Nurse?

A. I don't recall seeing it at the time, but in a way, I am not surprised. It would have gone to my correspondence unit and they would have read it, and I agree with all of it, and we were already acting on these points, and you can tell that by the fact that we were, on that very day, the day this was written, we were already acting on the, as he puts it, the emerging evidence of asymptomatic testing, and you've got to recall the timing is absolutely critical here, that the CDC had come out with the first concrete evidence just under two weeks before on 2 April.

And I've -- since this was --

Q. Mr Hancock, can I just pick you up on that. So you've just identified that the CDC had picked up on the first concrete evidence of 2 April --

A. Published about the first concrete evidence, yes.

Q. So with that answer, can you help, then, why that had not resulted in action before 14 April?

A. Well, we had -- the moment that the CDC publication came

out, we took immediate action to consider the impact of that on all the policy that we had, and the publication with respect to asymptomatic testing and care homes, as you can see, I was -- the formal advice was changed to me, following Chris Whitty's evidence review on 14 April. So 12 days later.

This letter, I understand having -- I was a bit surprised to see the reference to it on Friday, because I knew that Paul Nurse was talking to Lord Bethell, who was my junior minister on this area and was absolutely brilliant throughout this period, and I've since discovered that the day after this letter was sent, Paul Nurse and James Bethell had a discussion about it.

So the letter was clearly acted upon within the department despite the fact that, as you can see from the other paperwork, all of the points in it were already under consideration at that time.

So essentially, my reading of it is that the team at the Crick, the eminent scientists, had come to essentially the same conclusion in essentially the same period of time as Chris Whitty had, and we were acting upon those, upon the new evidence and the insights in the letter already, and therefore my -- the team in the department must have decided not to put the letter up to me because it didn't contain any new information.

Q. And you've identified that these are eminent scientists, both Sir Peter Ratcliffe and Sir Paul Nurse are Nobel Laureates. Was that known and appreciated by you in April of 2020?

A. Well, of course it was, but it was also irrelevant. What mattered, given how unbelievably pressured everybody in the system was, was: is there new information, and how credible is that new scientific information? And from what I've read of the paperwork, that which I was aware of at the time, and that which I was not aware of at the time, it wasn't my decision not to see the letter, obviously. But it was the correct decision not to show it to me because it didn't bring any further insight, over and above that which Chris Whitty and Patrick Vallance had already brought to me in doing, as Chris put it, the evidence review, and therefore changing policy.

So what happened, my summary of the timeline here is that evidence accumulated of asymptomatic transmission. The CDC publication on 2 April was critical. As it happened on the same day, the WHO reiterated its position that there was no asymptomatic transmission, so you've got to think about the global context here. We acted immediately upon that new evidence. Chris Whitty did an evidence review and 12 days later he came forward

with his evidence review. It took into account the points made by these and many other, no doubt, eminent scientists, and on 15 April, so the day after the evidence review was concluded, we changed the policy.

I think, having considered this and looked back on it, would it have been better, with hindsight, to have assumed asymptomatic transmission from January? Yes, because there was asymptomatic transmission. Were we on that issue all the time considering all the evidence? Yes, we were considering it, we were debating the exact nuance of how to describe it. And as soon as the concrete evidence came through, we then changed policy within 12 days. That's what happened.

Q. Mr Hancock, you've characterised that it was the right decision for this correspondence not to be placed before you.

A. Yes.

Q. But particularly Sir Peter Ratcliffe is one of the preeminent experts in this area.

A. Yes.

Q. And set against a background of you having had conflicting or differing advice on a key and important issue of policy, at the very least should this letter have not potentially supported you reaching out to these eminent Nobel Laureate experts to seek their input or

views to assist you in decisions of policy and strategy?
A. I guess the answer to that question explains why the contextual piece at the start of this discussion was important, because on 14 April, I'm driving the vaccine push, we're in the middle of the work to reach 100,000 tests. We are a month into -- no, we're three weeks into lockdown, so the number of cases will just have been turning. We were working on the -- expanding the Nightingale project to ensure that there was bed capacity -- which was used, by the way. An often forgotten fact.

So these people are wonderfully eminent scientists and their scientific evidence was taken into account by my scientific advisers who had, by the time the letter was completed, had already taken the evidence contained with it into account and put it into government policy which we published the next day.

So, you know, I could have spent my whole pandemic corresponding with former Nobel Laureates. They're amazing people. They've done incredible work. But to complain about the actions of the correspondence unit when they got a call from the minister the very next day, I think is a bit much.
Q. Can we then look at the response that followed on 6 July, please, INQ000587061.

Obviously it was a letter that was not sent back by you, so INQ000587061. So 6 July 2020. This is the response that was received by Sir Ratcliffe, Sir Nurse, and Dr Barrell.

Can you assist as to, firstly, why it took until July for the response to what were clearly concerning issues for the Crick to be responded to?
A. Well, obviously you're not calling the Departmental Correspondence Unit but in their defence -- and I feel quite strongly about this -- in their defence we were unbelievably busy, there was a global pandemic, and the amount of correspondence that the department received increased enormously, and critically, most of the jobs that most of the people in the department were doing at this point directly affected how many people died. How quickly we replied to eminent scientists and their team on matters that had already been taken into account, were already in the scientific advice, were already in the government policy, was not going to save anybody's life.

I apologise profusely if they are upset by how this happened, but I think -- personally, I think that getting a phone call from the junior minister and having continued engagement with the team over that time, that's what matters.

Q. Mr Hancock, just to complete the issue, and then I'll take you to the document, the reference is the Crick, are you able to help as to why this correspondence responding made -- didn't address at all the issue that they had been raising and flagging around the issue of asymptomatic transmission?
A. No, I've not seen this letter before today, but -- all I can reiterate, and I'm sorry to bore on about this, is that, in the department, what we were doing was everything we possibly could to save lives. If something didn't have an impact on saving lives, it wasn't a priority.

And of course there were many bruised egos in this whole process, but my total focus was on saving lives. And the team would have known that, and -- you know, that's -- and that's -- that's the answer. We got the information that we needed. There was engagement with the appropriate person. And no doubt there was engagement with the scientific team with Chris Whitty. I know for a fact, because I've seen it, there was engagement with the junior minister. This Inquiry should be about how we respond next time, not how the correspondence unit acted during the -- (overspeaking) --
LADY HALLETT: Can I just interrupt, Mr Hancock. You said

there are bruised egos. With respect, the evidence of Sir Paul Nurse wasn't about his ego or that of Sir James Ratcliffe, it was about their expertise and their skill that they're offering.

Now, I understand the arguments you made, I just wanted to correct the bruised egos point. That wasn't the point that was being made.
A. Well, in that case, how it was put was very unusual, because what matters is, if they had valuable additional evidence, that it was brought to bear. Right? And they were engaging with my scientific team, they were engaging with my ministerial team, the information was already being taken into account, it was already being put into government policy.

You know, we had endless people writing to us saying, "We have this insight", "We have that insight."

What mattered was the quality of the insight, not the number of letters after people's names.
MS CARTWRIGHT: Mr Hancock, this not an issue about a correspondence, this is about expertise in London that had identified that asymptomatic healthcare workers did have Covid. They had identified it on the tests that they were running, and they had sought, from February onwards, to communicate that, and then, latterly with this direct letter to you, with a desire to influence

and change policy and strategy. So it's not about correspondence or egos.

A. Well, you say that, but this letter, the incoming letter on 14 April was written after the contents of the letter had been inculcated into government policy, so I just don't know why we are getting so caught up on it. If you have evidence that they -- that the Crick had concrete evidence of asymptomatic transmission in February that I don't know about, then I wish I'd known about that at the time. It wasn't brought to me.

I don't -- I haven't seen any of that evidence and I think that's because there wasn't evidence. Right?

And so the point of hindsight is to tease out what matters and what doesn't for the future, for lessons for the future. There was, of course, anecdotal unproven evidence of asymptomatic transmission. I knew about that in January, not February. The official advice, and the global position on this, remained that there shouldn't -- that that there is no proven asymptomatic transmission.

It would be perfectly reasonable to conclude from this that in future we should assume asymptomatic transmission, whether or not we have evidence for it. That's worth having. The argument that is implied by this whole last 15 minutes is that somehow somebody

eminent, who had won a Nobel Prize, knew something and we ignored it. It's just not true. It's not what happened.

Q. Mr Hancock, then with a view to building on views that might assist recommendations, let's just briefly look, please, at the guidance that was issued by the department, please.

INQ000566086, please, which is guidance from the Department of Health and Social Care of 8 April.

Thank you.

So this is obviously a guidance document but within the document, if we could just move forward, please, to page 11, one of the annexes to the document was detail in setting out the work of the Crick Institute. And so one of the first things I just want to touch upon, then, was there then a lost opportunity for proper engagement and liaison with the department to then harvest the important research and outcomes that the Crick had identified, and particularly where the Department itself was relying upon the Francis Crick as the work that they were doing?

A. No, not -- unless you've got evidence of that, I don't think it's possible to conclude that.

Q. Then can we use, then, this to build on, I think, something you do have a view about, because the Inquiry

has heard evidence from a number of professors, including Sir Paul Nurse, that there was a missed opportunity here to -- as part of the scaling up, to utilise the laboratory network that existed --

A. Yeah.

Q. -- for places like the Crick?

A. Yeah.

Q. We've heard evidence from Professor McNally about the ability and availability that existed in university laboratories.

A. Yeah.

Q. And with a view to address this evidence through the prism of recommendations, can we seek your views as to that utilisation in a future pandemic of the wider network of laboratories that exist that could do the PCR testing, please.

A. So I think this is a really, really important question, and if this module of the Inquiry concludes any one thing, the single most important thing is to conclude that the industrial scale expansion of testing is necessary, and we need to be ready to do it.

And I put this point very, very emphatically, because there are, entirely understandably, people who say that the disaggregated scientific, PHE and NHS facilities should have and should in future be used to

scale up to deliver the testing programme.

The challenge, as per our discussion right at the start of this session, is that the degree of scale-up needed is of a wholly different order to what is possible --

LADY HALLETT: I'm going to stop you there, Mr Hancock, sorry, because (a) you've made that point before but the point that Sir Paul Nurse was making was different. It's not that you don't need the industrial scale --

A. The big one as well.

LADY HALLETT: -- what he was saying was: did we sufficiently utilise the existing local network --

A. Yeah, yeah.

LADY HALLETT: -- whilst we built --

A. Yeah.

LADY HALLETT: So that's the point that --

A. Okay, that's totally reasonable, and the answer is we continued to use the disaggregated local area. It was Pillar 2 of the testing programme. And they continued to scale up slowly in the same way that they'd scaled up slowly from mid-January, when the tests became available, to mid-March when I took responsibility and we started building the mass testing.

So the answer -- he's absolutely right, that we should continue to use it, but to -- but nobody should

argue, or we certainly, in my view, shouldn't recommend that that should be the main focus. It's just not -- it's just not possible.

Some people have said we should have done -- put more into that area, but -- I would have liked to put more into every area, but the area that was delivering the scale-up at the speed that was needed was the industrialisation pillars, essentially. I think Pillar 4, because Pillar 3 was the antibody testing. The -- that is what is necessary.

And it's totally understandable. I understand that how -- if your testing unit is expanding a bit and making a contribution, then you feel like you should do that even more. Well, yes, but if there's a great big factory over here that can radically increase capacity, that's understandably and correctly where the focus was.

MS CARTWRIGHT: Mr Hancock, then can I explore with you whether there was thought given to what was possible and capable in the existing laboratory network.

Sir Paul Nurse has indicated it would have been -- they would have had an ability, improving on the sort of 3,000, 4,000 tests that they got to, to get pretty quickly to 10,000 tests.

A. Well, great, but we needed 300,000 tests.

Q. Let's look at this through the target that you set at

the end of the April to get to 100,000 --

A. 100,000 tests, yes.

Q. So, in terms of the speed to get there, if that was the target --

A. Yes.

Q. -- the example given is that you only need ten such laboratories, at that time, to get to your figure. And on top of that, we've heard evidence that the university network, so the 40 or so universities that have laboratories -- with a connectivity to the local hospitals and for the data to go across -- they also were preparing and ready to scale up to provide thousands of tests also, but that was brought to an end when essentially their PCR equipment was collected following the email of 19 March from Jeremy Farrar.

A. Yes.

Q. So at any point when you were seeking to achieve the 100,000 as quickly as possible, that was needed urgently, did you give a thought to the alternative --

A. Yeah.

Q. -- which was being offered by individuals such as the Crick and --

A. Yeah, of course we did.

Q. -- and the university network?

A. Of course we did. That's what we'd relied on for two

months before the middle of March. And even on the figures you've just given, if a lab doing 3,000 had managed to get to 10,000, that is a 2.5 times increase, and it's laudable and it's great, but we didn't need a 2.5 times increase. I'd asked for a ten times increase over one month, and we then went to 200,000 the next month.

So it's absolutely reasonable, laudable and great that they continued working in that direction, and they did, and they continued what I would describe as a linear expansion of the capability; what we needed was an exponential expansion of the capability. And when we moved to an industrial-scale system, that's what we got.

And it's no surprise that the people involved in doing the disaggregated approach support the disaggregated approach. Of course they do. And they threw themselves at it, and we should all be very grateful for that effort.

It made a contribution. It was just that we got a far bigger contribution in the systematised, industrialised process.

And just think about it in, sort of, basic process engineering, right? Universities are not designed for Henry Ford-style throughput, and that's what we needed, and that's what we built.

Q. And then finally before the break, and after the break, Mr Hancock, to give you the assurance, we'll go through the messages of 14 April, but again, on the decision that's made, then, to move to the industrial scale and the first four Lighthouse laboratories that came online in April --

A. Yeah.

Q. -- necessarily, creating this vision was not going to happen overnight. They had to be equipped, resourced with both the skills and expertise. And was any thought given that, rather than simply taking the equipment from places where they could continue to provide tests into the system, that a better option would have been to time when the equipment moved, because essentially there was no, then, test, because you've removed the test from where there was the expertise and the skills when the machines were taken --

A. No, we didn't --

Q. -- to be placed in the Lighthouse laboratories?

A. No, we didn't. We didn't not have tests then. We increased the number of tests. So it's a totally reasonable line of questioning, so long as we don't think that it's the only answer, or a valid critique of the system as a whole that was built.

Of course there's an impact. If a university lab is

doing, you know, a few hundred tests on a PCR machine, and you essentially requisition the PCR machine and you put it into a factory setting, then of course you get -- that university can't do the test. I understand that. And we took the people with them in some cases, but the machine is there in the factory setting doing more tests.

So this is --

Q. That's the issue, Mr Hancock. It wasn't.

A. No, but --

Q. It was a time before it then scaled up.

A. That's simply not reflected in the figures. The figures are that the number of tests increased during this period. There was -- it's absolutely true that it increased slowly during April as we built the system, and then exponentially towards the end of April, but, please, please, if this Inquiry concludes that what we need is a, next time round, is a -- that to use the disaggregated system because the voices who advocate it are eminent scientists, there is a totally different capacity between scientific inquiry and industrial-scale testing, and if we make the wrong conclusion for the nation on this, then we -- then whoever is in my shoes next time round will take exactly the same decision that I did, but instead of preparing for the mass

scale-up, there will not have been the preparation done.

LADY HALLETT: I have that well in mind --

A. And that will be a mistake.

LADY HALLETT: -- Mr Hancock.

MS CARTWRIGHT: My Lady, is that a convenient moment?

LADY HALLETT: It is. I shall return at 11.35.

(11.17 am)

(A short break)

(11.35 am)

LADY HALLETT: Ms Cartwright.

MS CARTWRIGHT: Thank you.

Now, Mr Hancock, we've got the exchanges relating to 14 April now ready to go, and with great gratitude to the Relativity operator in the room.

Can we start, then, please, by displaying INQ000093326, please.

Thank you. And can we go to page 3 within this document, please, and if we can look at the entry timed at 8.16. Thank you. We can see there, Mr Hancock, you're the owner of the cellphone; is that correct?

A. That is right, yes.

Q. Thank you.

We've got:

"Chris Whitty has done an evidence review and now recommend testing of all going into care homes, and

segregation whilst awaiting result. This is obviously a good positive step & we must put into the [document]."

So is this the new information that's being brought to you on 14 April that you've been telling us about?

A. Yes. And I'm sorry that in my evidence before the break I was a bit emphatic.

But in a way, this message sort of encompasses that, which is that we'd had this enormous frustration over the evidence and the formal evidence, and finally, after all of that, which I sort of slightly relived in the previous session unintentionally, finally, on 14 April, I get the formal evidence review from Chris Whitty that recommends testing of all going into care homes, and this is something that I had wanted, worried about from the start, but had not had formally advised to me, so you can see it here that there's a sort of sense of release and relief that, finally, what we had been, all of us had had worries about, and I, you know, it was now formally acknowledged, and we could now get on.

Q. Thank you and we can see the questions asked:

"These include all those asymptomatic too, right?"

And if we just go, we get your answer "Yes".

A. Yeah, and Allan saying, "Just checking -- this includes all asymptomatic", so he is sort of -- there's an element of surprise in that, that this is all

asymptomatic cases because of course until then tests have been regarded as not reliable on asymptomatic test cases.

Q. I'm going to move across documents just to capture the timeline.

Can we next, please, display INQ000292604, please. So that was 8.16. We can then see at 9.19 an email from Allan and that's the same Allan in the messages; is that correct?

A. Correct, yes.

Q. Where he says:

"Hi all -- [Secretary of State] has just texted to say: Chris Whitty has done an evidence review and now recommend testing of all going into care homes, and segregation whilst awaiting result. This is obviously a good positive step & we must put into the doc.

"Please can we action this asap?"

So we're just going to follow these through, I don't think that needs any extra commentary, Mr Hancock, unless there's anything else you wish to say about that document?

A. No.

Q. Thank you.

Can we now go to INQ000292606, so we move from 9.19, and at INQ000292606, we're now at 12.14. Thank you.

We can see, an email from Ros. Can you just identify Ros's role, please.

A. Yes, Ros Roughton was head of social care policy at the department.

Q. Thank you, and we can see she details in this email:

"Dear all, in light of the prevalence/transmission of Covid in care homes, the [Chief Medical Officer] has asked us to move to a policy of:

" -- Testing all individuals before admission to a care home.

" -- Testing all symptomatic residents in a care home.

"This will be announced tomorrow as part of the social care action plan publication.

"Hitherto, local [Public Health England] health protection teams have been undertaking some measure of testing in care homes. But it is clear that there is insufficient capacity to do this at the scale now asked, and we will need to develop a different operational model to deliver this new ask. I don't know realistically what that is, but I am copying you all as people who might be able to help generate ideas, and help us access, eg community health, [Care Quality Commission], the testing community."

And then we can see a little further down:

"Please can you set up a meeting this afternoon, if possible, of people on the copy list, or people they recommend," and then we can see the suggested agenda, scope of new tests being asked.

A. That's right.

Q. Thank you.

Can we move then from this email timed at 12.14 to INQ000292606, which is a readout of that meeting, which is at 13.44.

So INQ000292606. Thank you.

Sorry, I do apologise, I've been a rogue -- INQ000292605. I do apologise. Sorry, this is the readout of the meeting at 1.44.

If we just go down -- thank you -- we can see:

"Ros updated that we have agreed with NHSE and local [government] wording on discharges in light of CMO testing wording. A lot of work to operationalise, looking at getting nursing staff to take swabs in care homes. [Secretary of State] said we need to ensure the nurses are in PPE or have been tested. MS(C) noted the wording on whether testing is on admission or discharge is a bit confusing."

And then again:

"Action: team to clarify wording on testing."

Again, is there anything extra commentary you wish

to give in respect of this email or is it simply to ensure we've captured the chronology?

A. No, it makes sense. The key point of this is that the new CMO advice came in that morning. By lunchtime we were turning that clinical advice, operationalising that clinical advice, taking into account the constraints that Ros put in her previous email, the availability of testing for instance, and all in the context of them publishing the government policy the next day.

Q. Thank you.

And can we move, please, to INQ000093326. So we are now at 5.23 on 14 April.

That's INQ000093326.

I think in this exchange it's the update around what had happened in the meeting, and the change to the decision on testing.

Mr Hancock, is there anything else in respect of this exchange you wish to highlight?

A. No, so this is just merely a distinction between the advice was to test those going from hospitals into care homes, and there was a debate about whether to also say that in the future we would test those going from the community into care homes, and we decided only to say the former until we were confident that we could do the -- to do the latter, but it didn't make a policy

change; it was merely about whether we would forward indicate the testing of those from the community.

Q. Thank you.

Can we then move to INQ000292608, please.

That's INQ000292608. Thank you.

We can see this email is 6.49 in the evening. If we can scroll down, please, this another email from Ros Roughton, where again we can see she identifies:

"I have just talked to Ed in [Secretary of State's] office about this, informed by a meeting with PHE, CQC, NHS E and others from testing world on how we operationalise this.

"We agreed

"- We can press ahead straight away with hospitals testing patients who are going to care homes."

Then we can see the aspiration:

"We think the numbers on this are under 8,000 a month.

"It's really important that we keep this aspiration in, as we need to build care home confidence that we are doing our best to help them keep their residents safe -- and this will be an important part of it. This was also the advice earlier today via [the Chief Medical Officer]."

A. Right.

Q. Thank you. Then if we move, please, to the next paragraph of the chronology.

INQ000292609. Thank you.

We're now at 8.12 in the evening, and we can see essentially again a recording that:

"We agreed that on expanding of testing to all residents of a care home where an outbreak is suspected/confirmed the next steps by close tomorrow are ..."

And then we can see, again, that through.

And again:

"We agreed that on the policy to test all hospital patients ahead of discharge to a care home:

"Discharges are estimated to be c500 per week ..."

A. Yeah.

Q. So, Mr Hancock, is there any other context we need to consider on this email as part of the chain that went to the policy change on 14 April?

A. No. I guess what it shows is the -- simply the speed of action from the policy change -- the advice change first thing in the morning, through to here we are at 8 o'clock at night with the team putting together the details of how this can then go into action.

Q. Thank you. And finally, then, just to complete the point of the chronology, INQ000292611, please.

Thank you.

So we're now at the following day at 10.07 in the morning. Again, Ros to the various recipients, but again we can see:

"Hi Natasha ..."

And then the detail, essentially detailing that:

"[They] want us to restrict the testing of patients in hospitals going to care ..."

So let's just identify, "NHS England (Simon)" --

A. That'll be Simon Stevens.

Q. Thank you.

You say:

"[They] want us to restrict the testing of patients in hospitals going to care homes, only to those patients who are going to care homes for the FIRST TIME, not those who are returning to their care home. They are concerned about their operational capacity to do that as they are trying to establish how many people are admitted from a care home.

"I think in policy terms, we should be committing to testing everyone going into a care home from hospital.

"Any" --

A. And that's what we did.

Q. "Any thoughts on handling?"

Thank you.

And so, Mr Hancock, I said we'd go through the wider exchange that you were anxious that was properly considered when you had that change of advice from Mr Whitty.

A. Yeah.

Q. Is there anything else before we move to the last number of topics that I wish to consider with you, be ...

A. No, I think that takes us through the chronology on that.

Q. Thank you.

Then can I ask, again on asymptomatic workers and testing, one of the issues that's been explored with a number of witnesses in this Inquiry is then the fact that Wales then implemented the policy at a later time to England, a couple of weeks later, but also there'd been some reference or suggestion that there was no value in asymptomatic testing. Can I ask you, having gone on the journey you've told us about, particularly through March and April, do you have any views about, at a later time, sort of two weeks on, a position being adopted at a different devolved nation that was still saying there's no value in this?

A. Yes, well, I do remember the First Minister of Wales saying that you shouldn't test people who are asymptomatic, a bit later, and I remember thinking we

need to make sure that he gets the updated advice that I've seen and -- but I didn't -- I can't remember being any more involved than that.

Q. Thank you.

Now, Mr Hancock, I'm going to deal with Lord Bethell because he was essentially tasked with the scaling up from 17 March --

A. Yeah.

Q. -- when the decision was made to move towards the mass testing approach. So please know that that chronology will be dealt with with Lord Bethell.

A. Yeah.

Q. But can I ask you, then, just if you can do it in a compact way, we know that PHE was essentially disbanded and it moved, then, into essentially what became NHS Test and Trace and then UKHSA.

A. Yes.

Q. Is there anything else particularly that this Inquiry should consider as to that decision for you to disband Public Health England?

A. To disband them overall?

Q. Yes.

A. Well, that was a decision taken in August of 2020. The reason to do it was to ensure that -- it was really about preparedness. It was about making sure that there

was a body whose only worry was to prevent communicable diseases, and to keep up the fight even when there wasn't a pandemic on the horizon. Like now. And a group of people whose job and the -- where the leadership of the organisation had a job to wake up every day worrying about the next pandemic.

Q. Thank you.

A. There was a debate about to be whether we should do that in August 2020, given that the pandemic was still ongoing. There's a perfectly reasonable argument that we should have waited. But it was clear to me that we needed to take the action, and we also needed to find a permanent home for NHS Test and Trace.

Q. Thank you.

Mr Hancock, there's a number of topics I just need to deal with, so they -- they don't follow a particular order, but -- so please just bear with me in talking --

A. No problem.

Q. -- to these topics.

Now, the Inquiry has some evidence that we are going to hear later, so I want to give you an opportunity -- we're going to hear from Professor Pillay on the last day of the Inquiry, and essentially he has summarised that you conflated tests available with tests undertaken.

Can I ask, regardless of your intention, do you accept that this inevitably risked creating public confusion, particularly when you were making daily statements that gave the impression those tests were actively being used to protect lives?

A. No, we published both the availability of tests and the total number of tests done. So I -- we went out of our way to try to ensure clarity on that, and we put quite a lot of effort into precisely designing how that was published to try to minimise anybody conflating the two.

Q. Thank you.

And, again, the source of this question is also from Professor Pillay's statement, which I know was provided with the pack.

A. Yeah.

Q. He also notes that:

[As read] "Both virus tests and antibody tests were counted towards the target, despite antibody tests providing no useful information at that time."

Are you able to assist us with why tests with no diagnostic value were included in a figure being presented as a measure of pandemic control?

A. It's not quite right to say that antibody tests did not matter at that time, because it was absolutely critical to have enough antibody tests to do the survey that

later both Lord Ara Darzi and the ONS put together, to understand how many people had the antibodies, because at that point we didn't know how much of the population had been exposed to Covid and whether enough had been exposed that we wouldn't need a vaccine to get out of the pandemic, and it turned out that not enough -- there wasn't enough exposure.

So antibody tests were important.

Of course they were different, but we needed a metric. And the point about the 100,000 target is, in a way, incredibly simple and obvious, which is: it was there to galvanise the system to grow radically. And we slotted all of the different testing pillars, as we called them, into it, because we wanted to measure the overall growth of the system.

And, you know, people have said, you know, that that was done at the expense of what we should have used the tests on or the exact type. The point of the target was precisely to be simple and bold so everybody knew what we were going after. And it achieved that result. And by growing testing, we removed a whole load of the other problems that came from not having enough tests.

Q. Thank you.

Now, my next topic of questions, please, Mr Hancock, is the award of contracts to Randox. You detail the

full context so, again, please know that that will be uploaded today.

Now, if we could, please, have displayed your paragraph 129, please, in the witness statement just so you have it in front of you as I summarise that.

So paragraph 129 of INQ000587294, please. I think it's page 40, INQ000587294. Thank you.

Now you detail and defend the awarding of substantial contracts to Randox by emphasising their role in stepping up during the national effort.

A. Yeah.

Q. But you'll be aware that the National Audit Office recorded that a $328.3 million contract variation was awarded to Randox in October 2020 without competition, more than double the original value.

Do you accept, Mr Hancock, that at the very least, to maintain confidence, a contract of that scale should have been handled with maximum transparency as part of the creation of the test, trace, isolate system, please?

A. In a utopia, yes. But we weren't living in a utopia. People were dying every day, and Randox had the capacity to radically increase the number of tests available, along with the other testing companies. And the idea that these contracts should have been competed implies that we might not have taken them because we were

choosing between companies, which would be normal in normal times, but these weren't normal times.

So we needed to buy in all of the testing capacity that was possible, and testing capacity that hadn't yet been built, and that's why we took the approach that we did. It's a context question, again, because the context was that tests were necessary to keep people alive, and we didn't have enough tests as a nation and so we were buying them from where ever we could get them.

Q. Thank you, now --

A. I mean, look, Randox -- I just want to put on the record my thanks to Randox, who did an amazing job during this period, and they were -- they -- as I put it here, they stepped up, but they really leant into this problem and tried to grow, as did other testing companies.

Q. Thank you.

Mr Hancock, I'm sure you appreciate that these questions are asked in a context of a pandemic but also in the importance of transparency and by reference to the involvement of Mr Paterson.

A. Yeah.

Q. But can I ask you then, please, there were plainly ministerial meetings that were not recorded that have also been commented about. Were you at the time aware

that those meetings had not been properly recorded by references?

A. No, not that I can recall.

Q. Thank you.

Could I next ask, please, to be displayed your paragraph 258.

Mr Hancock, this is the last topic before I'll finally give you an opportunity to say anything else around recommendations.

So paragraph 258, please. Thank you so much.

Now we can see -- this is in the context, please, of just some assistance on the support payments.

A. Oh yeah.

Q. You detail:

"There was agreement at COVID-O to ramping up communication, providing greater funds for discretionary support payments and increasing non-financial support but not despite [your] arguments for making universal support payments."

Now, we know that the 500 figure was available in October 2020, and the question, please, under this theme, can I ask you, you agreed to introduce the £500 support payment for some groups. Do you accept that under that scheme many working people were ineligible, yet still unable to afford to isolate?

A. Yes, you said I agreed. I wanted these to be much more generous.

Q. Thank you.

A. So, of course, I accepted some movement in the right direction but I didn't think it was adequate.

Q. Thank you. And I think there's more detail about that and the liaison with the Treasury in your statement.

Then can I ask additionally, given the strong evidence that financial reasons were essentially causing people not to adhere to self-isolation requirements and particularly when it became enforceable, do you believe that the Treasury was placing politics over public health?

A. That is not how I'd phrase it, no. They had a concern that if you introduced a scheme of universal payments it may be gamed or it may be hard to withdraw afterwards, but their concerns, I thought, were -- they were valid balancing arguments, they were made for the right reasons, but they were, in my view, outweighed by the arguments in favour.

It comes down to the doctrine again. Spending public money to pay people to isolate in order to stop the spread of the virus is not only obviously good for health; it's actually good for the economy because you have to have fewer other NPIs. So my view is that this

would have been good value for money as well as the right thing to do from a health point of view. The Treasury made the argument that they were concerned more about the direct payments. I respect their arguments, and they were made in a respectable way, and I lost that argument inside government, but one of my recommendations would be to have generous universal payments for required self-isolation.

Q. Thank you, Mr Hancock.

Then finally, plainly you've woven through your evidence a number of recommendations, but can we move, please, to paragraph 274 of the statement at page 96. That's 274, page 96. Thank you.

You detail by way of lessons learned and reflections, that the key lesson for the future is that:

"... a rapidly scalable testing and tracing infrastructure should be maintained, ready for urgent expansion."

You say this:

"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 in the event of new variants or an entirely new pandemic."

A. Yes.

Q. And so Mr Hancock, can I ask you, in terms of what we now know that the whole of the Lighthouse laboratory infrastructure has been dismantled, have you any views on that, it being part of the infrastructure that you created in the pandemic?

A. Yes. Think about it practically. You can't have -- it's hard to make the case for permanent large factory settings sat empty, waiting for the next pandemic. That would be, in a perfect world, what you would have in the same way you would have a standing army.

There is a case for it. What there is, in my -- but there is also a case against, because it's expensive. What, in my view, there is absolutely no case against is having a plan and a system ready to go to build those factories, to take the units, to bring in the PCR testing machines, or whatever the latest technology is, and to be ready to go, and to the point you made -- asked about earlier, having the data structures ready with the integrations so that this can all be stood up.

Now, taking the army comparison one stage further, we do have a standing army even though there have been times when we haven't been physically under threat. And considering we spent a drop in the ocean on biological defence comparing to physical defence, there is actually, you know, a good argument to have this system actually maintained. But I can see the case against. What I can't see a case against is having the rapidly scalable testing and tracing infrastructure.

And I reinforce the point I made earlier that of course the disaggregated element of this is a contribution, but on its own, it will not be enough, in the case of a pandemic that is as virulent and transmissible as last time.

MS CARTWRIGHT: Thank you. Mr Hancock, those are my questions.

My Lady, there are Core Participants questions.

LADY HALLETT: Thank you.

Mr Jacobs, who is right over there, Mr Hancock.

MR JACOBS: My Lady, questions on behalf of the Trades Union Congress were regarding financial support for self-isolation.

In fact, given the questions just a few moments ago and the clear answers given, I don't think I need to take your time.

LADY HALLETT: I did wonder. Thank you very much for your helpful position, Mr Jacobs.

Mr Thomas, who is over there as well.

Questions from PROFESSOR THOMAS KC

PROFESSOR THOMAS: Good afternoon, Mr Hancock.

A. Good afternoon. Very good to see you again.

Q. Thank you.

Mr Hancock, I've got a few questions for you. As you know, I represent FEMHO, the Federation of Ethnic Minority Healthcare Organisations.

FEMHO members have reported concerns that in the early stages of the pandemic, there was a lack of tests available, (a) for those working in healthcare settings outside of hot zones, such as porters, cleaners, all of whom have since been shown to have had high rates of exposure and transmission. And secondly, for households of healthcare workers, despite the risk of transmission at home.

So my questions are firstly, were these issues considered when decisions were made as to the prioritisation and rules on who was and who was not eligible for testing in the early stages?

A. Yes.

Q. Can you explain how those decisions were made?

A. Ultimately, I relied on clinical advice on the

prioritisation of availability of tests. The question I asked the advisory team was: how do we prioritise these tests in order to keep as many people alive as possible? And I don't recall deviating from the clinical advice that I was given in making the decisions on testing prioritisation.

What I would say for the future is that it's vital to understand what happened, and the disproportionate number of deaths amongst people from ethnic minority backgrounds, and in the public-facing and patient-facing roles especially within the NHS, and ensure that that learning informs a clinical prioritisation next time.

Q. Well, I think you've just answered my second question, which is what -- looking forward, what you would do differently. And you've answered that.

So let me move on to my third question.

How was data and modelling used to inform the TTI policies and operational decisions during your tenure, particularly in relation to identifying areas or communities at heightened risk?

A. Well, it improved during the whole period, I think is the best summary. We started with very little information, as you know, and the first, the early information was about proven cases and hospitalisations and deaths, because sadly they are the most measurable

things in a pandemic before we had better testing available.

Once we had the various surveys up and running, the ONS survey, the REACT survey, looking at the work of Professor Tim Spector, the -- we had -- that gave us better information to be able to make decisions which were more led by the data.

Unfortunately, I remember very clearly the early data coming through with very strong and clear disparities in terms of negative impact of those who were in these -- in the frontline medical positions. And I say positions because it was, whether clinical or non-clinical, it was about how many interactions you had with patients, ultimately. But the data started off very poor and it got better.

Q. Can I ask you this: was disaggregated data by ethnicity, socioeconomic status or geography used as a guide to guide resource allocation or the targeting of support?

A. Yes, it was, and I would say that we got better at that, and there's a lot of lessons from what happened that can and should be learned that should then go into best practice right from the start. We touched on this, I guess, with the interaction of a national and local testing system, because local capacity, both in contact tracing and in testing, can be better at responding to

and reflecting the community that it's close to.

National systems inevitably find that harder because they tend to be more one-size-fits-all, and that's why an interaction of the two is probably best.

Q. Okay. Were there gaps or any limitations in data collected that impeded understanding of the pandemic's impact on minority ethnic communities?

A. Well, there absolutely were at first, because there was a lack of testing. And I guess this -- the question that you ask, and the implication in it, reinforces the point about the importance of antibody testing as part of our suite of tests. Because knowing who has antibodies as a result of being proximate -- being infected is a really important data point to understand who is being affected over and above the hospitalisations and the deaths data.

Q. Okay. To what extent did the Department of Health and Social Care seek to involve community-led organisations or frontline healthcare providers in interpreting data trends, particularly those affecting minority groups?

A. Again, I think the answer is increasingly. So by the autumn of 2020 and certainly during the vaccination programme, this was a major focus. And we had the data to be able to -- and -- to be able to target the areas that needed extra support, and the data integrations, as

we've heard earlier, to ensure that local teams could see the national data as it affected their area.

Again, we had to build that over time, and it wasn't available at the start.

Q. Were concerns raised by some of these organisations about data blindspots or misinterpretations formally incorporated into the TTI policy responses?

A. Yes, they were. We were concerned about data blindspots, about differing information coming from local and national systems, and not just blindspots but hotspots, as well, areas where there was a huge amount of activity, and that was something we would go through in the weekly gold meetings once they were set up as the high-level management of the TTI system from around September 2020.

Q. Were, and if so what, specific strategies were developed to engage and build trust within communities who historically experienced health inequalities or systemic mistrust of government?

A. Well, again, we built this and got better at it over time. In a way, from my experience and really reflecting on it, the early contribution that I could make to this was simply to acknowledge it. I mean, that was the starting point. And I remember the early press conferences when, you know, the first four deaths of

clinicians were all from people from ethnic minority backgrounds and I talked about that in public.

So at first we didn't have much data to give a rich picture of, or a detailed picture, is maybe a better word, but we could see it with our eyes. And so I tried to talk about it, and then we tried to bring in analysis; some of which was done within government, within the Department, within PHE, within the Government Equalities Office. Also, there was excellent work done externally. Ben Goldacre's work which he published regularly was very impressive, for instance, at being able to highlight these problems.

Q. A couple more questions. The strategies that I was just touching upon, were there any successful strategies, and how were their impact measured?

A. So there were a number of successful strategies, and most of them worked, in my view -- sorry, most of them worked -- the ones that were most effective were the ones that looked at the issue from the lens of the community who we were trying to support. So instead of talking about hard-to-reach groups, we tried to think of groups who feel distant from government. They may be suspicious of government, more so than the average population, for instance, or concerned when the armed forces were used in an execution of a policy, as one

example which came up quite regularly.
I think it's really important that you look at it through the correct lens -- look through the telescope the right way, because otherwise you end up in an ivory tower in Whitehall thinking that people are disconnected and it's not -- and instead it's important to take responsibility for that disconnect and try to do something about it.
Q. Let me come to my last question, I'm going to roll it up because time is short, and it's that issue of structural racism that I just want to return to in this module.
A. Yeah.
Q. So I'll roll up my question in this way. Can you tell us, can you tell her Ladyship what consideration was given to the impact of existing structural racism within the NHS and wider health systems, when you were designing the -- and implementing the test, trace and isolate programme?
A. Well, I think the best way to answer this is to -- is that we were trying to understand and respond to the likelihood of somebody being infected and being very negatively affected by that. And one of the challenges we had in the data was to disaggregate how much of that was due to socioeconomic factors and how much of that was due to biological factors. And we put quite a lot

of effort into trying to work that out.
And a large -- because if this is a structural problem that is because a virus affects people from a given ethnicity differently, then you need to respond to that. If it's because there are more people in, say, groups that are patient-facing, proportionately, then you need to address that. But getting to the root cause of why there is a disparity in impact of the virus by ethnicity, by gender, and by socioeconomic status, is important because you can then only address it if you can understand the root cause of it.
Q. What would you do differently, going forward?
A. Well --
LADY HALLETT: I think that's too broad a question, Mr Thomas, sorry. We've got a huge amount to get through today, I'm really sorry -- and this isn't also a thesis -- so I appreciate how important the point is, Mr Thomas, but I think we're going to have to leave it there.
PROFESSOR THOMAS: Thank you, my Lady.
LADY HALLETT: That completes the questions we have for you in this module, Mr Hancock. Please don't worry about your passionate responses earlier, I do understand, and I also understand the pressure that you and your colleagues at the DHSC were under and it's in that

context and in that light that any findings I make -- I'm not somebody who believes in sitting in a hearing or a courtroom centre in the cold light of day who comes along and says, "Oh, I could have done it better". That's not my way. So please be reassured.
THE WITNESS: That's kind of you to say. Thank you.
LADY HALLETT: I believe we are going to call on you once more.
THE WITNESS: Yes.
LADY HALLETT: But I'm hopeful, pretty confident that will be the final time. So thank you very much for your help this time and I shall see you again, I hope, just the once more.
THE WITNESS: Thank you very much.
LADY HALLETT: Thank you.
Lord Bethell, I'm sorry to keep you waiting but I see you've been following proceedings anyway.
MS CARTWRIGHT: My Lady, could, please, Lord Bethell be sworn.

LORD JAMES BETHELL (sworn)

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 7

MS CARTWRIGHT: Lord Bethell, could you give your full name , please.
A. Yes, James Nicholas Bethell.
Q. Thank you.

Lord Bethell, we thank you for the provision of your third witness statement to the Inquiry but the first to Module 7. Could we please turn to page 58 of that statement, please, where we see it's dated 16 April of 2025. And can I ask you to confirm that the content of that statement is true to the best of your knowledge and belief?
A. Yes, it is true.
Q. Thank you. Now, Lord Bethell, you've given evidence already to the Inquiry twice, and you've already identified, but let's just deal with that now.
It's right, isn't it, that you were, during the pandemic, Minister for Technology, Innovation and Life Sciences, and you are going to help us with the development of that role relevant to test, trace and isolate from 1 January 2020?
A. That's right.
Q. Thank you. And can you just confirm when you ceased to act in that role, please?
A. September 2021.
Q. Thank you. Now, you have helpfully within your witness statement, at the very beginning, set out reflections, which I think are quite helpful to deal with at the outset to give some context to the evidence you wish to give by reference to test, trace and isolate.

Could I ask, please, for page 7 and paragraph 4, please, to be displayed.

Paragraph 4 at page 3. I do apologise, I said 7. Paragraph 4 at page 3. Thank you.

Now, I think you provide your reflections, including the huge sense of pride at what you were able to achieve, from what you've described as a "low base". And would it be fair to say, Lord Bethell, that you are going to assist us today with, essentially, the mass testing that you played a key role in terms of development of for increasing testing capacity but also contact tracing also?

A. Well, I would just add -- thank you for that -- I would just add that there was also airport testing, which was very, very important, and there was also a huge amount of research and surveillance testing, and there was also testing that was done in hospitals.

So I think it's broader than just the mass testing.

Q. I appreciate that, and I think you also, within the statement, deal with the red list.

A. Yeah.

Q. Your statement will be published that gives the full context of your relevant roles relating to test, trace and isolate, but necessarily we're going to focus on the significant role you played for the increase in mass

testing because I think you have got key and relevant evidence that can assist by way of chronology of that matter.

A. I understand.

Q. Can we then have a look at this. You say, as follows:

"I also look back with a mixture of frustration and anger that we were put in a position where the public health doctrine, the public health infrastructure, and the domestic diagnostic industry meant that we started in such a weak position. And that our other policies, particularly the non-pharmaceutical interventions ... and the welfare support, did not work to support the credible objectives of the test-and-trace mission as effectively as they could have done."

Lord Bethell, do you want to perhaps start with being absolutely clear about your views, having essentially worked practically through the pandemic to scale up in the way that you did?

A. Yes, well, thank you very much. I think that a lot of the dialogue so far has been about the management of what I would call the mad scramble to stand up testing. And there has been a lot of dialogue about whether that scramble was done correctly or not, and whether we should have used academic testing or other infrastructure in different ways. I think my point here

is that we shouldn't have had a scramble in the first place. In a 21st century country there should be a priority on basic public health.

Now, we have chosen in this country, quite unusually, to put a huge amount of our resources, about 95% of the £220 billion into either primary care or acute hospitals, and we put a huge amount into life science research, billions of pounds in terms of research funds. And we put a tiny amount, 2%, into public health.

The local public health system, as Matt Hancock made the point, of local directors of public health are tiny. They have minute resources. We have no standing testing facility. Local authorities are -- have very, very small imprint on their local community, and there is very little dialogue between primary and acute care and the public health system.

In other words, the basic foundations of public health are not here in this country, and we will not be able to react to the next pandemic unless the question is asked: why is that the case? And, actually, an investment is made.

In other words, arguments for putting our attention into how to use research laboratories or hospital laboratories better are arguments for the status quo,

for not changing the resource prioritisation of this country. And in order to avoid this happening again, we actually need to change the status quo and move the resources to supporting basic public health infrastructure in this country.

And in terms of the NPIs and the welfare support, which I would be happy to talk about separately if we've run out of time, I do think a degree of coordination between these things is very important. Specifically I think a test and trace system can be extremely effective, but if you're late on every single lockdown, and if the prevalence rate nudges up from half a percent, 1%, 2%, 3%, you're not going to be able to catch up and you'll get a pingdemic, as many of us remember.

So I think that coordination point is very important.

Q. Thank you. Can we move to your paragraph 5, please, because, again, with the task that her Ladyship has around recommendations you tell us in paragraph 5 that:

"... in the last three years we have gone backwards, not forwards. The diagnostic infrastructure is dismantled. The data spine is closed down. The UK diagnostic industry has reverted to a small-scale under-capitalised, science-led cottage industry. Our

public health infrastructure, particularly the local representation is weaker than ever. There is little surveillance of domestic or foreign pathogens, and the social habits around home testing and regular health screening have gone backwards. It is therefore imperative that this module lifts its head from any undiscerning interpretation of the headlines and simplistic anecdotage around testing and instead tackles the more serious issues."

And you then set out, essentially, a framework to consider the issue.

But can I ask you, then, if we start with this context, because the infrastructure that was dismantled, you played a key role in having set up around the Lighthouse laboratories, and so do you have any particular reflections, having now seen that all of that work and the scaling-up no longer exists?

A. Yes, I'm completely unsentimental about this. A huge amount of money was spent, and to wind down that cost base is very important, and taking tough decisions on that, I think, is a priority not just for the Treasury but for the country. But to leave -- to go back to the old way of doing things has been, I think, a huge mistake. We could have in place a bigger commitment to day-to-day public health screening of day-to-day

diseases that means that we would have infrastructure, maybe in the private sector, maybe in the public sector, that could be suitable for the kind of industrial scaling that we've talked about. In other words, not to just rely on the scientific and pathology labs but to actually have in place a better basic infrastructure.

In terms of the data spine, that didn't work at the time, and we still don't have really good interchange of pathology and tracing in place, and that infrastructure has gone away.

The UK diagnostics industry has shrunk to almost nothing and remains extremely weak. And as we know, when the boundary -- when the international boundaries are shut, we'll be relying on our own support.

In other words, there is no effort to try to learn the lessons and to put in place the kind of warm system that could be fired up when the next pandemic comes along.

Q. Thank you.

Lord Bethell, with your assistance now, I would like to just deal with the chronology of your involvement for the scale-up please.

Can we must have to paragraph 7, please, because you clarify that it was, in fact, 9 March of 2020 when you were appointed as the Parliamentary Under Secretary of

State for Technology, Innovation and Life Sciences.

And you've detailed then all of the portfolios. We can see it goes over the page again. Significantly, obviously, it dealt with test, trace -- testing and tracing technology.

We can see at paragraph (e) data and technology was included, but plainly your portfolio included much more than just the test, trace and isolate. But it's that I wish to look at with you now.

A. It is worth just adding that I had been a whip to the department and therefore had been very much embedded in the day-to-day work from, I think, September the previous year.

Q. I think -- well, let's just make sure, then, the context.

You tell us you entered of the government as a whip in the House of Lords in mid-2019, responsibilities for the Home Office, but then you moved to work as a whip with responsibility for the Department of Health and Social Care.

Can you just confirm the date of that? I think you talk about mid-January 2020, so I want to be clear when you became a whip for the Department of Health and Social Care.

A. I'm -- I think it was earlier than that. I think it was

in September, previous year.

Q. Thank you.

Can we then, please, move to paragraph 10, where you deal with the priorities that developed and -- that were then revised. But I'd like to ask you a question, please, in respect of -- obviously we're going to come to deal with offering mass testing for community in the workplace, but you also include at paragraph 10(g):

"Working to increase public confidence in NHS and [Her Majesty's -- at the time -- Government's] Health policy at a local and national level measured via robust research, especially targeting hard to reach groups."

And I think there's a question in terms of that terminology around -- if we're looking at it -- bearing in mind you want us to look at the cultural issues and looking at things through the right perspective, could I ask, first of all, do you agree that it's looking at it through the wrong way to say --

A. Yeah, hundred per cent, "targeting hard to reach groups" is unfortunate. I wish that phrase wasn't in there. I thought the way Matt Hancock put it was quite right.

And that was a learning that I came up to speed on very, very quickly.

Listen, we -- the NHS did not make itself a very easy organisation to interact with for about 20% or 25%

of the country. And I was stunned, really, to understand that we have blindspots -- communities, ethnic groups, geographies and certain areas of poverty -- where, really, government on the whole, and particularly the health service, has very, very little trust or reach, and therefore we invested a huge amount in order to create that bridge. And that meant, for different things, literally knocking on doors, working with local community groups, engaging media, and a huge investment in thought, time, resources and expertise went into that.

Q. Thank you.

And building on that, Lord Bethell, can I ask, were any impact assessments conducted specifically to evaluate how well the test and trace communications reached and were understood by diverse ethnic minority communities?

A. Yes, they were. I mean, we -- it had been explained to us in January by Chris Whitty, in the most emphatic terms, that the people who would be hardest hit by the pandemic were the most vulnerable. That's how a pandemic works, full stop. Every single conversation we had about the pandemic started with the assumption and included a discussion of how was it hitting vulnerable groups, including ethnic minorities and the

poor. Therefore, we had in place measures on every part of the pandemic, whether it was the vaccine, the testing, the NPIs, and so on, and also the impact of the fines. How was this being -- impacting those who were clearly going to be the hardest hit?

And I could go through with you some of the specific measures if you like.

Q. Thank you.

Can I ask you, then, by way of broad topics before we get into the detail, do you agree that financial, physical and mental support were necessary pillars to a successful test, trace and isolate policy?

A. Yes, we were -- we fought hard. In particular, we were conscious that some of the people who were being hardest hit depended on the cash economy in order to keep -- to sustain their households, and it was very tough for them to isolate without any financial support.

Q. Then can I ask you, then, we know when the financial support was available; would you agree that the test, trace and isolate policy and system did not provide adequate support to people who tested positive for Covid and were required to isolate?

A. Yes, I would. I would even go further and say there's pretty much no point in doing it testing, tracing and isolating if you don't create the circumstances where

people can actually isolate.

Q. Thank you.

Lord Bethell, I'm going to work from 17 March, with the change that happened, I think, where the department essentially took the grip and control over the testing from Public Health England. But before we deal with that chronology, can you give us an impression -- bearing in mind you'd taken over the responsibility also in a role within test, trace and isolate -- of what it was like at that time before you had to move to the mass scaling of testing, please.

A. Yes. I think that -- it was astonishing to me that there was no plan or ambition in this area when we arrived. In fact, quite the opposite. The advice was really that such a programme was not a thoughtful approach. And we were generally nudged away from the idea that you could have a whole-of-nation regular daily testing programme. And it took quite a lot to persuade the system that this was something that we should undertake. It was prioritised partly because this was a way to contain the spread of the disease, which as been discussed earlier was not the original plan at all, but also as a fallback plan for the vaccine, because, at that stage, the strong advice was that we shouldn't rely on the vaccine and that we should be thinking about

treatments and test and trace as really the alternatives.

Q. Thank you.

A. Therefore, there was a huge amount needed to be done to galvanise everyone and to enjoin in that vision and ambition.

Q. Thank you.

Can we please display INQ000592582. That's INQ000592582, please. Thank you.

Now, we can see this is 17 March, and it's significant, isn't it, Lord Bethell, because --

A. Who's it from? Sorry, I can't see.

Q. Mr Hancock. If we go to the bottom of the actions --

A. Oh, from his private office, yeah.

Q. Because it's right, isn't it, that there was a Number 10 roundtable on diagnostic testing that happened in the evening of 17 March --

A. Yeah.

Q. -- that was coming up at what is described at point 4 as a task allocated to you, Lord Bethell, and Professor Farrar, Kristen McLeod, to come up with a plan for the fastest way to scale up antigen testing using entirely non-NHS/PHE facilities, starting with Thermo Fisher possible capacity?

A. Yes, this memo doesn't -- isn't so clear about the role

of the NHS, which was very important indeed.
Steve Powis was leading that at that point, yeah.
Q. Thank you.
Now, can we move then to look at a document that arises from the roundtable, please.
It is INQ000119570.
This looks like it was the briefing that was available before the various individuals had been invited, so it -- to give an understanding about the purpose of the meeting but also who was attending and why, to consider the issue and the scaling up; is that correct?
A. Yeah.
Q. And so are you able to help us, in terms of moving to this stage, who was driving this as the key players to move towards something different?
A. Well, I think that there was a collective feeling that this was the right approach. All countries around the world were considering this. In fact, although we didn't have a domestic testing industry and we didn't have a public health infrastructure, we did have the benefit of a cohort government approach and we had the NHS. So in some ways we were ahead of other countries.
Downing Street were very ambitious in this area, as were the eighth floor at DHSC.

Q. Thank you. Now, are you able to assist us as to who identified what we know ended up being the players that provided the infrastructure of the mass testing system? So who identified Thermo Fisher, Roche, Qiagen, and then -- we'll see as we go through -- Amazon, Boots and the like. Who identified the significant companies that were going to assist with setting up and scaling up the system?
A. Well, that list changed over time, to be honest, and different people came in at different times. Roche, for instance, are a great partner for the NHS. They, though, weren't able to provide the supplies we needed to run their machines, so they actually faded away a bit.
So it was an ongoing role and people came to us all the time with fresh ideas. The company that brought the robots, for instance, that helped enable mass testing came in quite late and were very important indeed.
A. So I don't think there's an easy answer to that. A few of the key players included Sir John Bell, who you've taken evidence from, Ara Darzi, who was very helpful on the surveillance, Chris Molloy, who has given evidence as well. There was a number of people who were extremely helpful.
Q. Thank you. And the reason why I ask that, Lord Bethell,

it's just as we move through this document, plainly there's been some issues raised as to the individuals or the companies that were identified and contracted with to set up this mass testing and whether it created almost an unfair advantage as to who they went to --
A. No, that is a massive distraction. There is a very close and effective partnership in the life sciences industry between government, universities, and the private sector. And that collaboration, that tripartite collaboration, is something that works extremely well for the patient, for research, and for creating jobs.
In this industry, everyone knows each other. It's a tightknit, well-organised industry, and the idea that one company over another gets preferential treatment because they happen to know the minister is a misread of how this ecosystem works.
Q. Thank you. Let's move through, we'll just display all of that page before we move along, because I think it is helpful because it identifies all of those that were contributing on 17 March at Number 10. Thank you.
Can we move, please, through the document, I want to stop, next, at page 3 please, you can see the agenda and the plan, and stopping at page 3, we see the identification of Roche and Thermo Fisher, thank you, and then if we go over to page 4, please, we have the

attendees at that meeting. And if we could just scroll through as to --
A. Sorry, this is the meeting in Number 10, is it?
Q. Yes, that's my understanding. If any of this isn't correct, Lord Bethell, please say, and we can move through.
A. Yeah.
Q. Thank you.
June Raine, Sharon Peacock, Professor Dame Sue Hill, Matthew Gould, who the Inquiry has heard evidence from, Kristen McLeod, Professor Jeremy Farrar, Doug Gurr from Amazon, representatives from Boots and Roche, Thermo Fisher Scientific, Professor Sir John Bell, who you've just referenced, a representative from Randox.
A. Yes.
Q. Thank you.
Now if we can move then, please, to the next document because you, following on from this meeting at Downing Street, is it correct, Lord Bethell, essentially overnight created a mass testing strategy?
A. Yes. So I drafted the document. I'd say that the ideas had been fleshed out amongst a group of people but it definitely got put on a piece of paper that night, yeah.
Q. So if we can turn to INQ000055915, I think we see this strategy that you had identified and fleshed out

overnight, please. That's INQ00055915, thank you.
I'm not going to through the detail because I think it's more important what was then established, Lord Bethell, unless there's anything you want to say about the preparation after that meeting overnight to start to create what became mass testing and the Lighthouse laboratories?
A. Yeah. I think just two things. Firstly, this document should have been on the server ready to go at the beginning of January. The fact that it wasn't is astonishing to me, and I hope there is one sitting there ready for next time.
And secondly, this is actually how things largely played out, this pillar system did essentially work, not without a few bumps, but what it shows is that collectively, that partnership between the NHS, government, and the private sector, did get to the right answer and could provide a good solution. It's just a shame we didn't start earlier.
Q. Thank you, and Lord Bethell, I'm not going to explore with you issues of capitalisation and what it did for the nation, but I know you've dealt with that in previous modules.
Can we then move to the next day, 18 March, please, INQ000592585. Thank you.

So we're now at 18 March. And essentially that --
A. Sorry, the "from" is the ...
Q. Sorry.
A. Do you know who that's from?
Q. No, I'm --
A. I'm presuming it's a private office.
Q. We can clarify that certainly. If we look, essentially, following on from that meeting there was a creation, would you agree, Lord Bethell, of a testing working group that was now working almost, I think, until May of 2020 --
A. Yeah.
Q. -- that really got the first four Lighthouse laboratories off the ground?
A. That's right.
Q. Thank you. If we go over the page, please, again we can see, essentially, the allocation of tasks and roles to individuals. Is there anything you want to say by reference to the actions, Lord Bethell --
A. Well, I think one thing that was notable about that period, where there was just an enormous amount of goodwill, and I would pay tribute to the private sector companies that brought expertise, they leant in, they brought ambition, and sometimes they just did things off their own back without any remuneration at all, and this

partnership was incredibly impressive.
Q. Well, Lord Bethell, we've heard passionate evidence of Professor Molloy already as to his company and how they leant in.
A. Yeah.
Q. So please know that some fuller context has already been heard. Thank you.
Can I then ask, please -- if we have this removed from the screen -- it's right, isn't it, that one of the partners to bringing this into reality that's not yet been identified is the involvement of Deloitte, who were then assisting in pulling together the various players that we've seen? Can you assist us as to why, from your perspective, we've heard Deloitte's, that Deloitte were necessary to bring mass testing to fruition?
A. Yes. So, firstly, they weren't the only consultancy at the beginning. During this very, very busy period we engaged with I think just about every consultancy in the country, and in fact some tidying up had to be done by officials in order -- because they started overlapping with each other.
So the idea that Deloitte were somehow the only and exclusive player is not correct.
And secondly, this is how government works. Government is basically a commissioning body on the

whole. It doesn't do well to employ large numbers of people. It is better at contracting out to the private sector. That's how a lot of government services are delivered. So it is no surprise.
There is no way we could have done a formal recruitment process in order to get the right people in the right place. We needed agility, speed and expertise, and that can only be found through the private sector, and a firm like Deloitte, and it could have been any others of them, but they happened to be the ones that are good at that kind of lower-level public service, manual-style delivery, that they held the reins, and they also contracted to other parties in a way that, frankly, government procurement systems are not so good at.
MS CARTWRIGHT: Thank you, Lord Bethell.
My Lady, is that a convenient moment?
LADY HALLETT: Yes, certainly, if that suits you.
Lord Bethell, I'm sorry we're going to have to take you over lunch, but you appreciate we have to think of our poor stenographer, who copes so well. I shall return at 1.45.
(12.44 am)
(The Short Adjournment)
(1.45 pm)

MS CARTWRIGHT: Good afternoon, my Lady.

Lord Bethell, I hope you'll indulge me just to continue using the documents to give an overview, chronology, around the scaling up of the National Testing Programme, please.

Please could we display INQ000566069.

That's INQ000566069, please.

Thank you.

Now, Lord Bethell, the date's not on the front of this, but the information we have is this is now 22 March 2020 and we can see this was the briefing put together for the Prime Minister. And again, if we move through, I'm not intending to dwell on the pages but we really see the evolution as we move through the pages of the ambition, but also the practical things that were happening to get the laboratory test centres and distribution centres set up.

A. Yeah, haha! This is how not to do a test lab, by the way.

Q. But we also see, as well, there's plainly been forecasting, modelling, and projections as to the scale-up.

A. Yeah.

Q. Thank you.

A. I mean, it's just an incredibly thoughtful and

data-driven amount of work. I hope -- this sort of presentation I hope gives you an idea of what was involved.

Q. Thank you. And we can keep going and just so -- I mean no disrespect to the project, Lord Bethell, with not going through the detail of it, but it gives an idea as to the evolution of, perhaps if we look at page 21, we keep going, I think what you've described as the battle plan.

A. Yeah.

Q. And I don't know whether this is in the context of what you've said already about scramble and the culture of scrambling?

A. Yeah.

Q. But can we then move to another document because we've then got what we've analysed in detail, and I promise I'm not going to take you through the 168 plan of Deloitte other than to identify it, please.

I'm going to need my glasses for this one, I do apologise, INQ000581552.

Now, can I ask -- sorry it's the 168 plan of Deloitte. INQ000581552. I hope that it's not a 6. It might be INQ000561552, I do apologise. Deloitte did recommend we use the hard copy.

Sorry. Thank you for your patience, Lord Bethell.

Now, Lord Bethell, this draft has got the June date on it but with the evidence of Mr Cook for Deloitte we had an earlier iteration of 25 March which follows on from the PM's briefing. This is how it develops a little bit more by the June, but did you see and have access to the Deloitte 168 plan to understand how they were bringing together the strands and the flow, as we can see on this, of Kingfisher, Roche, NHS, and digital Platforms to bring the project to fruition?

A. Yes, well, I was very involved in, at this stage, all steps of it. Many of them were based on sixth floor, below my office, and I had daily engagement with the team on their progress.

Q. Thank you. And I think, in fact, you tell us in your witness statement, was it from 19 March there was a Deloitte team located in Victoria?

A. Yes, there was, downstairs. Absolutely.

Q. Thank you.

Now, pausing where we are on the chronology, I've a number of questions to contextualise the scale-up of the industry. So can I ask from your perspective, Lord Bethell, was there sufficient consideration given to working with universities as laboratories?

A. Yes, I mean, I think we've been through this quite a lot. A huge amount of effort went into not just

universities, but hospital pathology labs, animal pathology labs, all manner of private, public and university testing laboratories, in order to create, out of the battalion of small ships, some kind of network that could somehow utilise this expertise, infrastructure, and passion, because they were very enthusiastic, and I was lobbied on an hourly basis by just about everyone who had a PCR machine, about how they could play an important role.

And I personally spent a huge amount of effort to try to figure out a way of creating an "Uber" for diagnostics, and that vision I thought was a very powerful one. Matthew Gould wrote a very thoughtful note on how we could apply modern insight from Silicon Valley on how to somehow harness this collective effort.

It was a total disaster. It just didn't work. They were regularly late, they regularly lost tests. The turnaround times weren't quick enough. The data got in a mess. It was very, very expensive. And I would have loved for that effort to have worked. But the thought that it could in any way play a significant role is not just a distraction, it is, as I said in my opening remarks, promulgating this status quo mentality that we don't need to change anything in the way that this country does health, that backing acute care in the NHS

and research in life sciences is enough, and we need to focus on this thought that public health diagnostics is a different beast and we need to think about how we provide a platform for scaled-up industrial throughput if we're going to be ready for the next pandemic.

Q. Thank you.

LADY HALLETT: Lord Bethell, you're obviously very thoughtful about this, as I think you were on the last couple of times you've helped me.

I have to craft recommendations, you're a politician.

A. Yes.

LADY HALLETT: And you know that there's a temptation for governments of whatever political hue, to focus on the immediate problems, not necessarily spend as much on the long term. Is there a way you can think of where I could craft a recommendation, accepting the points you make about underinvestment in public health and not prioritising it, where I could craft a recommendation that might be attractive to government because it wouldn't be just an insurance policy; it could be something that could be cost effective now.

A. Yes. Listen, I understand your priority, and strongly support it. And I will try to give you what you've asked for in a second, but if I may just make my

intervention to you. My biggest fear about where this module is going is that you are looking for a sort of list of micro-recommendations of around the sort of 10 million to 50 million ticket. And it would be great if that was the answer, but genuinely, I don't think it is.

I think that there are two things that you need to lean into. One is the fact that we have utterly defunded public health, UKHSA was meant to be a kick-ass, cross-departmental, organisation of the kind like the National Security Council, run by really senior, well-paid people with good scientific budgets and a reach into local government. And that hasn't worked out at all. It is a microscopic version of what it should be.

And that is an indication of a broad defunding of public health across the board. And we see that in NHS screening, NHS vaccinations, health checks. In other words, we have abandoned the idea of prevention and the disciplines around prevention are what you need to create the foundation for the pandemic response.

So there is a direct link between defunding prevention-style public health and not being ready for the next pandemic; and secondly, it would be very important to have the underlying health of our nation

improved because if there is one thing that causes a pile-up at ICU units is that we have 42% of the country are overweight, and it was those people who were hit hardest by the virus.

So if we want to be ready for the next pandemic, I know that this is a long way from the kind of bite-sized recommendation that you're asking me for, but really, this, you should look at what is the state of the underlying health of our nation, and that needs to be put on, we need to find political space for our leaders to be able to prioritise that.

Now, to try to be helpful --

LADY HALLETT: I'm not interested in just the bite-size, obviously if I can get it implemented, I'd be happy to think of any size recommendation.

A. Listen, maybe it's not for me to say what this Inquiry should do, but I honestly think you should have module on the underlying health of Britain and you should have a module on 21st century public health, and I'd be very happy to design those two modules for you, and I'm brimming with ideas for how they might play out.

LADY HALLETT: I have to stick to my terms of reference, Lord Bethell, I'm afraid, so I can't do that. But, basically, your argument would be that investment in public health would be cost effective because it would

be cost effective for now.

A. Yes.

LADY HALLETT: And would then be cost effective for a pandemic.

A. Yes.

LADY HALLETT: And -- (overspeaking) -- that way.

A. That's right. And what I'm saying is not some kind of wonkish weird suggestion, it is how mainstream health systems in the western world are going about their business and Britain is unusual for turning its back on what I'm calling a modern 21st century health system with the foundational pillars of on-the-ground local health, and you had a very helpful discussion about local directors of public health. It is an embarrassment, it is awful how little resources they have available. Day-to-day prevention, testing, screening, vaccination, public health, data that flows both from -- in and out of the NHS and into local authorities. A workforce that is trained, available, and can then be redeployed in a pandemic; and lastly, a private industry that has, in other words a prevent-tech industry for which -- we don't really have one in this country which is very unusual.

We have a wonderful pharmaceutical industry, we have biotech, we don't have prevent-tech. So those are the

five pillars that I would recommend.

LADY HALLETT: Thank you very much.

MS CARTWRIGHT: Lord Bethell, just on the chronology, we know that the UK Government moved from the 'contain' to the 'delay' phase on 12 March and what that meant for testing, but can I ask in terms of the small boats that were offering assistance, and in particular the Crick institute. I'm also going to ask you to deal with the dealings you had with Sir Paul Nurse, because certainly Mr Hancock has suggested you'd had some relevant contact.

A. Yes, I spoke to him all the time.

Q. We'll come to that in a moment. But can I ask, first of all, in terms of, had -- whilst the Lighthouse laboratories that were being set up, had the United Kingdom Government utilised the offers from laboratories, research institutes and universities, could that have essentially impacted on the decision to move from 'contain' to 'delay' so there was another option to --

A. Oh, we used every single scrap of capacity we had. I spent hours every day on the phone to just about anyone who had anything like a testing kit available. I spent a lot of time talking to the animal veterinary industry, the racehorse industry in Newmarket, the very

wonderful team at Cambridge University who, sponsored by AstraZeneca, did stand up a laboratory. My goodness, we looked at every single laboratory.

We also looked at every single test. We looked at breath tests, cough tests, poo tests, water tests, pee tests, sweat tests. We had a whole partnership scheme run by the very able Lord O'Shaughnessy looking at every single test and every single laboratory in the country. We bust a gut to try to make the system that you're describing work. And it didn't. It failed completely. Because you cannot go to somewhere like the Crick.

And I don't know if you've been to the Crick, but it's an absolutely stunning building and it's won design awards and it has one feature to it, which is incredibly exciting, in order to encourage creativity: it has no walls. No walls, a building without walls. Really exciting.

This not a place where you want to base a laboratory for a highly contagious disease. I mean, this is not -- doesn't make sense.

I went to the Cambridge University laboratory. I nearly ran out in anxiety. There were piles of tests in the corner, you had to climb over things in order to get from one place to another.

Compare that to the Rosalind Franklin, which is in a massive white box, just off a motorway, where the tests arrive at 6, 7 in the evening, are automatically unzipped -- unzipping a test is a very dangerous thing to be doing. You don't have to have teams of students doing it, you have robots unpicking them.

They then get put into a massive conveyor belt, which is about 100 yards along. It's banging them out on strips -- no trays, strips -- and doing 30,000 on one machine in an hour.

This a million miles from Paul Nurse and all the others. But that's what you need.

Q. I don't mean to interrupt you, Lord Bethell, but we have heard from Professor McNally, who set up part of the Milton Keynes laboratory, so we understand something as to the process, and equally I think there's quite a lot of videos on YouTube if anyone wants to look at it in action.

But because Mr Hancock giving evidence referenced discussions you were having with Sir Paul Nurse, do you want to just give some context to -- and anything you want to tell us that's relevant to this discussion around scaling up by reference to the conversations you were having with Sir Paul Nurse?

A. Yeah, sure. Paul is a complete hero.

I think I've said in the last module that I had a sense of: where is everyone? Why is there no one to help?

Paul was there. He went above and beyond to try to stand up a testing facility when the country needed it, and deserves our praise and thanks. But Paul was writing to everyone. He was writing to the CMO's office about his scientific insight and he wasn't getting the reply he needed.

If you're writing with scientific insight, you need to write to the scientists, to the Chief Scientific Adviser or to the CMO. And if you're not getting a reply, you need to ring them up.

Phoning ministers because the CMO hasn't returned your -- is a misreading of how government works. And if you've got ideas about the NHS and nosocomial infection, you need to write to the head of the NHS, because the way our NHS works is that ministers do not tell the head of the NHS how to run the NHS.

I had a lot of sympathy for what he was saying on asymptomatic transmission and nosocomial infection. I thought he was absolutely right. We had a large number of conversations about it. And I was just looking at my phone just now, there are dozens and dozens of text messages and missed calls between us.

He went on the Today programme after one of our calls to complain about the lack of action on nosocomial infection, and he referred to me as a blancmange, which was something that didn't do much to improve our relationship, but we stayed in touch, and I'm baffled by the way in which he described that people didn't get back to him.

Q. Thank you. Can we then go back to complete, my assistance, please, the chronology, again, that gives a perspective about what you were doing in March through to April, please.

INQ000119438, please.

Now, again, I don't want to dwell long on this, because we've heard from Professor Molloy about his leaning in, as you call it.

This is 26 March, a co-signed letter from you and Mr Hancock thanking Sir John Bell for the "very generous offer of voluntary support during this time of national emergency", and we've already identified both by the slides of the PM briefing the role that Sir John Bell had as part of the team that were stepping up the testing.

If we move over the page, please, we can see this was really a thanks as he hadn't been one of the many individuals that formed part of this testing scientific

advisory panel that was working until the handover to the test and trace in the May, and then ultimately to set up UKHSA. But again, is this an example of selflessness of a number of professionals to assist with the national effort?

A. It was, but the purpose of this letter was much more important than that. It was to give a licence to trade to a team of people who were going to validate tests, because there was a gap left by PHE for who was actually going to say which tests worked and which didn't, and this became incredibly important once we realised that quite a lot of the tests that were being sold to us didn't actually work, and this team did very valuable work at calling out the tests that were not scientifically proven and led, therefore, to tests that could be proven, and as a result, we bought 3.5 billion of them.

Q. Thank you.

And can we please then display INQ000497424, please, which is the terms of reference for the testing taskforce.

That's INQ000497424, please. Thank you.

And it's the next page, really, where we have an ability to identify, in a quick way, those that were part of the taskforce. We can see the various names

there that comprised the team, thank you -- if we could scroll up -- thank you. You see we've heard from Professor Molloy. Thank you.

Can I ask you, then, when we look at this testing taskforce, we don't see anyone from Deloitte as part of the taskforce.

A. No.

Q. Is there any reason why they weren't part of the taskforce?

A. Yes, they were a delivery partner. The instructions to Deloitte would have been given to them by officials, and I should just clarify, in terms of my personal meetings, my meetings would largely be with officials who would then pass policy on to Deloitte. Periodically, in order to overcome operational problems, I met with Deloitte officials but that wouldn't be the typical run of things.

Q. And I think you tell us in your witness statement, essentially after those initial contacts with Deloitte, that you were no part of the setting up of the contract?

A. No. No way.

Q. Thank you.

Again, just on the timeline, if we could display, please, INQ000106325. Thank you.

This now 4 April. We know this is when the

Lighthouse laboratories were starting to come online, the scaling-up of the testing programme, and please if we can move through this document.

Thank you. And if we could move through until we get to the pillars, we've already -- which is on page 6 -- sorry, page 8, please. Thank you.

And over the page again, to the Public Health England partnerships at that time. So I think this is showing, I think, the PHE-Roche partnership, so this is just a time just before the four Lighthouse laboratories came online, but if we go over of the page, please, we can see that the Pillar 2 testing for which the Lighthouse laboratories were to assist is in the latter part of this document.

Then if we go over the page, please, we then see the plan for Pillar 3, and over the page again, Pillar 4, surveillance testing, and then finally the Pillar 5 and the plan for spearheading a diagnostics national effort.

Lord Bethell, I know that was the plan in April 2020 but the evolution of the pillars, I think, differed, really, over the course of the period. Is there anything you want to say about the evolution of the pillars?

A. Well, they did evolve a little bit but not really. I mean, it remained pretty much the structure of things.

I'd say that the Pillar 5 only really kicked in after a few months when we started to try to build a local industry and that was a struggle and has faded away.

Pillar 4 was slow to start but delivered amazing surveillance data and, I would say, in that, Britain was ahead of anywhere else in the world.

Pillar 3 fell away, except for trying to understand the science of the virus, which became very important, but it was Pillar 2 that delivered the mass throughput testing.

Pillar 1, NHS testing. There, NHS colleagues did struggle with capacity all the time, and one of the -- and this is an area that many people, including Paul Nurse, emphasised, is asymptomatic testing in hospitals remained something that was a real challenge in the UK, and could be an area for your recommendations.

Q. Thank you. Do you want to expand upon that with -- (overspeaking) -- recommendations?

A. Yes, if you have 1.5 million people going to hospitals and care settings where there are a lot of sick people, there is, therefore, a lot of virus in the air, and as a result, we had up to 12% of our own workforce ill. By the way, in a really bad pandemic, you can have half or more. So it's very, very important. I don't think we

ever figured out a formula for protecting people from the virus, and testing them on a sufficient scale, and also, having the workforce consequentials of replacing people who had then been isolated.

And NHS colleagues were understandably, but frustratingly, concerned about testing, because they thought it might lead to 10, 20, 30% of the workforce literally being sent home, which was something that they couldn't sustain if they wanted to keep the NHS going.

Q. Thank you. Can we next move, then, on the chronology, and I appreciate we're looking just at snapshots and I know there's huge industry over the timeline, but I'm trying to use documents that I hope tell the narrative in an efficient way, but this is in no way meant to reflect all of the chronology.

But please can we go to the INQ000088699, please, which is the Covid Strategy Ministerial Group from 14 April -- that is INQ0088699, thank you -- and we can see that you and Mr Hancock were present at that meeting. If we go over the page again, we can see other members of the testing. So we've got an official who was the Director for Testing -- in fact she's named, Kathy Hall, Director for Testing.

A. Yes, Kathy -- (overspeaking) --

Q. I've gone to this one because you've offered a view on international comparators and I think this is quite a helpful document to use.

Can we move forward, please, four pages. I'm sorry, the numbering is cut off on my copy. So it's should be the page that starts with "Told that" at the top. There we go.

Can I ask you then, because we can see there's a discussion about Taiwan here and I think again in your statement you make a recommendation around or a reflection that there was perhaps not sufficient consideration of the -- Taiwan. And so I don't know whether using this you want to provide your views linked --

A. Thank you.

Q. -- to the international models that you considered?

A. Thank you. My wife is originally Taiwanese, therefore I was speaking to my family in Taiwan all the time, and it was personally very striking to me that they were very well informed by SARS. It had been a really bruising experience for the country and they had completely changed their protocols, and it was a shame that we hadn't changed ours, and I think that's been quite widely discussed.

I remember, as a brief anecdote, phoning up my

in-laws and when my father was sent to the shops very early on, when he came back he had to take all his clothes off, put them in a black plastic bag and then my mother-in-law would squirt him with Dettol and then he was allowed to come in in order to have a shower. And when they said that to me, I literally laughed out loud, I thought how ridiculous. Boy, they had a point. I mean, in other words other countries were on it straight away, and when I brought this up amongst colleagues at DHSC, they likewise had a good laugh and said, well, you know, Asian culture is very different.

That kind of attitude I think was a mistake. There's lots you could say about that attitude but epidemiologically at least it was a mistake.

Q. Thank you. And if we move over the page, two pages, please. And the next page, please. And if we could scroll up, please. Essentially it references at this stage now we've got three of the super labs running and that they'll be ramping up production well, and can I then, please, just display the Lighthouse labs map just to again look at this on the chronology.

INQ000587456, please. Thank you.

So there's reference to three but we know in April of 2020 four, then, Lighthouse laboratories were available in Milton Keynes, Cambridge, Glasgow, and

Alderley Park.
A. Yes.
Q. Thank you. Then can I ask from your perspective, because obviously there was a great deal of effort to get the four Lighthouse laboratories up and running.
A. Mm.
Q. But then there seems to be quite a delay between the next set of Lighthouse laboratories coming online, and can you offer any perspective or commentary about what seems to be a really great start but then slight longer delay with the rest of the Lighthouse laboratories coming on?
A. Well, I think that Cambridge actually was stood down. That wasn't really a mass throughput lab although -- I think scale counted for a huge amount. We didn't necessarily need a lot of labs. We just needed really big ones, because the insight we learned was moving the samples around could be done quite quickly. It was more important that they were accurate and quick.

The Leamington Spa lab that came in in June was really the big mother ship and that one, for me, dealt, you know, was a model of the kind that we should be having in the future. The idea that there was going to be a second wave was something that a lot of people really struggled with. It was something that Chris

Whitty said to us in January. When he first said it to me, I couldn't get my head around it, but instinctively, emotionally, culturally, I think that a lot of people in senior leadership positions resisted the idea and that did create a bit of a stall in progress.
Q. Can I then, obviously, reference the mother ship, the Rosalind Franklin. Obviously there's been quite a lot written about that in terms of the cost and expense, and then obviously, again, all of this gone. Can I ask for any views you have -- we heard yesterday from Vaughan Gething that essentially they were part of the investment in this structure --
A. Yes.
Q. -- and no one consulted them before they were all mothballed.
A. I know.
Q. And I think that felt like, if they've contributed financially as a nation, a government, that someone should have at least done them the courtesy of speaking to them about the plan before they were decommissioned. Can I have your perspective on that, please, Lord Bethell.
A. Well, he's got a point on courtesy, but that's not really the serious point. There was no consultation with the future pandemic thinking strategy team about

how we should mothball this. I remember in -- I, obviously, got sacked in September. One of my last meetings was when DHSC colleagues had tabled an idea for how we should have a phased retreat and how we should try to preserve some of the infrastructure from the test and trace, in order to create the kind of capability that we're talking about. And when we met with NHS colleagues, they had a completely different plan that I was shocked and surprised to see, but I now understand prevailed, which was to essentially dismember the entire outfit, to ransack it for stuff that the NHS need, and sell the rest on eBay.

How that decision was arrived at I think was disappointing, and definitely did not include the kind of strategic thinking that should have happened and that this Inquiry should be calling for.
Q. Thank you.

I just have a few more documents now, please, Lord Bethell, that I hope give some insight.

Can we move then, please, to INQ000592613. That's INQ000592613, please.

Just going back to the pillars, this is a document you authored to give an update from Pillar 4 from 15 April. And again, if we move into the document, I think you've described others as thoughtful, and if we

move through again we can see the update in progress that was being collated to speak to each of the pillars.
A. Yeah.
Q. And I think this is just one example, but is it right that these were being prepared throughout the period of time --
A. I can't speak -- all of the time, there was very thoughtful data-driven analysis, very tricky questions about what kind of posts to use, what kind of swab to use, what kind of tube to use, which machines, which -- where we're going to get a biomedical workforce from, hundreds of knotty little problems really analysed very carefully. So there was a massive investment that went into the creation of this system, and I hope very much indeed it has been preserved, and would be disappointed if it wasn't.
Q. Thank you.

Can we next then, please, move to INQ000592636, please.

Again, on the timeline, although there's not an immediately apparent date, this document is dated 21 April 2020. We can see contact tracing and testing. We've already heard quite a lot of evidence the apps and the development of the apps. I don't want to use the precious time we've got to deal with that, but can we go

over the page, please, and really seek your input with what we see here in the pyramid and the criticism that's been levelled by a number, including Lord Agnew in Module 5, as to how it was 15,000 call handlers were in a test centre that were never really fully utilised, and the cost and expense that caused.

And can I, whilst dealing with this topic, you describe, essentially, creating contact tracing from scratch.

A. Yeah.

Q. You've already made comments about directors of public health. We've statements from the Local Government Association and the associate directors of public health and I think they feel that they were really under-utilised, and we know that they came on later, but can you offer your opinion on this whole issue of contact tracers in a central call centre remote from their local communities, not knowing their local communities, and then the move to include the directors of public health, please.

A. Absolutely. Do you mind if I -- I'm going to do it in the other order, if you don't mind.

Q. I appreciate I've rolled up a lot of questions there.

A. So, essentially, on the central and local point, Matt Hancock kind of dealt with this and I would just build

on what he said. Without doubt, having local contact tracing is basically better than national. It is what they have in places like Korea. We have in the UK neighbourhood policing. In my ward we have a sergeant, a constable and a special. They know my ward and they deal with crime extremely well.

We do not have the equivalent in public health. They do it in some other countries, and in those countries a local public health official understands that community and has the kit in order to deal with things like a pandemic. That is definitely a better way of doing things, but we don't have it.

I would strongly support the Inquiry looking at whether that is something that Britain should be looking at more closely.

Q. Thank you.

A. Secondly, in terms of the standing up, and therefore, just as a final point, we kind of got there towards the end and we had a mixture of the national programme and hopefully worked with local directors of public health and others in order to do the local implementation, but I agree that it was a shame it took us a long time to get there, but under the circumstances I think we did very well.

Q. Lord Bethell, can I then be absolutely clear, I asked

the question of Mr Hancock because on one view when you look at it, it almost looked like, did, actually, the decision makers at this time appreciate that there was resource of local authority, directors of public health, contact tracing? It seemed -- (overspeaking) -- knew about it.

A. Yes.

Q. But can I just be clear, that you appreciated when you talked about essentially doing contact tracing from scratch that you completely appreciated the role of the directors of public health?

A. Absolutely, and although I was new in post I'd been given a very clear briefing about their importance. There is some variety in the quality but some of them are absolutely stunning figures, and someone like Kevin Fenton, here in London, we worked extremely closely with, and there are about a dozen of them who I spoke to on the phone all the time.

But if I may just give you an example of how minimal the resources are in a local basis, I remember doing a roundtable, a Zoom call, with leaders of local authorities about standing up tracing in their areas, and I said, "What we're going to do is we are going to have a car park, and we're going to have a table with a gazebo on it, we're going to send you some squaddies,

they're going to do the swabbing; could you please sort things out?"

And the question was, "Where do we get the gazebo from?"

In other words, resources were so thin on the ground they needed 500 quid to buy a few gazebos, because they don't have the spare cash to do that.

So the idea that we could have somehow handed responsibility for tracing and testing to people in those situations is just not realistic.

Q. Thank you. And I think you have already identified, you think you got it right in the latter period where the local resource was then brought in?

A. Yes, I mean, we recognised from the beginning that local is best, but we needed to stand something up quickly.

Q. And we've heard one example, what was done in Leicester and Sandwell about, I think, where, essentially, they took a grip and started doing local contact tracing. Did those sorts of actions in certain local authorities highlight --

A. Yes.

Q. -- the need that something was missing?

A. Yes, I remember Leicester. Do you remember what happened in Leicester and the mayor and everything? That happened partly because we sent them a tonne of

money and people and officials and contracts.
I remember sending them telephone numbers of people that they could call. There was a lot of support from the centre of some of these local initiatives, and that wouldn't have happen if we hadn't have got behind the idea of local tracing.

Q. Thank you.

And then finally for the chronology --

A. Do you want me to just quickly say about the Lord Agnew point?

Q. Oh, sorry, yes, please do. And then there's another Lord Agnew point I'll go to.

A. Oh good.

Listen, they weren't in call centres. They were working from home. So work from home -- just a few things to remember. Work from home then was new. No one that really done it before. And we were recruiting a new force.

Also, don't underestimate how spiky use of something like this is. It would go to nothing and then go up very quickly.

So as we were entering the second -- well, not even -- we could see the second wave coming, so we needed to train and also make capable 20,000 people or so.

We sent quite a lot of them laptops. Initially there was great cyber security issues. So some of them were doing strange things with their laptops; those all had to be locked down. They had to be given some hours of training. There was a waterfall of training that had to be gone through.

Some of them were not capable, so they had to be taken off. In other words, standing up something like that is a non-trivial exercise and you can't predict exactly when the spike is going to be.

So we did amazingly to get 20,000 people working from home up to speed on how to do tracing and then also to insert the extra level of expertise needed for complex cases.

That happened very, very quickly, Theo is right that at times usage was very low, but that is just a fact of life if you're dealing with a highly spiky virus.

Q. Thank you. And then just to identify another issue that Lord Agnew has raised, can we go, please, to INQ000471020.

INQ00471020, please. Thank you. And can we move forward to page 3.

Now, I'm not suggesting you're copied into these and you may have had nothing to do with the financials and this scenario, but, again, with dealing with issues that

Lord Agnew has identified.

We can see this is in July of 2020, where he was being asked to approve, by reference to test, trace and isolate, a one and a quarter billion programme in one day, which plainly he's identified as being ridiculous.

And asking you the question:

"What interaction ... has there been since the meeting on 27th May?"

And over the page again we see him querying aspects of the pricing and the costings.

Can I ask you, then, is any aspect of this something that you had input on or --

A. Yeah, sure, of course.

Q. Can we have your perspective on the sort of very short window to approve eye-watering amounts from Lord Agnew, which plainly he was concerned about?

A. Yes, so you have put up already a huge amount of very clear data-driven analysis from the test and trace team. That was all available to Cabinet Office colleagues on request whenever they liked. There was absolutely no shroud of secrecy at all. In fact we were very evangelical about the work we were doing, I was happy to talk to anyone about it if they liked.

There is quite well-documented correspondence between the test and trace team and the Cabinet Office

about the one-day sign-off incident. I don't recognise Theo's description of it being a half-day opportunity to sign something off. I think that's a question that should be put to his Cabinet Office colleagues on why that sub was only put on his table at the last minute.

We were desperate to get large parts of government involved, creatively and practically, in the funding, finance and implementation of this. It was quite hard to get their attention. I think a lot of them rather hoped that there want be future spikes. There was this cognitive challenge of trying to get people to believe that this was a three-year challenge, not an Easter challenge. And I think it would have been better if the whole of government had had a slightly more realistic attitude to the length of which -- the long period in which Covid was going to be hitting us.

Q. Thank you.

Then finally, please, for the chronology, can we move to INQ000497170, please. Thank you.

We're now at 28 May 2020, and we can see that the decision was made to pause the taskforce, it's said here, for the next few weeks.

A. Yeah.

Q. Is it right this was essentially the end of the taskforce at the time --

A. Yes, the taskforce was a sort of band of brothers -- that's an unfortunate phrase, but it was meant to be a scratch team of people from a lot of different backgrounds, including the private sector, who were going to throw themselves into hacking, jump-starting this project. So it quite reasonably got retired the moment we had proper structures in place.

Q. Thank you.

And we can see it was stood down because Baroness Dido Harding was taking up the reins --

A. Yes, absolutely.

Q. -- and we're going to be hearing from her next week about what she did. But I think until you left your post, in reality you were still over all of these issues linked to test, trace and isolate; is that correct?

A. Yes, although it became like a functioning proper agency of government, and needed much less of my involvement later on.

Q. Thank you.

Lord Bethell, that was my intention as to the chronology. Is there any aspect that you think is important of the chronology that we've not dealt with that essentially helps tell the story of the scaling up of the testing in the Lighthouse laboratories?

A. Well, the only thing I'd say is -- that's right, you've

asked questions about the scaling-up period. I would just emphasise that, for instance on genomic analysis of the virus, there was a huge amount of expertise and important science that went into other aspects of this that shouldn't be overlooked.

And there were parts of the surveillance and research components, and also the implementation of the community-led testing that really only matured later on, and so you're putting a spotlight on almost the most difficult period and maybe not at what the situation was when it was a sort of running speed.

And I think I would hope very much indeed you could look at that and see what the benefits were of getting the system up and running.

Q. Thank you.

Can I then, for the final part of my time with you, just deal with some discrete topics and then we'll finally deal with anything else you want to say about lessons learning.

Can I ask you about symptomatology, and the Inquiry has heard evidence from Professor Spector around the different symptoms and when they had identified loss of taste and smell as a symptom, an indicator, and certainly by 1 April it was on their website.

Were the test and trace taskforce aware of those

additional symptoms before they were formally recognised on 18 May 2020?

A. Yes, absolutely we were. Thank you for raising this.

I can't emphasise enough how complicated the symptomology of this virus was. Lots of people had lots of different symptoms. Some lost taste, some didn't. Some coughed, some didn't. Some had headaches, some didn't. There was no categoric symptom for Covid.

Now, if you have measles and you put a glass -- and is it around, that's a symptom -- you know if you've got measles. It is just not true with Covid. Early on most of the people who thought they had a cold probably had Covid. Later on, most of the people who thought they had Covid probably had a cold.

Professor Spector is a serious scientist who I respect a lot, but he should know that you cannot test for Covid on the symptoms, and that his app, although a fascinating and interesting use of patient data, a principle that I happen to support, simply isn't an accurate definition or surveillance tool for Covid.

Q. Thank you.

Can I then, please, ask you about some questions around asymptomatic exposure, please.

And can we please display INQ000279754, please. That's INQ000279754.

And there's a number of questions I just want to ask around asymptomatic?

So this is Catherine Houlsby, from the Department of Health and Social Care, querying whether there had been asymptomatic exposure in Birmingham and London in an email exchange with you on 31 March 2020, which was to be included in your readout.

Given that -- the query raised, why wasn't asymptomatic transmission included in test and trace policy at this stage?

A. I'm so sorry, but I don't understand the question. Do you mind putting that to me again?

Q. Yes, I mean, if I do it under a more general issue --

A. Yeah.

Q. -- certainly the knowledge and the evolution of asymptomatic transmission -- and I think we've heard a lot of that from Mr Hancock, but did there come a time before -- when we've heard that it was formally accepted by Mr Hancock and policy changing at the end of April, did you appreciate that actually you should have been doing something to accommodate asymptomatic transmission within the policy and decision making around the test and trace strategies?

A. Yes, well, thank you for asking me. Well, not -- with the risk of re-prosecuting the conversation from earlier

today or triggering in myself any anxieties, I've got to be honest with you that the discussion around asymptomatic transmission was absolutely at the heart of everything we did from the very beginning.

For me personally, I noted that in the chalet of superspreaders -- which you may remember began the Covid experience for Britain, when I think it was about ten doctors who had been on a skiing trip brought Covid and then spread it all around the country. A very notable feature of that story struck me, which was that, in their chalet, none of them had symptoms.

So that's the question: how did these ten people all catch Covid off each other and none of them had a symptom?

So that question of asymptomatic transmission was crystal clear to everyone, but it took until April 14 to get the clinical advice that we could put asymptomatic infection into our policy making.

So, to answer your question directly, no, we were led by the science, and it was very much how we rolled, and we were respectful of the experts. But until the April 14th advice came through, no, asymptomatic infection wasn't in our official policies.

I must admit, that I, like many other people, assumed that this day was going to come and therefore we

did build it into our thinking.

Q. Thank you.

Can I take it from the screen.

Can I ask you, we've heard some evidence about Operation Moonshot and how that then became part of the Community Testing Programme.

Do you have any -- did you have any concerns when the Prime Minister announced his big Operation Moonshot as a policy or proposition before it then essentially used the tests that had been developed to move into the Universal Testing Offer?

A. Yes -- well, yes and no. On the one hand, I was thrilled that mass community testing had such strong sponsorship from the Prime Minister and that he had become super engaged in the opportunity there. So I was absolutely delighted to ride the tide of his enthusiasm on this.

There was a piece of Moonshot, which was the idea in Slovakia, that you could somehow eradicate the virus altogether from the community and have it open. Actually, I don't think that that was realistic. You can use test and trace to keep levels down, but if you're running red hot, if you've got a prevalence of 1, 2, 3%, as I said earlier, testing can't really fight against that kind of tidal wave. So I did have

hesitations about the idea of a total zero-Covid strategy in as much as that was part of Moonshot thinking at some parts.

Q. Thank you.

And can I ask, then, in terms of you referencing Slovakia, I think that's very different in any event because they have a population register; is that correct?

A. Well, lots of countries -- yes, that's one aspect of it. They also have quite an autocratic regime which we don't.

Q. Thank you. And before we deal with recommendations, can I ask you some questions about accessibility of testing, please.

And can we display your paragraph 76(b), which is in your statement, which is INQ000587383, at page 35, please. Thank you.

This is where you're telling us about meetings you'd had with the Minister for Equalities, Kemi Badenoch.

Then if we look, please, at paragraph 76(d) you mention raising deep concerns about the government's communication with what you've referred to as "hard-to-reach" communities.

A. Yes.

Q. I think we've already qualified it's -- they should be

referred to in a different way because it makes it look like the problem is them --

A. Yes.

Q. -- rather than they're seldom heard.

A. Correct.

Q. But could you outline the specific deep concerns you had regarding the communication strategy and what further work was undertaken to address these concerns and improve engagement with the relevant stakeholders, please?

A. Yes. Well, I had done a lot of roundtables and engagement with communities because this was always a priority. We understood that the people who were going to be hardest hit by the pandemic were going to be the vulnerable and the dispossessed and the poor.

The feedback that I got consistently was that these communities didn't trust the NHS, didn't trust government, and weren't really hearing the message.

My own experience in the music industry, which I know seems very distant from this, is that I used to sell music to these communities, and I know that in order to talk to them you have to go about it in a very different way. And when I was in the room with our communications team I couldn't see the people or the strategies or the tactics that were going to be

successful in getting these messages across, and I raised these with Kemi, who agreed with the point.

And actually, I pay tribute to the communications team at both Cabinet Office and DHSC, because they moved very quickly. They were very creative. They brought new people onboard, new staff, and at the end of the day, they proved to be very effective and testing rates in these communities did go up and ultimately vaccine rates in these communities were a great success.

Q. Thank you. Still on the same page, and in fact if we look up to paragraph (b), please, of your 76(b) you mention that the data indicated it was less to do with ethnicity so much as cultural and socioeconomic factors, and the need to understand how groups were behaving to understand how to target NHS Test and Trace communication.

A. Yes, so it was a story of --

Q. Sorry. So the specific question, please, Lord Bethell, is: could you provide any insights on the understanding gained about cultural attitudes towards testing within these communities, and how this was incorporated into the design of the testing strategy?

A. Sure. If I may give, by anecdote, I remember some testing team turned up amongst a caravan park of Herefordshire apple pickers, and when they arrived,

everyone climbed out of the windows of their caravans and ran off into the trees because they were terrified that it was some kind of police raid because they were from eastern Europe and weren't used to public health officials being trustworthy.

I remember in streets in Tooting where -- which I know well from having fought an election there, where many women aren't registered in the NHS, and you would have to have people from the same group and often speaking the same village language, knocking on the door in order to build the kind of trust necessary in order to reach very, very important groups who were very vulnerable to the disease.

Those are two examples of, I'd say, 100 different local patterns that aren't really to do with ethnicity, they're to do with pockets of culture, and also, broadly, poverty. And it is a -- I'm not saying that everyone who is poor is disconnected with government, or everyone that's disconnected with government is poor, but there is a big correlation between them.

Q. Thank you. Can I then ask you about location of test sites, please. The location of testing sites in the first five months of availability of tests to the public, saw many people travelling large distances to have tests undertaken at the regional testing locations.

Can I ask, were the locations of the testing sites informed by impact assessments and the needs of the general community, including age, disability, and socioeconomic factors?

A. Yes. So to begin with, we were just trying to stand them up wherever we could, and so they correlated to where B&Q was, more or less. But we were conscious from the beginning that, by definition, having a drive-in testing site was essentially middle-class, because you needed a car to attend, and so we were -- we prioritised from the beginning other ways of trying to get tests into communities that maybe wouldn't have a car, and that's why things like door-knocking and driving to caravan sites became more of a priority.

There was a sequence to that. Without doubt, early on, we went for the most convenient template possible, which was the drive-through. But I think that we went a very long way, and I would very much commend Baroness Harding for the huge amount of work that she and her team did on that.

Q. Thank you. Can I ask, would you agree, then, that the location of test sites was in some instances a barrier to testing?

A. Early on, the lack of tests was the barrier to testing.

Q. Can I ask you, there's information that suggests there

was a shortage of tests in the September of 2020; do you have any views on whether that was foreseeable and the result of poor planning in response?

A. Ugh. I had evangelized for being better prepared for the second wave. I think that plenty of colleagues in Treasury/Cabinet Office had reservations about whether that was necessary. It was, in part, to protect the taxpayer and in part to protect the society from unnecessary lockdowns. It was an argument that I thought was unfortunate, but it was well intended.

I think that understanding how pandemics play out and that they take a long time is something that we've all grown more accustomed to.

Q. Thank you. And then Lord Bethell, finally, you've already touched throughout your evidence, you've told us about the scramble and the rethink to approach. You detail within the statement your reflections and lessons learning, but is there any other recommendation, I'm not going to go through each, your statement will be published, but is there any particular lessons learning or view you wish to provide to her Ladyship to inform her thoughts in respect of Module 7 that you've not spoken about that you'd like to end your questioning with me, to just make clear?

A. Thank you. I think that the science around testing and

behaviour change is really moving forwards quickly, and a lot of what we did would be -- would have been helped by even the AI we have today, in terms of the data, the surveillance, the interactions with people.

There is a tendency for British health to focus on people, essentially turning up at a late stage of disease, peeing blood, coughing, and then being treated at the end. The nature of medicine is changing to try to catch that early, which means that early diagnosis is becoming a more regular part of everyday -- of everyone's lives, bowel tests, prostate tests, people checking on their hormones. I'd like to see that built much more into the healthcare system that we've got today because that's the platform on which we can build the future pandemic.

In other words, the patient behaviours, the data systems, the at-home testing kits, the domestic industry, all the things that I've talked about, there's a heaven-sent opportunity to use the change in the science, the actual diagnostics, the use of the data, the AI, the interest that people now have to try and prevent disease, to try and capture that excitement and that ability and turn that into a public health good.

MS CARTWRIGHT: Lord Bethell, those are my questions.

My Lady, there are Core Participant questions.

LADY HALLETT: Thank you, Ms Cartwright.

Mr Thomas.

Questions from PROFESSOR THOMAS KC

PROFESSOR THOMAS: Good afternoon, Lord Bethell.

A. Good afternoon.

Q. My name is Leslie Thomas and I'm representing FEMHO, that's the Federation of Ethnic Minority Healthcare Organisations.

Lord Bethell, do you agree that the track, trace and isolate programmes needed to be localised and culturally tailored to better meet -- better reach ethnic minority communities and populations? Do you agree with that?

A. Well, I would definitely agree that best practice is exactly along the lines you've described. We were creating a system, as it were, flying in the air, fixing the engines. Under the circumstances, we did have to take a one-size-fits-all approach at the beginning, but we understood the limitations of that approach and did as much as we could as quickly as we could in order, as you say, to provide that kind of local and culturally-tailored service.

Q. Many of FEMHO members have given evidence about the efforts made by ethnic minority healthcare workers and organisations who, in the absence of centralised initiatives, worked to engage and support their

communities during the pandemic. Can you outline any efforts made by the government to engage with those groups or individuals, and better utilise their insights and resources to address the gaps in the TTI system and/or difficulties in reaching certain groups?

A. Yes, well, I think the point you make is a very good one. I can give two examples. We did a large amount of roundtables with the Muslim community around Eid when we were extremely concerned about families coming together, communities coming together, despite the rising prevalence, and I must have done 20 such roundtables with mullahs and other leaders in the Muslim community. So we were very much aware of the importance of trying to communicate to key groups.

Also -- I can't remember the other example.

But your broad point I think is correct. Oh, in terms of the advertising and the use of a local media, particularly radio and, which I hadn't previously appreciated, local language television, which is a massive thing in very specific languages, I think we did about 50 or 60 different languages, and there we used doctors from the NHS who had local language ability to appear on televisions where families would have the television on in their kitchen, in order to provide a trusted voice to explain some of the principles.

So yes, the understanding of that importance was there, and the use of healthcare workers was used at times, but it could have been used a lot more, and should be a recommendation of this Inquiry.

Q. Let me move on to my final area, and that is lessons learned or lessons to be learned. Were any lessons learned or best practices identified from engaging with ethnic minority communities during the test and trace programmes, and how have these been integrated into current or future public health communication strategies?

A. So yes, we learnt a hell of a lot. I personally learnt a lot. I understood a lot more about your very first point, which is that the frontline workers who took a lot of risks, were exposed to a lot of patients, and including the bus drivers and the taxi drivers, were often from ethnic minorities. And although you can say well, that's more of a socioeconomic factor, you've still got to wake up that these are people who have got lots of pressures in their lives because of their background and their racial background, and we should have a better consideration for the circumstances they're in.

So for sure, I did learn a lot. Whether that is still built in, I'm afraid I can't say. I haven't been

a minister since September, but -- September 2021, but I very much hope so.

PROFESSOR THOMAS: Thank you, my Lady.

LADY HALLETT: Thank you, Mr Thomas.

Ms Munroe, she's just there.

Questions from MS MUNROE KC

MS MUNROE: Good afternoon, my Lady.

Good afternoon, Lord Bethell.

A. Good afternoon.

Q. My name is Allison Munroe and I ask questions on behalf of Covid Bereaved Families for Justice UK. The areas that I'm going to ask you about are: equality and access and equality considerations which you have, indeed, touched upon both in answer to questions from Ms Cartwright King's Counsel and just now from Mr Thomas King's Counsel. So what's left of my questions, I hope I can deal with compendiously.

And I should also say that I ask these questions very much mindful of, and in agreement with, your sort of basic premise that health is inherently unequal, and that the highest density of disease often strikes the poorest members of the community.

A. Yeah.

Q. So my first question, arising out of your paragraph 75, was the equality, diversity and inclusion update that

you refer to dated 8 July 2020 --

A. Would it be possible to have a look at that?

Q. Of course. Oh, you don't have your -- shall I just read it to you?

A. Sure. Yes, thank you.

MS MUNROE: My Lady, as I said, it's paragraph 75 of Lord Bethell's witness statement. And you say this:

"On 8 July 2020, I held a meeting with officials from DHSC on the subject of equality and inclusion communications with NHS T&T [and you give the exhibit-numbers and the INQ numbers]. I asked the team to design a risk register to understand how to engage with groups who had poor engagement with NHS T&T and to help guide our targeting of communications," and you go on to say that you received submissions on 14 July setting out communications and engagement strategies.

So my question was, Lord Bethell, was that risk register and the diversity inclusion update, was that an acknowledgement from the government that the T&T policy was not accessible to all sections of society, and would you agree that, consequently, people from certain characteristics, you've described them as the vulnerable, dispossessed and poor, were at an increased risk of contracting Covid and sadly, ultimately, dying.

A. I think that we inherited an approach to media buying

and creativity and all of the skills of modern communication from a health and NHS playbook that was itself very out of date, conventional, and didn't have much ambition for reaching the kinds of groups that we're talking about.

In other words, it was a cut-and-paste from the regular style which was, frankly, targeted more at the Waitrose classes than at broader Britain. And so when I did my meetings with officials and agencies, they themselves weren't representative of the groups that we were trying to target, which was something that was acknowledged. It wasn't a -- I don't want you to think that -- I was, in many ways, repeating what everyone in the room was concerned about. And therefore, because of the pandemic, that gave us a reason and a budget to do things differently and to have more ambition to do the things that, frankly, the health system should be doing anyway to reach the audiences that aren't typically connecting with government broadly and the NHS, specifically, and therefore test and trace.

So this was a -- the risk register is a ministerial device to try to lift ambition and to signal that resources would be available for going above and beyond the norm.

Q. Thank you. My third question, to an extent I think

you've answered that in answer to Mr Thomas King's Counsel, but I'll ask it just to see if there's any further expansion you wish to make, it's very much with these vulnerable groups still in mind and the fact that they form part of a cohort of the population that there are these issues of access about.

What, in your opinion, accounted for the failure previously to include adequate support, in the broader sense of the word, for these individuals in the government's test and trace policy?

A. Well, as I alluded to before, I don't think it's unique to test and trace. In fact, if anything, test and trace, because it was born of public health and epidemiological disciplines, was more aware than almost anyone else in government of the importance of reaching the groups we're talking about. It inherited a playbook that wasn't sufficient, and the government broadly doesn't reach these groups very well. For instance, the pattern of NHS resources, like GPs, and community health hubs, is very much balanced towards richer areas over poorer areas. This isn't a test and trace invention; this a long legacy and historic inheritance.

So I think it's a misrepresentation to imply that test and trace was somehow off the pace on this. Actually, test and trace did things that have never been

seen by government before, and I would applaud both the ambition and effort that test and trace colleagues put into trying to reach the groups.

Now, I think where you have -- absolutely have a point, is that, of course, these groups shouldn't have been neglected in the first place, and my big pitch to the Inquiry is to address that fundamental point.

For goodness sake, if we're going to have another pandemic, please let's not have 20% or 30% of the country having very tentative and unequal relationships with the NHS and the government in the round. That is the best protection we can have.

Q. Thank you, Lord Bethell. And finally, again I think I can roll up my last two points, was the NHS Test and Trace equality considerations, which is, again, another document dated 8 January 2021 -- a guidance, I think it was described as -- was that the first guidance on equality for Test and Trace?

And secondly, in terms of equality assessments which you've referred to, did those come in, and were they undertaken after July 2020 or after this second document I've just mentioned, in January --

A. I understand.

Q. -- 2021?

A. So, in terms of the process, I'm afraid I can't answer

your question off the top of my head, but I would like to reassure you that the principles of equality and the understanding and the insight that vulnerable groups were going to be hardest hit was absolutely baked into test and trace from the very beginning.

Matt Hancock referred to the Goldacre interrogation of the data, which came back to us as a big shock. I remember the day when I had first sight of that report, and I hadn't expected or anticipated the huge discrepancies that we saw in terms of Covid prevalence amongst ethnic minority groups. And that was definitely a wake-up call that, whatever our good intentions, we hadn't achieved fairness and equality, and it led to a doubling down of efforts, for sure. And we needed that kind of reminder and that kind of evidence to keep us on mission.

So I think to answer your question, we were looking all the time for evidence that we were doing the right thing, and when that evidence showed that we hadn't achieved our ambition, we doubled down and put more resources into the effort.

MS MUNROE: Thank you very much, Lord Bethell.

Thank you, my Lady.

LADY HALLETT: Thank you, Ms Munroe.

That completes the questions we have for you,

Lord Bethell. I think it probably completes the burden we've placed on you in helping us, and if there's something that you haven't mentioned but it's in the written material, please don't forget that when I reach my findings and make my recommendations, I take into account all the witness statements as well.

If I may say so, you've been an extremely helpful and insightful witness and I'm very grateful for your input. Whether your wife will forgive you for the reference to your father-in-law, I don't know. Putting that into the public domain is something you may have to make up for.

THE WITNESS: I'm still begging forgiveness from my wife for a lot of things. Thank you very much.

LADY HALLETT: Thank you very much for your help.

I gather you still need to see the next witness, Ms Cartwright, so I shall come back at 3.15.

MS CARTWRIGHT: Thank you, my Lady.

(2.57 pm)

(A short break)

(3.19 pm)

MS CARTWRIGHT: My Lady, please could Lord Vallance be sworn.

THE RIGHT HONOURABLE LORD PATRICK VALLANCE (affirmed)

LADY HALLETT: Thank you for your continuing help,

Lord Vallance. I hope the last slot of the week was suitable for your diary.

THE WITNESS: Thank you.

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 7

MS CARTWRIGHT: Could you please give the Inquiry your full name.

A. Yes. Patrick John Thompson Vallance.

Q. Lord Vallance, on behalf of Module 7, can we thank you, once again, for providing further witness evidence to assist the work of the Inquiry.

Can we then, please, turn to your fifth witness statement, please, and if we could move to internal page 31, please, we can see that it's dated 13 March 2025, and can I ask you to confirm that the contents of that statement are true to the best of your knowledge and belief.

A. Yes, I can confirm that.

Q. Lord Vallance, can we please just identify the role you were performing at the relevant time; it's right, isn't it, that you were the Chief Scientific Adviser during the pandemic?

A. Yes, I was.

Q. And I know you have a huge CV and expertise and background, but -- it's been spoken about before so I hope you don't see any disrespect by dealing with your

background -- (overspeaking) --
A. I'm delighted not to have to go through it again.
Q. And can I just say, for my purposes, I'm delighted that as part of your Module 7 statement you provided all of the other witness statements of relevance to TTI to assist our work and, in fact, the earlier Module 2 statement is particularly relevant now to a topic I'd like to deal with you first, please, which is the question of asymptomatic transmission and testing, and I think the best way to deal with that issue, please, is to move to your statement, please, INQ000238826.

That's INQ000238826, this your Module 2 statement and move to internal page 170, please.

That's INQ000238826. Page 170. Thank you.

Lord Vallance, we heard a good degree of evidence this morning from Mr Hancock, who wished to give his perspective as to asymptomatic transmission and testing, and particularly by reference to his concern that there was confusion, and where the confusion came, and particularly by reference to yourself. And so can we work through your statement from Module 2, just so we're absolutely clear of your position as to the advice or challenge you gave at any point to Mr Hancock in respect of concerns you may or may not have had relating to his understanding of asymptomatic transmission and testing.

Can we then, please, start with your paragraph 511. You say this:

"... as early as the first formal SAGE meeting, (SAGE 2 on 28 January 2020) it was recognised that there was some evidence of asymptomatic transmission. The meeting anticipated a specific test for Covid-19 being available by the end of that week but in low numbers, and advised that: 'Currently it would not be useful to test asymptomatic individuals, as a negative test could not be interpreted with certainty'. This did not mean that the test would not work on asymptomatic people; it meant that a negative test result could not be safely interpreted as evidence that an individual was not infected. It was a question about test sensitivity, and not using it to assure non-infectiousness."

Now, can I ask you in terms of that position, can you just confirm whether that SAGE advice and position, and particularly what that means for testing, from your perspective, was understood to have been passed on to Mr Hancock?
A. Oh, yes, I'm sure he would have seen this. We had -- I think he was chairing COBR meetings at the time and, indeed, I think chaired a COBR meeting where asymptomatic transmission was discussed. So I think there is no doubt that then, and over the subsequent

weeks, we were clear that the likelihood of asymptomatic or pauci-symptomatic, so few symptoms, transmission was highly likely.
Q. Thank you. Can we then, please, have highlighted your next paragraph, 512, and rather than me read what's detailed about sensitivity and specificity, could you please, just again, in the straightforward explanation explain what the issue is and what you were advising in relation to being able to test, on a PCR, someone that was asymptomatic or pauci-symptomatic.
A. Well, the first thing we wanted to know was that the test picked up Covid and didn't pick up other things, so you weren't getting so-called false positives, people who had other diseases who were appearing to have Covid. And the second thing, which is the ability to pick up everybody who's got it, in other words, there's a threshold of virus below which it might not work, so that's the sensitivity. Were there a number of people who might have had the infection but they had very low viral amounts which meant you didn't pick it up? And those were the things that needed to be sorted out in order to be sure when the test was giving you a reliable negative result, ie, you didn't have the disease for sure.
Q. Thank you.

Now, we can then move to the next paragraph, please. You tell us that:

"As the pandemic progressed and data increased, the evidence of asymptomatic transmission became clearer, though the precise ratio of symptomatic to asymptomatic cases and infections remained uncertain. There was also a debate among scientists as to whether there was true asymptomatic transmission, or transmission by pauci-symptomatic people, (ie, those with few or mild symptoms."

And you say this:

"Early CRIPs for COBR, which at that time was chaired by Mr Hancock, noted the likelihood of asymptomatic transmission ..."

And again, are you clear about that?
A. Yes.
Q. Now, you then also referenced I think the emerging literature that was supporting asymptomatic transmission and given one example there from 30 January of a journal (sic) published in The New England Journal of Medicine?
A. Yes.
Q. Thank you.

And then, again, the Inquiry has heard some evidence from both Professor Fraser and Sir Paul Nurse as to what their search is at the relevant time, from February

through to March, was identifying as to the significance of asymptomatic transmission and testing.

Can we then, please, move to 11 February. You reference then:

"... SAGE 6 recorded that 'Peak infectivity is probably around the start of symptoms onset', and that 'Virus shredding may reach significant levels just before onset of symptoms and continues for 1-2 days after ...'"

And you then say that:

"The revised [reasonable worst-case scenario] ..."

Is that what RWCS --

A. Yes.

Q. "... discussed at SAGE 11 on 27 February 2020 stated that: '80% of the UK population may become infected, with an overall 1% fatality rate in those infected. Only a proportion of those infected will experience symptoms' ..."

Is that correct?

A. Yes.

Q. And again, we've heard some evidence about PCRs, but can you just explain, when you talk about virus shredding and the levels at one to two days, can we just, again, have that in complete layman's terms, that would assist a layperson at a SAGE meeting, to explain complex

medical concepts to someone that does not have a scientific or medical background?

A. Yes, so viral infection starts, you catch the virus, and at that point you may have very few viral particles. So you wouldn't pick that up. But quite quickly the virus replicates, and as it replicates, you start shedding some of the virus, and that's when you become infectious to other people.

And what this tells us is that the shedding of virus, the virus actually coming out of your nose or mouth, is high before you get symptoms, and that is when you peak infectiousness, around that time, before you get symptoms and during the first few days of having symptoms. Which, again, indicates very clearly that there's going to be high viral shedding and therefore the test would pick up a positive case before you have symptoms.

Q. And so, again, the test here, would you agree, would be the PCR -- the polymerase chain reaction, PCR -- test was at that stage the gold standard for detecting a Covid virus? And is it right that it picks it up when that virus starts shredding happening, but also, as the gold standard, it also picks it up long after the infection has passed because it's still that sensitive?

A. Yes. So that was the only test that was available at

that time. It's very, very sensitive and, as you say, it will continue to pick up the shedding of virus even when you may no longer be infectious.

Q. Thank you.

And in terms of the way you are helpfully describing it and explaining it within the Inquiry, would you be explaining it in the same way to the relevant ministers, civil servants, and officials that were in the meeting, where they had come to SAGE and the experts and yourself for advice to inform their policy and decision making?

A. Yes, but also, in any department, and particularly the Department of Health, of course, there were many medical experts and many scientists who would be there to advise people on what this meant. And of course Public Health England experts as well. So there would be many places in which this can be explained.

Q. Thank you.

Now, continuing, please, with paragraph 514 on page 170, please, you tell us that on 13 March, in your interview with the Today programme on Radio 4, you said that:

"It looks quite likely that there is some degree of asymptomatic transmission. There's definitely quite a lot of transmission very early on in the disease when there are very mild symptoms."

A. Yes.

Q. And so, again, this is you making a public statement to assist the general public, and is there any doubt that you would have been saying the same things in the SAGE meetings and the advice provided to officials?

A. Well, there was no doubt what we were saying in the SAGE meetings. The previous minutes from 6 February make that clear, and this is what would have been said in all of the meetings that we had.

Q. Thank you.

Now can we go to the next paragraph, please, 515, you tell us then about SAGE 16, from 16 March:

"... it was noted that: 'Antibody testing is particularly vital to address the central unknown question of the ratio of asymptomatic to symptomatic cases'."

And you tell us that:

"This was in the context of a discussion on the importance of scaling up diagnostic testing to manage the epidemic."

You say:

"I made a similar point the following day in evidence to the Parliamentary Select Committee on Health and Social Care."

A. So the point here is, if you've been infected, the

presumption is you'd develop an antibody response, and therefore, by looking at the antibody responses in the population, you could work out how many people might have been asymptomatic throughout the entire duration of their infection. In fact, that turned out to be very difficult to get those data, but that was the idea.

Q. Thank you.

Can we then deal with 11 March, which is dealt with at paragraph 516, where you say this:

"I am aware that there appears to have been some confusion about the efficacy of testing people without symptoms."

And you describe that:

"On 11 March 2020 a WhatsApp exchange took place about a public statement concerning the Prime Minister's contact with Nadine Dorries MP ... who had tested positive for Covid-19. The proposed draft circulated at 10.15 ... contained a line saying that the Prime Minister did not have symptoms and would not be taking a Covid-19 test, as 'there would be no point in testing as it does not work on people with no symptoms'."

And you say this:

"I intervened to say that this was wrong: 'Not correct that the test does not work on people with no symptoms. It does and that's why we contact trace. In

this case it is the contact tracing that is the key to who gets tested'."

And so can I ask you then, just to give a bit more context, because Mr Hancock in particular has sought to detail the exchange that happened on 11 March, to explain his understanding as to what he was being told from the scientific advice he was being provided from others and from yourself on 11 March of 2020.

A. Well, I think this is very clear: that you test people who are contacts of those who had Covid to try and find out if they are infected, and that was going on in other places around the world, and there was a reason to do it in this country, as well, but of course, a negative test wouldn't absolutely guarantee that you hadn't been infected. So that's why an isolation period was in place for contacts, irrespective of whether they had a negative test. So the positive tell us you have got Covid; the negative doesn't absolutely assure you haven't.

Q. Thank you. Can we just please go to the text messages that were -- sorry, the WhatsApp messages, which were gone through with Mr Hancock this morning.

Please could I ask to be displayed INQ000102697, and it's internal page 15, please. That's INQ000102697. Page 15 -- sorry, 16. My format is slightly different.

Thank you.

Now, we can see, thank you, at the top of that page, we can see the exchange that's happened if you can see the -- perhaps if you read for yourself rather than my going through, it says:

"Having spoken to Chris Whitty and [Public Health England] people I'm with now, Patrick what you've said is not right.

"The clinical advice I've had is that the test is not reliable on people without symptoms. The reason is that there are so many false negatives when there are no symptoms that testing is counterproductive. Can the scientists please clear this up urgently?"

Then if we follow it down, we can see then Chris Whitty saying:

"Not reliable is correct. It can pick up some asymptomatic cases but not advised."

And then we can see, again, Chris Whitty saying:

"Patrick and I will do a joint note, not on WhatsApp, on testing."

And then if we go over the page, please, to page 17, you say at 10:47:22:

"Agree, 'not reliable'. Not 'does not work'."

So can we be clear about what you say this exchange represents, particularly in the context of the other

occasions when you had discussed the issue of pauci or no symptoms in testing.

A. Yes. Well, I was worried that the view that this didn't work would obviously mean you wouldn't use it at all for contact tracing. That was not correct. It did work, but it may miss people, and may give people a negative result who actually were infected. And that's then a policy choice as to whether you want to use that for contact tracing or not. And I think that's, to some extent, the exchange that Mr Hancock was presumably having with Public Health England officials and others.

LADY HALLETT: Was there any difference between your opinion and that of Professor Sir Chris Whitty's?

A. I don't think so.

MS CARTWRIGHT: Thank you.

If we then go back into your statement, please, we've used the underpinning document that Mr Hancock wished us to go through, but can we go back to your witness statement INQ000328826 at page 171, please. Again, what's using -- thank you. That's -- thank you.

We can see essentially you set out in your Module 2 statement the exchanges over WhatsApp that we've just looked at together.

Can we then go over the page to 172. And to paragraph 520, please. You say this:

"Following this exchange, I sent a message to the [Chief Medical Officer] asking if he could draft something on testing".

And in quotes again you've got:

"'It's not true to say it doesn't work. It can detect cases but would miss a lot and so isn't recommended'."

You say:

"Again this refers to using a negative test result to assert that someone is definitely not infected. The [Chief Medical Officer] expressed his agreement and commented that this was 'A classic example of why government by WhatsApp is not the way to deal with these kinds of things.'"

Is there any expansion you wish to say about that paragraph, please, Lord Vallance?

A. Well, I think it was clear that Chris Whitty would then make sure that within the Department of Health this position was clearly understood and that fact that the tests did pick up people who were asymptomatic, but not necessarily everybody who was positive who's asymptomatic, and could take that into account with their planning on what their policy should be.

Q. Now, can I ask you from your perspective where you have the Health Minister having, I think, some confusion or

needing clarity, when we looked at 11 March, can you help us in terms of on the range of whether that's concern or understandable depending on where the advice is coming from, your views, bearing in mind particularly that this is the relevant minister that's making policy and strategy decisions?

A. Well, I was obviously worried that he was getting advice that, or thought that he was getting advice that it didn't work, because that's incorrect. I was perfectly happy with the idea that he was getting advice that says it may not be reliable. That is correct. It may not pick up everybody. And those were important distinctions. So once that was clear, I was happy that he'd understood the position and that the people in the department were then reinforcing that.

Q. Thank you.

Then if we pick up the chronology, please, at paragraph 521, you say this:

"The issue arose again in April 2020, when I became aware that Mr Hancock had been saying that PCR testing did not work on asymptomatic individuals and that policy was being based on this."

Just pausing there, where had you been getting the information that Mr Hancock was repeating the similar position that had been expressed earlier in March?

A. I can't remember exactly but I think I was in a meeting where I heard this said again, and I think I again raised, "That's not correct", and I got the impression that then this was being promulgated as an idea in the Department of Health. So I wanted to speak to Chris Whitty just to be absolutely clear that we were on the same page as to what the situation was, and we obviously were.

But as a result of this, I decided that I needed to get something, again, written down so that there could be no ambiguity about what the position was. And I asked somebody within the Government Office for Science to do a piece of work to quickly document what the situation was. She did that that very day and the next day I sent the paper across to say: this is the position, can we please just make sure everybody is clear as to what this means?

Q. Thank you. Perhaps if I give some wider context to this timeframe that we're looking at, would you agree that it was a significant timeframe because decisions were made on 12 March 2020 by the government to move from 'contain' to 'delay', and so, if there was a misunderstanding about the virus and the testing, that could have been affecting policy decisions that were being made? I appreciate there's capacity, but would

you agree that that is a significant factor?

A. Well, I think it's a significant factor that I thought we'd put the issue to bed in March. I thought it was actually clear before that, but I thought we'd put it to bed in March and it obviously wasn't sorted out in some people's minds by mid-April.

I think the decision around stopping community testing was a very, very different decision. It was based, as I understand it, within the department on a very simple problem, which is there weren't enough tests to test people coming into hospital.

Q. Thank you.

A. And that therefore there were people coming into hospital with doctors unable to ascertain whether they had the disease. That was a pragmatic decision to use the tests quite rightly, in my view, for people who were ill with Covid.

Q. Thank you. Now, you've just detailed what is set out in paragraph 521. You exchanged those messages with the Chief Medical Officer on 13 April, and again, you confirmed that while the test was likely to be less sensitive in asymptomatic people, it was not correct to say that it did not work. And you added:

"... while it was not known whether it was helpful or not to test asymptomatic people, South Korea was

doing so."

And you detailed that:

"The [Chief Medical Officer] expressed agreement and said that he had changed a document to reflect this."

Can you give us any more detail? What was the document that he had changed to reflect this? Does that suggest --

A. I think it was probably their testing strategy document. I can't remember exactly which document it was.

Q. And again, we've looked, in the Inquiry, I'm not going to take you to testing strategies, we know there's a lot of documentation as to testing strategies as it evolved to the strategy of NHS Test and Trace were evolving over April.

You then go on to tell us and say you think that the paper that was produced, if we could just briefly display that, it's INQ000871777. That's INQ000871777. Apologies for the delay. Thank you.

So is this the paper, if we scroll down, where it was the clarity as to what you've said around that you could be -- there was a value to PCR-testing even individuals who were asymptomatic because it would pick up those that had the virus?

A. Yes.

Q. Thank you.

Now, if we go back to your statement, please, at paragraph 522, at page 172, you say this:

"The following day, 14 April, I sent an email to others in [the Government Office for Science] asking for some work to be done on this topic. I was unsure where Mr Hancock was getting his advice from ... and I wanted a definitive position documented. This led to an academic secondee to the SAGE Secretariat producing a rapid review paper ..."

Which we've just looked at together.

"... which laid out the evidence. It concluded that 'PCR screening of asymptomatic individuals is not only possible, but useful and being employed elsewhere'. I subsequently provided the paper to the [Chief Medical Officer], saying that I thought it was important that Mr Hancock see it as 'He is firmly under the impression that tests don't work in asymptomatic people and this is clearly wrong'."

You go on to say:

"In a later email I added that I thought there was a 'pretty high rate' of asymptomatic in infection in older people, and that this meant that 'testing was important and that isolation on return from hospital should probably be for all, not just the symptomatic'."

You say:

"The CMO took the matter forward and I understood that the relevant policy, the social care plan, was changed as a result so that everybody leaving hospital for a care home would be tested."

A. Yes.

Q. So, in terms of your expression or view, or what your account is, because, again, Mr Hancock was at pains to say about his views about confusion and advice, can we be absolutely clear about what your position is about Mr Hancock's knowledge and understanding around the value of testing of asymptomatic or pauci-symptomatic individuals on 14 April before this note was shared?

A. Well, I think all of this is backed up with documentary evidence. This is the advice that was given.

What I can't comment on is what advice he might have been getting from within the department, and therefore I don't know what else he may have heard. And he certainly had a lot of people from Public Health England and elsewhere who would be advising him on a day-to-day basis and feeding in the scientific advice. But this was the very clear position and it was the one that SAGE had discussed as well.

Q. Thank you.

Can I ask you, the document we looked at very briefly that had been drafted by the member of the

secretariat of SAGE, did Mr Whitty have any input into that document or was that a separate document that was then provided to Mr Whitty?

A. It was provided to him.

Q. Thank you.

A. I mean, I had just got frustrated by the fact that this kept getting repeated and just wanted something that was absolutely clear that everyone can have one version of, and that's why this paper was produced.

Q. Thank you.

I'll just complete the topic with your 523 before briefly taking you to an email exchange that Mr Hancock dealt with this morning.

You say this at 523:

"I am asked about the extent to which concerns about the reliability of testing of asymptomatic people affected the response to Covid-19. What was evident from an early stage, and was made apparent in the science advice to ministers, was that asymptomatic infection and transmission were possible and even likely but we did not know the proportion of asymptomatic infection. As described above, I sought to correct a misapprehension on Mr Hancock's part that the PCR test 'did not work' on asymptomatic patients. I do not know where this incorrect advice came from or why it was so

firmly adhered to."
A. That's correct.
Q. Now, can we display next, please, briefly there's a whole number of emails and documents that I went through with Mr Hancock this morning, but can we display INQ00093326.
That's INQ00093326. And if we can move to page 3, please, of this document. Thank you.
Now, the owner of the cellphone -- this is Mr Hancock's messages, and we can see at 8.16 he details:
"Chris Whitty has done an evidence review and now recommend testing of all going into care homes, and segregation whilst awaiting result. This is obviously a good positive step & we must put into the doc."
Then the clarification:
"Just checking -- this includes all the asymptomatic too, right?"
Obviously you're not on copy to these, but it seems to be -- it evidences the debate you've already told us about and what led you to provide the note from the SAGE secretariat to inform and give the absolutely clarity as to your position; is that correct?
A. Well, it looks like it. I don't know what these are. This is a policy discussion, and they're taking

into account the advice that's been given.
Q. Thank you. I'm not going to take you through all of the exchanges that Mr Hancock produced and we went through this morning, as to emails, to evidence, how that informed the change in policy, but can I ask you, because there was a suggestion that on 11 March, the exchange that we looked at, the WhatsApp, off the back of -- Nadine Dorries exchange, if we call it that, that Mr Hancock was saying that he had expected a paper from yourself and Mr Whitty and that the next he heard anything in reality was 14 April.
So some suggestion that had there been any ambiguity about confusion or what he needed to know, he would have expected a paper sooner than 14 April.
Lord Vallance, is there anything you wish to say to respond to the evidence we heard this morning on that topic?
A. Well, I think we've just seen it: that I had an exchange with Chris Whitty saying: Is it now clear that asymptomatic people can test positive; it's just that not all of them test positive?
To which he said: Yes, we just looked at it.
And I said: Will you now deal with that in the department?"
Or words to that effect. So I think -- I think that

was dealt with.
Q. Thank you. Just excuse me, there's one document I need to go through with you and I've just mislaid it, so I do apologise, Lord Vallance, for keeping you waiting.
Thank you very much indeed.
Lord Vallance, the next topic I want to deal with, please, is -- it's using some entries from your evening notes. And can I apologise that we're revisiting your evening notes, and perhaps if I give some context to these, Mr O'Connor King's Counsel went through some of these evening notes in an earlier module, and perhaps if we clarify the context to them.
I think, first of all, you had never intended anyone to see these evening notes. They were personal reflections at the end of the day; is that correct?
A. Yes. I'm not even sure that they were really reflections; they were sort of spontaneous ways to decompress at the end of the day.
Q. I think Mr O'Connor described them as late-night musings.
A. Yes, that's probably accurate.
Q. So I apologise that we're going to go through some very brief entries that are selective from wider entries of those late-night musings, but can we please just work through the few brief entries that we have and then

there's a number of them that I just want to ask some questions, because they do identify a little of the timeline.
Now, this is the first one to be displayed on the screen but, just to give some context, the day before, on 1 April, there was an entry:
[As read] "Testing, testing. Testing still not in a good place. PM right getting tetchy about it."
Then if we move -- now, the following day we've got:
"Crick offered 300 scientists and got no response from [Public Health England] -- crazy! & letter came from Peter Ratcliffe."
We have helpfully had clarified, or I have, that Sir Peter Ratcliffe is a Nobel Laureate and perhaps one of the eminent experts in this area.
Can you give a little bit more context that might assist some insight into this late-night musing, please, Lord Vallance.
A. Yes, on 10 March I got a message from Sir Paul Nurse which outlined some of the science they were doing in the Crick that might be useful to Covid. I think I had a conversation with him at the time -- it was quite detailed -- about the types of science they were doing. And we also talked, I think, about testing.
Seven days later, Peter Ratcliffe sent a message

saying that they could help out, and what was needed. Which I sent on to Public Health England, and also spoke to Chris Whitty about it. And he answered a letter at that time as well. So that was a very valuable thing.

On 2 April or 1 April, I sent a message to Peter Ratcliffe saying I heard that the Crick was now up and running with testing, and he said yes, and then gave me a lot of details of what they were doing. And one of them was that they'd offered 300 scientists but had run into difficulties with Public Health England, who wanted their occupational health people and their contracting officer to do things, and he had no contact from the contracting officer.

And I think I wrote in a response to him that: on the face of it that sounds barmy, and I'll look into it.

And I did actually then speak to somebody in Public Health England that afternoon, and later on that same day Peter Ratcliffe came back and said:

"Thank you, the position at Public Health England may be moving and I did finally get through to the head of contracting."

And I think something did happen as a result of that.

Q. Thank you.

I think that partially answers some of the follow-up

questions I had, but, just to complete the topic on this entry, please, did you or the Government Office for Science have any involvement in promoting liaison with academics or practitioners in this sector?

A. Well, generally yes. If you'd look at two other things that I was doing at the time -- and again, my role was not operational, and I tried to stop that. I did get drawn into operational things with the Vaccine Taskforce and with the genomic testing. And if you look at both of those, my principles for the Vaccine Taskforce was to bring together academia, government, and the private sector, led clearly by one person, to try to make sure that worked. And on the genomic side, we founded COG-UK as a network of academic labs to do the genomic sequencing across.

So the academic community was very, very linked into what we were doing in the Government Office for Science.

Q. Thank you and I think it perhaps bears repeating, I think the position has been very clearly set out by the Government Office for Science that you and page provide advice to the Prime Minister and members of the cabinet and the department, but essentially you are not implementing policy or decision making or strategy. And would you also agree that on many occasions you were only being asked on a specific issue to give advice,

without being over the nature of the advice, just answering the question that was brought to SAGE?

A. Well, that was the SAGE remit. And as I say, in some cases, like vaccines and genomic sequencing, I also pushed hard for the sorts of things that I thought needed to happen. But yes, it is not an operational department, it's a very small department, and -- 50 or so people. And of course there are operational organisations like Public Health England, with 5,000 people or more, including many, many scientists, who operationalise these things, and policy departments, like DHSC, which make the policy.

Q. Thank you.

Then can I ask a follow-up question again by reference to this entry relating to the offer from the Crick. Could you assist as to what steps you took to ensure that government took such offers seriously?

A. Well, every time I got an offer from somebody that I thought was credible, I made sure Public Health England knew about it. And then of course it's up to them to make sure that they either take it or don't take it, as they are trying to design a system.

Q. Thank you.

Then can I capture then your view and assessment of the scientists and expertise that existed at the Crick,

and the capability and offer that they were making to government, as to your views of it as a helpful and useful resource or otherwise? Can we just, perhaps, contextualise your view?

A. Well, the Crick Institute is absolutely the top research institute in this area, not in infectious diseases but in general, in biomedical science, one of the top institutes in the UK. It's full of absolutely outstanding scientists, it's got a very well-funded structure, it's got core facilities that allow you to do things at scale where necessary, and it's got two Nobel prizewinners in it. It's an outstanding research institution.

Q. Thank you.

Can we then move, please, to the next entry from your evening notes, please:

"14 May 2020 -- meeting on test trace and isolate and for some reason neither chris nor I have been invited."

That's -- the Chris there, is it correct that that would be Mr Whitty?

A. [No audible answer]

Q. "Dido Harding is impressive and has finally got a grip on the TTI stuff."

Is there any information or context you would wish to give that assists in any way with this entry in the evening notes?

A. Well, I'd become extremely worried during March that the capacity and capability of PHE to do the testing that was required was lacking. And there may be all sorts reasons for that that you would need to ask them and their chief executive at the time, Duncan Selbie, about. But I was worried about it and there had been a push from Number 10 to have a much more determined approach to trying to get this scaled up.

I don't know how Dido Harding was appointed to this and I don't know how the actual structure was decided, but obviously at this moment I thought: thank goodness somebody is taking this seriously and trying to get on top of what we need to do to get testing scaled up and active.

Q. Thank you.

Can we then move, please, to the next entry of 18 May. We can see:

"TTI now talking about 500,000 tests/day.

"Must record that the reason that ONS is doing the study is that when I asked PHE to do it they said NO (April) and the issue of testing asymptomatic (or not testing) that was a pure DHSC refusal until I wrote the

email. Remember DHSC tried to stop."

And if you're able, Lord Vallance, is there any additional context you'd wish to give to this?

A. Well, there are two different things here. There was the issue of community testing, and community testing was about trying to get on a regular way an assessment of what was going on across the country, so it wasn't diagnostic testing, it wasn't test, trace and isolate, it was to try to work out where the infection was, how many people had it, how it was changing over time. And it was something that SAGE had asked for very early on.

In fact, if you go back to Exercise Alice from 2016, one of the exercises around this, that said that sort of thing needed to happen.

And we had said repeatedly that we need this information, and there was a very important meeting in April, I can't remember the date, when the person from PHS said, "We can't do it." And at that point we asked the Office for National Statistics and said, "Can you do it?" And they said, "Yes", so they took it on. That was an important part of it.

Q. Thank you.

Can we then move on to the next entry, please, from 27 May and again, Lord Vallance, we've already caveated that these are out of context, there are plenty of other

notes and it's not said that all of these entries represent everything you were making notes about relating to test, trace and isolate, but can I ask you about 27 May entry, sorry.

"TTI -- lots of 'lock them in filing cabinets' type approach to isolation. I said clearly that SPI-B said incentives more important than punishment to those who don't.

"PM agrees but DC"--

Pausing there, is that Dominic Cummings?

A. I should think so, yes.

Q. "... and Cx" -- is that the Chancellor?

A. Yes.

Q. "... very against regards 'fairness' is a big issue and the [Dominic Cummings] position undermines it. The meeting on TTI was a shambles only saved by Dido."

Again, is there any further context, if there is any, to provide -- (overspeaking) --

A. Well, I think it's clear from other entrants in my witness statement that behavioural science was very, very clear that incentives were more likely to work than punishment, and gave several examples of the types of incentives which can be practical help with isolation, it can be monetary help, it can be sick leave pay. There are a number of things that the behavioural

science indicated would help. But clearly in this meeting, it was one where people were going in another direction.

Q. Thank you.

Can we move, then, next to 6 July, please, where it's recorded:

"NHS T&T has now done what we said and set up a central team ('the Feds') to assist local responding (exactly what Germany did)."

Can I ask for clarity around this, and I don't know whether you can give further context, we've heard some evidence that in Germany they operate a system where, essentially, universities are on stand down but have an ability to agilely assist, which is part of the German federation system to scale up testing. Is that any relevance to the reference to the "Germany did" and "the Feds"?

A. Yes, well, it is partially, I mean, they have a Länder system, anyway, of government which is very decentralised, it is very different from the UK, and they had a system which brought together academia, industry, so they have a lot of diagnostic capability in industry in Germany, and they brought that together, but they then had a central team that could supplement that if needed, and that is what this is referring to, the

idea that you have local application, whatever that is. It could be government laboratories, it could be industry laboratories, it could be academic laboratories, and then supplement that with -- I've called them "the Feds" here -- to send people in when you have a need for more help.

Q. Can I just ask you, Lord Vallance, we've heard some evidence last week and touched upon it this week about the value of universities being utilised, and their laboratories, as a potential source for scaling up in future pandemics. Is there any view, perspective, input you'd like to provide on what was one view from Professor McNally indicated as a potential area where her Ladyship might wish to consider, bearing in mind the financial sums that would be needed to retain or supplement the universities that could provide that scaling-up role?

A. Yes. So one of the principles in the 100 Days Mission that we said was make the exceptional routine, in other words use things that are used routinely so you can scale them during an exceptional time.

And obviously we do have laboratories right the way around the country that could be used. I don't think we can assume that they would be able to do that in an emergency. That would need to be tested, and I think

Paul Nurse said that in his evidence, as well. The Crick, clearly, was able to do something. It wasn't contact tracing; it was doing testing and that part of it, but you'd need to test the ability of that.

I think it would be quite difficult to assume that all of that could be stood up. And it goes back to one of the points I made in Module 1, which is that exercises should really test the practical application of these things and the operationalisation, not just the theory.

Q. Thank you.

Can we move then, please, Lord Vallance to an entry from 27 July 2020, please. Thank you. It records:

"Dido pushed to get financial support for people to get tested in low socioeconomic groups.

"Rishi reacted strongly against that and said just basically ... 'just stop the social interactions'.

"My paper on how quickly this can take off should be listened to. Hancock came in and said delay the August 1st additional measures opening up.

"But the PM says that he wanted to stick with August 1st measures.

"Rishi is getting very excited about it all and suggested everyone gets tested at work.

"It's perfectly obvious to me this could get out of

control again.

"PM Dido was very robust.

"For Rishi, it is all about personal responsible and get the state out."

Again, quite a lot covered there, but can you summarise or break down anything else additionally to help us understand --

A. Given these are my ramblings, it's a bit difficult to know exactly what was going on, but I think the point -- if I remember correctly, the point that I think the Chancellor was making was that if you reduce social interactions and allowed people to go back to work and tested them at work, you might have a positive effect. I think that's what he was pushing for.

Q. Thank you. Can we then move, please, to 3 August.

A. Sorry?

Q. Sorry, I was asking if we can move on -- thank you.

The next note, please:

"[It was] pointed out that I pushed very early on to decentralise testing and be more like Germany. I put Crick in touch with PHE several times."

I think we have perhaps touched upon and dealt with this issue. Is there anything else, Lord Vallance you wish to say?

A. I don't think I have anything else to add to that.

Q. Thank you.

Moving on then, please, 6 August:

"People changing all the time -- eg no one knows who actually is in charge of Lighthouse labs: 'Like wading through treacle to see process from start to end of testing process.' Continues the operational mess confirmed that PHE has had its science stripped over past decade."

Sorry, "confirmed". I do apologise.

Anything to add clarification to --

A. I think, the Lighthouse labs are obviously set up under the TTI framework. There was advice being given into the Department of Health at the time, including scientific advice from others, I think John Bell and others were involved in this. I wasn't involved in this operational side of it and obviously in that meeting it was quite difficult to see who was actually leading this on a practical day-to-day basis.

Q. Thank you. Can we move then to the next day --

A. Which may be my fault, by the way. I mean, it may just be I just couldn't see it.

Q. And if it assists, Lord Vallance, we've heard evidence about the system and who was involved.

Thank you. 7 August:

"OMG, discussion with testing lead Emma Stanton.

She has no scientists on her team. Why oh why is DHSC at this stage at this point in the pandemic, spoke to Chris".

Again, is that Chris Whitty?

A. Yes.

Q. "... and have a plan to help her, but what a mess."

A. Well, I was obviously surprised that Emma Stanton, who I think actually was very good, didn't have the science support from within the department that I thought she required.

Q. Thank you.

We move on to 12 August, please, and in fact there's two entries for 12 August. We see:

"PM very agitated about getting new higher throughput tests going. Freaked out because apparently [the Chancellor] told him this morning there is no money for an SR."

Pausing there, what's an SR?

A. Spending review.

Q. Thank you.

"They have finally clicked on the issue of clock speed. Backward contact tracing only started yesterday but Dido is trying really hard."

Again, can you give any further --

A. I think maybe the only point I would -- I mean, because

some of this is about money but the point that would make is that backward contact tracing is something that is really important to pick up clusters and to stop clusters spreading, and was a repeated advice from SAGE right from February onwards that that is an important part of the system. So it was disappointing, to say the least, that backward tracing took quite so long to get started.

Q. Thank you. Then moving to the next entry for 12 August, please:

"Then 2 hours with PM, [Dominic Cummings], CMO, Case, Mirza and a couple of others in next 8/12".

A. I don't know what that means.

Q. "And Imran" -- and is that Imran Mirza?

A. No, Imran Shafi.

Q. Thank you -- "set us up well with some facts and figures and built from the what we know, what we don't know paper.

"Then did 4 big areas -- Behaviours, tracing the virus, outbreak management and is the NHS ready? We voted -- red, amber yellow.

"1st 2 got lots of reds and ambers."

Pausing there, what's the red/amber vote that's relevant here? Can you give any extra context to that, please?

A. Well, it sounds like it was a meeting where -- trying to look at what we knew in those areas and what was actually being operationalised and people were being asked to say whether we were, you know, green, all good, or red, not good at all.

Q. Thank you.

And then you say:

"Instincts of this crew is to go for more enforcement and punitive measures. We suggested more carrot ..."

Pausing there, who is the "we"?

A. That would be a SAGE recommendation.

Q. "We suggested more carrot and incentives required to make people take a test, self-isolate, etc but they always want to go for stick, not carrot."

Who is the "they" that preferred the stick to the carrot?

A. Well, I think in this case it would have been the decision makers for policy.

Q. Thank you.

Can we then move, please, to the next entry, 25 August.

"Interesting email exchange with Sue Hill ..."

Is that Dame Sue Hill?

A. Yes.

Q. "... and others that clearly says that the reason NHS labs weren't used for testing was that they were too expensive. You couldn't make it up."

So Lord Vallance, is that relaying some information you were provided with that had come from Dame Hill?

A. Well, I asked why we weren't using more regional labs, and the answer I got in an email from the same date is:

[As read] "One of the reasons that the NHS labs had not increased capacity was the cost of the testing needing further funding, et cetera. The recent approval by DHSC of the business case for the NHS to increase delivery to 100,000 is predicated on improvements in the cost/efficiency etc".

Q. Thank you. Can we move then, please, to 7 September.

"Chief constables have said current rules too complex and difficult to police.

"[Chancellor] blocking all notion of paying to get people to isolate, despite all the evidence that this will be needed."

Lord Vallance, is there any extra context --

A. I don't think there's any -- I mean, presumably that was in a meeting that I was at.

Q. Thank you, and Lord Vallance, we have also heard from the National Police Chiefs' Council and Mr Hewitt's views on the rules that the police had to enforce.

Thank you.

Can we move then to 10 September, please?

"Moonshot with PM."

Is this a reference to project Moonshot or Operation Moonshot, sorry?

A. Sorry, well I think this was rather alarming that the PM wanted to know what the figure of 265,000 was that he was being presented with as a success story. Was it the number of tests actually taken? The number of people tested, or both, or something else? And he didn't get a very clear answer from the TTI team and I must say found that slightly surprising.

Q. Thank you and we can see:

"Started off with what is happening with existing testing and why it is so constrained and people having to travel miles. A complete car crash. PM wanted to know whether figure of 265,000 was tests, people tested or both ... They just couldn't answer questions. It was alarming. .....[I/S] [Chief Medical Officer] and I agreed that this is a mess and his concentration on moonshot has caused the whole story to be about that rather than the cautious message about sticking to the rules."

Lord Vallance, is there anything else you can assist with by reference to this entry?

A. I don't think I have anything else to say on that.

Q. Thank you. If we can move then to 14 September, please:

"(Re PM) We got him to understand the need to separate the TTI and the moonshot. Have clear accountability for the latter. Stop talking about it and get TTI sorted out with priorities published."

Is there any --

A. Again, I think that's pretty clear.

Q. Thank you. Two days later, please, 16 September:

"Testing has the 'loo roll panic phenomenon' Where it is overwhelmed because people perceive shortage. Simon Stevens says NHS labs are at 100% capacity."

And is the "loo roll panic phenomenon" a reference to the public and how they stopped buying --

A. Yes, I mean, it was, just, I think, something -- somebody must have said that in the meeting, that -- obviously at the beginning of the pandemic everyone went and bought loo rolls and suddenly there weren't any loo rolls anywhere, and that's a sort of behaviour phenomenon and there's a worry that because the message was that testing was in short supply, people may go and get tested and use up all the short supply and we would end up with a problem. I think that's what this refers to.

Q. Thank you.

Lord Vallance, I have just four more entries and then I suspect I have utilised all of my time with you. If we can move to the next page, please, 25 September:

"PM, 'Punish people who won't self-isolate.'

"'Punish people who aren't doing the right thing.'

"'Close some pubs and bars.'

"We need a lot more punishments and a lot more closing down. **I put a message in chat that support an engagement very important to get adherence up.

"... PM ends with 'Massive fines massive fines'."

A. Well, I said in an earlier one that the PM was on the side of doing incentives. I mean, I think he would change quite a lot between meetings.

Q. Thank you.

And again, against the timeframe, we know the decisions that were being made around isolation payments, and also the enforceability of isolation that came in place in England first of all and then later in Wales.

We can move to the next entry, please, 25 September:

"PM obsessed with testing again. Wants to know why not ramped up and why is turn around slow?

"PM asks, 'Why is the orange line in the graph so wonky?' Dido explains that things happen that mean their performance is not linear ..."

Is that essentially just someone like myself that would struggle with interpreting the graphs when they are -- (overspeaking) --

A. Possibly, I can't remember the specific example here.

Q. "Are people actually doing isolation.

"I argued that low levels of isolation is the key.

"They of course go straight to enforcement.

"... PM says 'We must have known that this wasn't working -- we have been pretending it has been whereas secretly we know it hasn't been.' Hancock lets out a big sigh. Hancock says other countries are asking him 'How have you managed to do this'."

Is there any other context you can give --

A. Well, this was a very fraught time, when the prevalence was going up pretty fast, and it looked like things were getting out of control and would get out of control to the extent that further very serious restrictions would need to be placed, and I think this reflects some of the anxieties at that time.

Q. Thank you.

And finally on the evening notes, 28 October, please -- sorry, there's two more, I do apologise, I bring false hope. 28th October:

"Dido gave a rather upbeat assessment of where T&T is. How correct is this? They now have a support

package in place for isolation & are calling people (they say 15-50% adherence). PM completely obsessed with testing as the solution even as numbers so bad that is obvious more action is needed"?

A. Well, there's two things to say here, it's really important, as we talk about testing, to remember testing was only done for a purpose, and the purpose in this case is to isolate and try to make sure that the isolation occurs. If the isolation isn't happening, then the testing isn't really doing what it's supposed to be doing.

And again, this is at a time when the prevalence was going up very fast, and I've made the point in previous modules that test, trace and isolate doesn't work when the prevalence gets so high that it's stamped. It stops being effective.

Q. Finally, just the last entry, please -- in fact it's 7 January 2021, I'll just read this:

[As read] "PM meeting. Testing. Testing performance looks much better. Now the challenge is self-isolation. Dido is saying we need to get better schemes in place to help people isolate. PM says 'We haven't been ruthless enough, we need to force more isolation, I favour a more authoritarian approach'. Rather late in the day, the PM isn't understanding that

incentives (or removal of disincentives) need to be in place to help people. Those instincts are punishment, not help. Sounds like a good testing system is gradually coming together and will be ready when lockdown released."

Is there anything --

A. I think that was the position.

Q. And perhaps, Lord Vallance, that's our time together up and an appropriate place to end. Can I thank you for answering my questions.

My Lady, there are no Core Participant questions.

LADY HALLETT: There are no more questions for you, Lord Vallance. I think it's probably the last time we've going to place the burden on you. I'm truly sorry, because I do understand how difficult it must be. I appreciate you are now in a different role but thank you so much for all the help that you and your colleagues have given to the Inquiry. And maybe as a minister, you may be able to be in a position to help implement any recommendations I make.

THE WITNESS: I hope I will be. Thank you.

LADY HALLETT: Thank you so much for your help.

Very well. I shall finish now and I shall return for a 10.30 start on Tuesday, 27 May.

MS CARTWRIGHT: Thank you, my Lady.

LADY HALLETT: I hope people get a decent weekend.

MS CARTWRIGHT: Thank you.

(4.17 pm)

(The hearing adjourned until 10.30 am on Tuesday, 27 May)

I N D E X